

## TRANSLATION

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

March 2017 – Appendix 530

### **HEALTH INSURANCE POLICY FOR FOREIGN WORKERS**

If this policy has been purchased and it is stated in the policy schedule, as aforementioned, the insurer will indemnify the insured for the costs of medical services and/or payments to service providers and/or medical institutions providing the health service in respect of an insured event and/or compensation to the insured, subject to the terms, conditions and exclusions as defined and detailed in the policy wording, during the period of insurance and up to the limits of liability of the company, in accordance with the terms and conditions of the policy. Any use of the masculine and/or the singular will have the same meaning, respectively, in the feminine and in the plural.

#### **SECTION A – DEFINITIONS AND GENERAL CONDITIONS**

##### **1. DEFINITIONS:**

**In this policy the following terms will have the meaning ascribed to them:**

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| 1.1 | <b>“The company / “the insurer”</b> | Ayalon Insurance Company Ltd.   |
| 1.2 | <b>“The insured”</b>                | A person currently staying in the State of Israel as a foreign worker, or who is intending to stay in Israel as a foreign worker, who is employed by the policyholder and/or any of their family members stated in the proposal form, provided that they are staying with the foreign worker in Israel. |
| 1.3 | <b>“The policyholder”</b>           | The employer, being a person, group of persons or company, arranging the insurance policy with the company, and whose name is stated in the policy as the policyholder, and who wishes to insure the foreign worker under this policy.  |
| 1.4 | <b>“The policy”</b>                 | The insurance contract between the insurer, the policyholder and the insured, the   |

employee of the policyholder, comprised of the schedule, appendices, the inception date of the period of insurance, the expiry date of the period of insurance, the premium amount, the payment dates etc.

- 1.5      **“The proposal form”**      The proposal form in the insurer’s standard format, being fully completed including the health declaration, declaration of the date of entry into Israel and a waiver of medical confidentiality, signed by the insured and by the policyholder in the appropriate place.
- 1.6      **“Heath declaration”**      A form containing a declaration of health and a waiver of medical confidentiality signed by the insured.
- 1.7      **“Policy schedule”**      The page attached to the policy and constituting an integral part thereof, containing amongst other things, personal details of the insured and the terms required to tailor the insurance policy to the conditions of the insurance contract for the insured. In the event of any discrepancy between the policy conditions and the conditions stated in the policy schedule – that stated in the policy schedule will prevail.
- 1.8      **“Premium”**      The amounts that the policyholder pays the insurer for the insurance cover under this policy, in accordance with the terms and conditions of the policy.
- 1.9      **“Insured event”**      An event during the period of insurance in which the insured needs medical treatment in Israel which is covered under this policy, and provided that the medical treatment is provided during the period of insurance and/or within 90 days of the expiry date of the period of insurance, all subject to the terms, conditions and exclusions detailed in this policy.
- 1.10     **“Medical certificate”**      A medical certificate as detailed in article 1B of the Foreign Workers Act, as defined

hereunder and/or a medical certificate confirming that the employee has undergone a medical examination in Israel, at the request of the insurer.

- 1.11 **“General hospital”** **An institution in Israel recognised by the competent authorities as a general hospital and serving solely as a general hospital,** other than an institution which is a sanatorium and/or rehabilitation centre.
- 1.12 **“The usual payment”** Payment, including a bond or deposit, incurred by the insured for the provision of the actual medical service, which is stated in the second and third amendment to the National Health Act on the inception date of the period of insurance or by notice regarding terms and payments that the state permitted to specify on the determining date in accordance with the National Health Act or Health Funds Act in accordance with article 8 (A1) of the Health Insurance Act, which have been approved in accordance with article 8 (A2) of the same act, and if the different directives contain different payments for the same medical service – the higher of the two.
- 1.13 **“Abroad” / “Outside of Israel” / “Overseas”** Anywhere outside of the State of Israel including whilst in transit to and from Israel.
- 1.14 **“Israel”** The boundaries of the State of Israel other than any transportation means to and from Israel, including the occupied territories but excluding the territories occupied by the Palestinian Authority.
- 1.15 **“National Health Act”** The National Health Act – 1994.
- 1.16 **“The Foreign Workers Act”** The Foreign Workers Act (Illegal Employment and Ensuring Fair Conditions) – 1991.
- 1.17 **“Service card”** A card issued by the insurer in addition to the policy containing the personal details of the

insured, which the insured will present to any medical institution in order to obtain the medical service.

- 1.18     **“Medical institution”**     A hospital or a clinic including a medical institute, laboratory, diagnostic centres, pharmacies.
- 1.19     **“Emergency medical situation”**     Circumstances in which a person’s life is in immediate danger or whether there is an immediate risk of severe and irreversible disability if urgent medical treatment is not provided.
- 1.20     **“Existing condition”**     Impairment, birth defect, including hereditary illnesses and/or a health condition and/or medical phenomenon and/or disease, either if treated or not, and/or their consequences, either directly or indirectly, which is caused and/or is worsened by a health condition that existing before the inception of the insurance, subject to the insured’s health declaration and/or medical certificate, all subject to that stated in clause 3.1.4 hereunder.
- 1.21     **“The service providers”**     A public hospital and doctors and/or a medical institute having a contract with the insurer **from who the insured be entitled to receive the medical services detailed in this policy and from them only, all subject to the terms and conditions of the policy.**
- 1.22     **“National Health Basket”**     As defined in the National Health Act.
- 1.23     **“Foreign worker”**     A person working in Israel who is not an Israeli citizen or resident.
- 1.24     **“Foreign Workers Ordinance”**     The Foreign Workers Ordinance (Prohibition of Unlawful Employment and Assurance of Fair Conditions) (Health Services Basket for Employees) – 2001.
- 1.25     **“Doctor”**     A person holding a qualification in medicine and who is legally authorised to work as a

doctor in Israel.

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| 1.26 | <b>“Attending doctor”</b>                    | A general practitioner, who is not a specialist, as well as a specialist in family medicine and/or internal medicine and/or gynaecology.                                |
| 1.27 | <b>“Health / medical services”</b>           | All of the medical services which the foreign worker is entitled to receive in accordance with the conditions of this policy.   |
| 1.28 | <b>“Primary healthcare services”</b>         | Services provided by an attending doctor as defined above.  |
| 1.29 | <b>“The period of insurance”</b>             | The period stated in the policy schedule attached to the policy, which will not exceed 12 months from the inception date of the period of insurance.                    |
| 1.30 | <b>“Single period of employment”</b>         | The entire period of work of the insured, even if it is not consecutive, in which employment relations exist between a specific employer and a specific foreign worker. |
| 1.31 | <b>“Health Services at Work Regulations”</b> | The Parallel Tax Regulations (Health Services at Work) – 1973.  |

## **2. GENERAL CONDITIONS:**

### **2.1. The liability of the insurer:**

2.1.1. The liability of the company is stated in the policy schedule and in the National Health Act – 1981.

2.1.2. The liability of the company will be valid for an insured event which occurs during the period of insurance only.

### **2.2. Duty of disclosure:**

The cover under this policy has been provided based on the written replies and declarations to the questions provided to the company by the policyholder and the insured or on their behalf, as applicable, and attached to the policy. Their accuracy constitutes a fundamental condition for the validity of the insurance cover.

If the insured and/or the policyholder provided replies which are not full and honest to the questions relating to their health condition, lifestyle, the

profession and occupation of the insured and/or withheld from the company a material fact that would have influenced their acceptance to the insured and/or the acceptance conditions – the following directions will apply:

2.2.1. If the company becomes aware of the matter before the insured event has occurred, the company will be entitled, within 30 days of becoming aware, to cancel the policy by written notice to the policyholder and/or to the insured.

If the company cancels the policy by virtue of this clause, it will refund to the policyholder the premiums paid to the company for the period after the cancellation, after deducting the expenses of the company, other than if the insured acted with fraudulent intent.

2.2.2. If the company becomes aware of the matter after the insured event has occurred, the company will make reduced indemnity payments at the ratio between the premium stated in the policy and the premium that would have been charged by the company if the said facts would have been brought to its attention, and will be entirely exempt in any of the following situations:

2.2.2.1. The non-disclosure of facts was made with fraudulent intent.

2.2.2.2. A reasonable company would not have entered into such a contract even at a much higher premium if it would have been aware of the true facts. 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.

2.2.3. **Negation of remedies:**

The insurer is not entitled to the remedies detailed in this policy in any of the following cases other than if the incomplete and dishonest reply was provided with fraudulent intent:

2.2.3.1. It knew or should have known of the actual situation at the time of arranging the contract or if it caused the incomplete and dishonest reply to be provided.

2.2.3.2. The fact regarding which the incomplete and dishonest reply was provided ceased to apply before

occurrence of the insured event, or did not affect the insured, the liability of the insurer or its scope.

2.2.4. The insured must prove their date of birth by providing a certificate to the satisfaction of the company. The date of birth of the insured is a material fact, on which the duty of disclosure as aforementioned applies.

### 2.3. **The validity of the policy**

This policy will take effect only after the first premium has actually been paid. This condition will not apply if the insurer has received payment means to collect the insurance premium. If any premium is paid to the company before the insurer has given its agreement to arrange the insurance, the payment will not be construed as the agreement of the insurer to arrange the insurance. In such a case, within 90 days of the date of receiving the first premium, the insurer will send a decision stating whether the proposer has been accepted to the insurance or not, and will send, as applicable, an insurance policy including the policy schedule or a declinature notice stating that the proposer has not been accepted to the insurance and that they have no valid cover in force, or a request for supplementary information or a counter-quotation. If the insurer does not send a declinature notice or a request for supplementary information or a counter-quotation as aforementioned within 90 days of the date of receiving the first premium, the insured will be considered to have been accepted to the insurance at the conditions stated in the proposal form. If an insured event occurs affecting the proposer for the insurance in the period between receiving the first premium and the decision of the insurer concerning acceptance or declinature to the insurance, and in accordance with the applicable medical underwriting directives of the insurer for proposers to the insurance with similar characteristics, the insurer would have notified the proposer to the insurance, after completing the underwriting process, that they have been accepted to the insurance (were it not for occurrence of the insured event), the proposer for the insurance will be entitled to cover under the policy for the insured event, this being subject to all other terms, conditions and exclusions of the policy.

### 2.4. **Health declaration**

2.4.1. The policyholder must send a health declaration and a waiver of medical confidentiality form to the insurer, signed by the insured, instructing its doctors and/or any medical entity or institute either in Israel or abroad and/or the National Insurance Institute and/or the Ministry of Defence and/or any other

government ministry and/or insurance company and/or health funds to provide the insurer will all reasonable medical information concerning the insured in its possession.

2.4.2. The policyholder will arrange for the insured to sign a health declaration and waiver of medical confidentiality form that the insurer will provide in a language that the insured understands, signed by the insured, together with a declaration by the policyholder that the waiver of medical confidentiality form has been signed by the insured after having explained the content to them in the language they understand and/or that the insured has signed the waiver of medical confidentiality form after reading its contents in a language they understand.

## 2.5. **Premiums**

2.5.1. The policyholder and/or the insured must pay the premiums due as stated in the policy schedule for each of the insureds, for the period of insurance of each of the insureds, being adjusted as stated in clauses 2.5.4 and 2.5.5 hereunder.

2.5.2. The premium will be paid in advance for each month or other agreed period of time in the period of insurance, on the first of each month or each agreed period of time, or on any other date in the same periods, respectively, as will be decided on by the company.

2.5.3. If the premium is payable by direct debit or credit card, or any other payment method agreed with the company, to credit the account of the company, then crediting the bank account of the company on the respective date by the bank will be considered as payment of the premium on the same date or crediting the account of the insurer by the credit card company.

2.5.4. The premiums and sums insured will be linked to the rate of increase in the index, between the base index and the latest index published before each payment is made, on the dates stated in the policy schedule.

2.5.5. If any premiums are not paid on time, in addition to indexation increments as stated in clause 2.5.4 above, interest will be added at the standard rate applicable at the time of payment on current loan accounts, from the date the payment arrears is generated until the actual payment by the insured.



- 2.5.6. If the premium and/or the amount in arrears is not paid in time, the policy will be cancelled in accordance with the Insurance Contract Act – 1981.
- 2.5.7. **The company will be entitled to amend the premium and the conditions of this policy for everyone insured under the policy. Such an amendment will take effect provided that the Commissioner of Insurance of the Capital Market, Insurance and Savings Division of the Ministry of Finance has approved it in advance. If the premium is amended as aforementioned, the new premium will be calculated without taking into account any change that has occurred to the health condition of the insured during the period that preceded the said amendment. The company will notify the policyholder in writing 60 days in advance of any change which has been approved to the insurance plaintiff in accordance with this clause, with full disclosure of all increases or developments expected in the tariff or in the scope of the insurance cover.**

## 2.6. Claims

- 2.6.1. Notice of an insured event must be submitted to the insurer in a reasonable time and as soon as possible by sending a letter or a fax. All of the details regarding the insured event must be attached to the notice which will be sent to the insurer to enable it to obtain all of the information it requires.
- 2.6.2. The policyholder and/or the insured must attach to the notice of the insured event all of the relevant medical documents relating to the insured event, including diagnoses and an anamnesis (history) of the event and if any payments have been made by the policyholder and/or the insured – original receipts of the payment or if the original receipt is not available – a copy attaching an explanation of where the original receipt has been sent and confirmation from the recipient of the payment of the amount they have paid to the insured for these documents or attaching a reasonable explanation of where the original documents were sent and details of why they are unable to provide them.

## 2.7. **Medical examination**

The insured will be required at the request of the insurer to attend a medical examination by a doctor appointed by and paid for by the insurer.

## 2.8. **Cancellation of the policy**

2.8.1. If the insured and/or the policyholder do not pay or have not paid the premium on time, the insurer will be entitled to cancel the policy in accordance with the provisions of the Insurance Contract Act - 1981 (hereinafter: “the Insurance Contract Act”).

2.8.2. If the policyholder cancels the policy before the expiry of the period of insurance due to the termination of the period of employment of the insured by the policyholder, the insurer will refund the proportional share of the premium to the policyholder for the period in which the cover is no longer in force, subject to its duty in accordance with the Insurance Contract Act.

2.8.3. As regards clause 2.8.2: The proportional share of the premium will be refunded to the policyholder for the period after the insured’s card has been returned to the insurer and in the event of cancellation within less than two months from the inception date of the period of insurance – handling fees will be deducted from the proportional share of the premium which is refunded, equivalent to the premium for two months covered under this policy.

2.8.4. If the insured withholds a material fact from the insurer as stated in clause 2.2 above – the policy may be cancelled in accordance with the provisions of the Insurance Contract Act.

2.8.5. If the insured acted intentionally to prevent the insurer from clarifying its liability or interfered with it, the insurer will only be liable to pay the amount that it would have paid if nothing had been done.

2.8.6. The policyholder and/or the insured are entitled to cancel the policy by written notice to the insurer at any time.

## 2.9. **Extension of the period of insurance**

2.9.1. The insurer undertakes to extend the period of insurance for the insured, consecutively, at the request of the policyholder or the insured to the insurer on expiry of the period of insurance

provided that the premium for the period between the expiry of the original period of insurance and the extension period has been paid and for as long as the insured continues to work as a foreign worker in Israel for the employer.

- 2.9.2. The insured or the policyholder is entitled to renew the policy without repeating the underwriting process within 90 days.
- 2.9.3. In the case of an insured who is not entitled to an extension without repeating the underwriting process as stated in clause 2.9.2; the provisions of clauses 2.9.4 and 2.9.5 hereunder will apply. The provisions of clauses 2.9.5 and 2.9.6 will apply to any type of extension.
- 2.9.4. In any other which is not included in the cases detailed in clauses 2.9.1 and 2.9.2 – the policyholder is entitled to request the insurer to extend the period of insurance for a further period. Extension of the period of insurance will be subject to the standard underwriting process of the insurer and subject to the prior written confirmation of the insurer. It is hereby clarified that at the end of the period of insurance, as defined in the policy, the policy will not be automatically extended without its agreement as stated in this clause within the period of time stated in clause 2.9.4.2 hereunder, even if the policyholder and the insured offered the insurer to extend it in any other manner.
  - 2.9.4.1. The policyholder is entitled to request an extension of the period of insurance (hereinafter: “the extension request”). The extension request will be sent to the insurer by post at least 30 days before the expiry of the period of insurance.
  - 2.9.4.2. If the insurer agrees to extend the period of insurance – the insurer will notify the policyholder in writing of its agreement. The letter will be sent to the policyholder within 20 days of the date of receiving the extension request. If the insurer agrees to extend the period of insurance, the continuity of insurance for the insured will be maintained including the first date as defined hereunder in the framework of the existing situation.
- 2.9.5. The premium for the additional period will be calculated in accordance with the number of days extension according to the

premium tariff of the insurer which applies on the commencement date of the extension.

2.9.6. The insurer will be entitled to amend the premium on the commencement date of each extension of this policy.

**2.10. Changes to the health services:**

**2.10.1. The insured will be entitled to the services contained in the basket of health services, the basket of medications and the basket of services at work, as defined hereunder with amendments which may be made from time to time:**

**2.10.2. If there are any changes to the basket of health services and/or the basket of medications and/or the basket of services at work and/or to the Health Act and/or any other ordinance and/or directive after the inception of the period of insurance (hereinafter: “the new health basket”), the insurer will notify the policyholder and/or the insureds regarding the changes that have occurred to the basket of health services and/or the basket of medications and/or the basket of services at work and/or the Health Act and/or any other ordinance and/or directive after inception of the period of insurance, and will be entitled to amend the policy and the premium including by way of requesting an additional premium if required following the said change.**

**2.11. Indexation conditions**

The premiums and sums insured stated in the policy are linked to the rate of increase in the index – from the base index to the latest index published before occurrence of the insured event.

**2.12. Payment of the premium, taxes and levies**

The policyholder or the insured will pay the premium and all statutory and other taxes applicable to this policy or which are imposed on the premiums and all other payments which the insurer is liable to pay in under the policy – either if these taxes applied at the time of arranging the policy or if they were imposed at any subsequent date.

**2.13. Notices**

The policyholder must notify the insurer of any change of address in writing. Notice which is sent by the insurer to the last known address of

the policyholder will be considered as notice which has been duly delivered.

**2.14. The insurer is not liable for the errors and/or omissions of the service providers**

The insurer will not be liable in any way for the quality of the medical services and/or others provided to the insured in the framework of this policy. The insurer is not liable for any direct or indirect loss or damage to the insured and/or to any other person due to the decisions of the insured and/or referring the insured to the medical service providers and/or others and/or due to the professional negligence of the service providers.

**2.15. Legal prescription**

The prescription period in respect of a claim for indemnity payments due to an insured event covered under this policy is 3 years from the date of the occurrence of the insured event. If the cause of the claim is disability of the insured due to an accident as stated in section D hereunder, the prescription period will start to be calculated from the date on which the insured's right to claim benefits in accordance with the Insurance Contract Act is established.

**2.16. Insurance Contract Act**

The provisions of the Insurance Contract Act - 1981 will apply to this policy.

**2.17. Situate and jurisdiction**

The sole and exclusive seat of jurisdiction for any matter connected to and arising from this policy will be the competent courts in Israel and in accordance with Israeli law, and no other court will have any jurisdictional authority in this regard.

The law applicable to claims arising from and/or connected to this policy is the Israeli law.

## **SECTION B – THE HEALTH SERVICES**

### **1. Subject to that stated in this policy, the insured will be entitled to the health services, all as detailed hereunder:**

#### **1.1. Basket of treatments –**

1.1.1. All of the services detailed in the second amendment to the National Health Act on the inception date of the period of insurance, which may be amended from time to time.

1.1.2. Hospitalisation services in a psychiatric hospital or psychiatric department of a general hospital, in a medical emergency situation, for a period of not more than 60 days in any single period of employment.

1.1.3. The following services –

1.1.3.1. Amniotic fluid tests for women over the age of 35 at the beginning of the pregnancy.

1.1.3.2. Vaccinations against tetanus, rabies and diphtheria.

1.1.3.3. Mantoux tests and lung x-rays.

1.1.3.4. Wheelchairs and walking frames.

#### **1.2. Basket of medication:**

All of the services detailed in the National Health Insurance Act (Medication in the National Health Basket) – 1995, applicable on the inception date of the period of insurance.

#### **1.3. The basket of services at work:**

All of the services detailed in regulations 2 and 5 of the Health Services at Work Regulations, in the manner stated in these regulations, with the requisite amendments on the inception date of the period of insurance.

#### **1.4. Special lump-sum compensation for workers in the care sector:**

1.4.1. In the period starting from 1.10.17 until 30.9.19:

Thirteen years after the employee first received a B-1 visa to work in the care sector – special lump-sum compensation of NIS 80,000 (linked to the US Dollar) for an employee who is unable to perform their work due to medical reasons as stated in clause 4 hereunder, provided that they have exercised their right to a

flight back to their home country as stated in clause 2 hereunder; the entitlement to the compensation will apply to an employee who at the time of the determination of the doctor as stated in clause 4 hereunder that they are unable to work, held a valid B-1 visa to work in the care sector or held a license as aforementioned at any time in the 12 month period that preceded the determination of the doctor as aforementioned.

1.4.2. In the period starting from 1.10.19:

Ten years after the employee first received a B-1 visa to work in the care sector – special lump-sum compensation of NIS 80,000 (linked to the US Dollar) for an employee who is unable to perform their work due to medical reasons as stated in clause 4 hereunder, provided that they have exercised their right to a flight back to their home country as stated in clause 2 hereunder; the entitlement to the compensation will apply to an employee who at the time of the determination of the doctor as stated in clause 4 hereunder that they are unable to work, held a valid B-1 visa to work in the care sector or held a license as aforementioned at any time in the 12 month period that preceded the determination of the doctor as aforementioned.

**The employee will be entitled to the lump-sum compensation in accordance with this clause solely if the determination of the doctor in accordance with clause 4 hereunder did not precede its commencement date, however will also apply in respect of a period of work that preceded its commencement date.**

## 2. Additional undertakings of the insurer

2.1. Subject to that stated in this policy, the insurer will pay all of the foreign worker expenses, all subject to the terms, conditions and exclusions of this policy –

2.1.1. **Usual payment:** For medical services covered under this policy, that the insured incurs in return for receiving them. **The insurer will not pay the usual payment in a situation where the medical service in respect of which the usual payment has been made is not covered under this policy.**

2.1.2. Cover will be provided for all of the expenses related to flying the insured from Israel to their country of origin including accompaniment or other special arrangements, at the time of the

flight in a case where the health condition of the employee necessitates this.

2.1.3. Corpse repatriation costs:

2.1.3.1. In the event of the death of the insured at circumstances which entitle them to medical service in accordance with the conditions of this policy, the insurer will pay the costs of repatriating the corpse from Israel to the country of origin.

2.1.3.2. Notwithstanding that stated in clause 2.1.3.1 above and in clause 3.1.7 hereunder if the insured dies in a work accident as defined in clause 3.1.7 hereunder, the insurer will pay the expenses for repatriating the corpse of the insured from Israel to their country of origin.

2.1.3.3. **The liability of the insurer in accordance with clause 2.1.3.1 and 2.1.3.2 is subject to receipt of the prior approval of the insurer and arranging the aforementioned flight via the insurer only.** If the insured or a representative of the insured does not contact the insurer to obtain its confirmation before the insured flies from Israel back to their country of origin, as aforementioned, the insurer will be entitled to reduce the payment to which the insured is entitled to the amount that the insurer would have paid if the insured would have contacted the insurer with a request for confirmation as aforementioned before arranging the flight.

2.1.4. Emergency flight for a close relative to come to Israel:

2.1.4.1. In this clause “**close relative**” means: wife, husband, son, daughter, brother or sister.

2.1.4.2. If the insured is hospitalised **under circumstances which entitle them to receive the medical services in accordance with this policy** for the purpose of undergoing an invasive surgical procedure with hospitalisation for more than 10 days or where the attending doctor determines that the life of the insured is in danger, the insurer will pay for a close relative the cost of purchasing a flight ticket to come to the place where the insured is hospitalised in Israel, up to



US\$ 1,500 and the cost of accommodation for up to 10 days in a hotel for up to US\$ 40 per day. **The undertaking of the insurer in accordance with this clause is subject to the flight ticket and the hotel accommodation being arranged via the insurer and approved in writing by the insurer in advance.** If the insured or a representative of the insured does not contact the insurer to obtain its confirmation for the aforementioned expenses, the insurer will be entitled to reduce the payment to which the insured is entitled to the amount that the insurer would have paid if the insured would have contacted the insurer with a request for confirmation as aforementioned.

- 2.1.5. Flight expenses in the event of incapacity to work: If a specialist doctor in the field of occupational medicine determines that the insured is unable to perform their work for which they have been accepted to work for the policyholder, and that they are unable to work for a period of 90 days from the date on which they were examined by the said doctor, even if they are provided with the medical treatment they need (hereinafter: “**incapacity to work**”), and all of this during the period of insurance, the insurer will pay the cost of a flight ticket to the country of origin of the insured up to the maximum sum of US\$ 2,000.

**The insurer will not pay the costs for a flight ticket as aforementioned in clause 2.1.5 above if the incapacity to work arises from circumstances which do not entitle the insured to the medical services under this policy, other than circumstances as stated in clause 2.1.5 above and 3.1.5 hereunder.**

2.1.6. **First aid dental treatment:**

2.1.6.1. The insured will be entitled to receive the emergency services and first aid dental treatments detailed hereunder and these services alone, in one of the nationwide dental clinics from the list which will be updated from time to time by the insurer, whose details can be obtained from the call centre of the insurer.

2.1.6.1.1. Extensive dental caries, temporary filling.

- 2.1.6.1.2. Open cavity in a tooth, temporary filling.
- 2.1.6.1.3. Exposed tooth neck, material for preventing sensitivity.
- 2.1.6.1.4. Acute infection – extraction of the nerve or embalming material.
- 2.1.6.1.5. Abscess from the source of the tooth, incision of the abscess and/or closure treatment.
- 2.1.6.1.6. Impacted food – gum treatment.
- 2.1.6.1.7. Infection under crown, rinsing and/or medication.
- 2.1.6.1.8. Pain following an extraction, pain relievers.
- 2.1.6.1.9. Pressure wounds underneath existing dentures, releasing pressure wounds.
- 2.1.6.1.10. Any other treatment provided due to tooth pain – pain relief treatment will be provided.
- 2.1.6.1.11. Examination and x-ray of painful teeth.
- 2.1.6.1.12. Issuing a prescription for pain relief medication if it is not possible to treat the tooth at the same time.

2.1.6.2. Notwithstanding that stated in clause 3.1.4 above, the insured will be entitled to the emergency services and first aid detailed in clause 2.1.6.1 above even if required due to an existing condition.

### **3. Exclusions to Section B:**

**3.1. Notwithstanding that stated in clause 1 and 2 above, the insurer will not pay cost and/or medical expenses in respect of the following services and the insured will not be entitled to these expenses and/or services in the framework of this policy –**

**3.1.1. In the framework of the basket of treatments**

**3.1.1.1. Psychological services.**

- 3.1.1.2. **Dead Sea treatments provided to psoriasis patients.**
  - 3.1.1.3. **Genetic testing.**
  - 3.1.1.4. **Hospitalisation in a nursing home or other long-term care type treatments.**
  - 3.1.1.5. **Services for treating impotence or sterility problems, sexual functioning disorders, male or female fertility as well as artificial insemination or artificial fertilisation.**
  - 3.1.1.6. **Services provided outside of Israel.**
  - 3.1.1.7. **An insured event which occurs after expiry of the period of insurance and/or consecutive periods of insurance as stated in the extension of the period of insurance clause.**
- 3.1.2. **In the framework of the basket of medication –**
- 3.1.2.1. **Medication for the treatment of Alzheimer's disease.**
  - 3.1.2.2. **Medication designated to treat impotence or sterility problems, sexual functioning disorders, male or female fertility or which is provided in the context of artificial insemination or artificial fertilisation treatment.**
- 3.1.3. **Pregnancy – Health services in connection with pregnancy during the first 9 months, accumulatively, in which there are employment relations between the employee and one or more employees in Israel, other than in the event of a medical emergency.**
- 3.1.4. **Pre-existing medical condition: Medical services which the insured needs due to a medical problem arising from a medical condition which preceded the first date on which any employer in Israel arranged medical insurance for them, and this for the first three years from the commencement date of the Foreign Workers Ordinance – 17.10.2001, or from the first date on which medical insurance was arranged for the insured, the latter of the two (hereinafter: “the first date”) if any one of the following two conditions exist:**

- 3.1.4.1.1. **The insured themselves has confirmed that the medical problem in respect of which they are in need of the service arises from a pre-existing medical condition.**
- 3.1.4.1.2. **A doctor confirms, in accordance with his findings, that the medical problem in respect of which the insured is in need of the service arises from a pre-existing medical condition.**
- 3.1.4.2. **If the insured spends time outside of Israel after the first date, for a period or periods exceeding 90 consecutive days for several employers, or for a period exceeding 120 consecutive days if the stay separated between periods of employment with the same employer – the first date, for the purpose of clause 3.1.4, will be considered to be the first date following the stay in which the employee was covered under medical insurance.**
- 3.1.4.3. **Medical services in the event of an emergency due to a pre-existing medical condition: Notwithstanding that stated in clause 3.1.4 above, the insurer will pay medical expenses for health services the insured needs in the event of a medical emergency arising from a pre-existing medical condition, in order to stabilise his medical condition until it is possible to continue to treat him outside of Israel as well as costs for other medical services the insured needs due to the same pre-existing medical condition, which the insured needs for a period of 30 days after the determination of the doctor as aforementioned or the determination of the medical condition as aforementioned.**
- 3.1.5. **Incapacity to work –**
  - 3.1.5.1. **Medical services that the insured needs after a specialist doctor in occupational medicine has determined that the insured is unable to perform the work for which they have been accepted to work for the policyholder, and that they are**

unable to work for a period of 90 days from the date on which they were examined by the said doctor, even if they are provided with the medical treatment they need.

3.1.5.2. Notwithstanding that stated in clause 3.1.5.1 above, the insured will be entitled to the medical services they need in a medical emergency to stabilise a pre-existing medical condition until their condition enables them to be treated outside of Israel, as well as other medical services they need for a period of 30 days after the determination of the doctor as aforementioned or the determination of the medical condition as aforementioned.

3.1.6. **Road accidents and hostilities – Medical services which the insured needs due to:**

3.1.6.1. **Road accidents as defined in the Road Accident Victims Compensation Act – 1975.**

3.1.6.2. **Hostilities, as defined in the Compensation for Victims of Hostile Act – 1970, if the insured was injured as defined in the same law.**

3.1.7. **Health services due to work accidents**

3.1.7.1. **The insurer will not pay costs for health services of the insured if the insured needs them due to a work accident, as defined in the National Insurance Institute Act [Combined Version] – 1995 (hereinafter: “work accident”) provided that the employer confirms, in the designated National Insurance Institute form (hereinafter: “the injury form”) that the said injury is a work accident.**

3.1.7.2. **If the employer provides an injury form and the National Insurance Institute does not determine, within three months of the work accident, that it was a work accident, the insurer will pay the costs for the health services which the insured needs due to the same work accident, within three months, even if they have not been provided by the service providers, and after three months, if provided by the service providers of the insurer.**

3.1.7.3. **If the injury arises from a work accident, the policyholder undertakes to confirm the injury as stated in clause 3.1.7.1 above on the National Insurance Institute injury form with a copy to the insurer within 7 days of the date of the work accident. If the policyholder does not provide the said confirmation and it is found that the injury was a work accident, as defined above, they [the policyholder] will pay all of the costs incurred by the insurer and will pay them with the addition of indexation increments and interest per legal provisions within 7 days of demand by the insurer.**

3.1.8. **Obtaining services from a service provider who does not have a contract with the insurer.**

**4. Rules for confirmation or determination of a specialist doctor – Pre-existing medical condition or incapacity to work**

4.1. The certification of a doctor that the medical problem in respect of which the insured needs medical service arises from a pre-existing medical condition and the determination of a doctor that the medical condition of the employee has been stabilised – will be provided by a specialist doctor. The determination of a doctor regarding incapacity of the insured to work, even if they are provided with medical treatment – will be made by a specialist in occupational medicine.

4.2. The 30 days mentioned in paragraphs 3.1.4 and 3.1.5 will only start to be counted from the date of the final certificate or final determination provided in accordance with clause 4.3 hereunder, however will not be viewed as final determination and determination regarding stabilisation of the medical condition of the insured, if a department manager in a hospital, in which the insured is hospitalised, or the deputy department manager – in the absence of the manager – that on the date when the entitlement of the insured to health services in accordance with the provisions of this policy, they have not yet attained medical stability. This determination will be binding for as long as no other determination has been made, either by the department manager or by their deputy as aforementioned.

4.3. The rules for approving or determining in accordance with clause 4.2 will be as follows:

4.3.1. The insurer will be entitled to ask the insured to undergo a medical examination by an expert it appoints, at the cost of the

insurer. The expert report of the doctor will be submitted to the insured together with a notice regarding the entitlement of the insured to a counter-expert report as stated in clause 4.3.2 hereunder together with details of entities or organisations that can assist them in obtaining such a report, who have given their agreement to do so.

- 4.3.2. The insured is entitled to a counter-opinion from a specialist doctor who they select, that will be submitted to the insurer within 21 days of the date on which the insured receives the specialist medical opinion from the insurer's doctor. The insurer will pay the fees for the counter-expert report up to the limit of liability that will be determined by the Director General of the Ministry of Health and the Commissioner of the Capital Markets, Insurance and Savings in the Ministry of Finance (hereinafter: "**the set fee**").
- 4.3.3. 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 engages 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 contacts 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 set fee and will be paid by the insurer.

## **SECTION C – SERVICE PROVIDERS AND SUBJECTING THE MEDICAL SERVICES TO APPROVAL**

### **5. The service providers**

**5.1. The medical services covered under this policy will be provided by the service providers only, subject to any change that the insurer will notify the policyholder of. If a service provider stops working with the insurer, the insured will contact the call centre of the insurer in order to obtain a referral to another service provider.**

**5.2.** The medical services covered under this policy will be provided to the insured according to medical discretion, at an adequate quality, within a reasonable time and a reasonable distance from the place where the insured lives.

**5.3.** Notwithstanding that stated in clause 5.1 above, the insured will be entitled to receive funding from the insurer for the medical services detailed above at the following circumstances:

5.3.1. Accident and emergency services at any general hospital in Israel, for any of the foreign worker events:

5.3.1.1. Any new fracture.

5.3.1.2. Severe dislodgement of a shoulder or elbow.

5.3.1.3. An injury which needs to be unified by stitches or alterative unification means.

5.3.1.4. Breathing a foreign matter into the respiratory system.

5.3.1.5. The penetration of a foreign matter into an eye.

5.3.1.6. Treatment of cancer.

5.3.1.7. Treatment of haemophilia.

5.3.1.8. Treatment of cystic fibrosis.

5.3.1.9. Transfer in an ambulance to an emergency room from the street or other public place, due to a sudden event.

5.3.1.10. Referral concluding in non-elective hospitalisation.

5.3.1.11. An emergency medical condition.



- 5.3.2. Hospitalisation services provided to the insured immediately after referral from the accident and emergency room, if given in the cases detailed in clause 5.3.1 above.

## **6. Obtaining the medical service**

### **6.1. Access to the various medical services will be subject to the prior approval of the insurer and/or approval by the attending doctor and/or freely, all as detailed hereunder:**

- 6.1.1. **The access to primary medical services covered under this policy will be free, and the insured will not be required to obtain the prior approval of the insurer before obtaining medical service of this type.**
- 6.1.2. **The access to non-primary medical service, other than in the cases detailed in clause 5.3 hereunder, will be subject to obtaining the prior agreement of the attending doctor in the primary medical services framework.** If the insured or a representative of the insured does not contact the insurer to obtain its confirmation for the aforementioned expenses, the insurer will be entitled to reduce the payment to which the insured is entitled to the amount that the insurer would have paid if the insured would have contacted the insurer with a request for confirmation as aforementioned.
- 6.1.3. **The access to imaging institutes, diagnostic institutes, gastroenterology clinics, elective hospitalisation laboratories and services, will be subject to the prior written agreement of the insurer.**

**The insured must submit a written request for approval for the services detailed in this clause to the insurer, together with a certificate from the attending doctor that the insured is in need of this medical service.**

**The requested approval or notice of declinature to provide it will be issued within 7 days of the date on which the attending doctor determines the need for the test or the hospitalisation as applicable and/or from the date on which the insurer received the request from the insured, the latter of the two, and in any case will not be delayed to a date which would endanger the insured or harm the reasonability of the treatment to which they are entitled to receive under this policy. If the insured or a representative of the insured does not contact the insurer to obtain its confirmation for**

**the aforementioned expenses, the insurer will be entitled to reduce the payment to which the insured is entitled to the amount that the insurer would have paid if the insured would have contacted the insurer with a request for confirmation as aforementioned.**

- 6.1.4. Other than the cases detailed in clause 5.3 above, the insurer will not be entitled to costs of medical services of the insured in an accident and emergency room other than if the insured has received the prior approval of the attending doctor.

## **SECTION D: COMPENSATION FOR DEATH AND DISABILITY AS A CONSEQUENCE OF AN ACCIDENT**

- 7. If the insured is under the age of 18 and/or over the age of 65 they will not be entitled to insurance cover under this section.**

**The total liability of the insurer in accordance with this section will not exceed the total amount of US\$ 10,000 per insured, which the insured will be entitled to receive once only.**

### **7.1. In this section –**

7.1.1. **“The insured”**: Anyone staying in the State of Israel as a foreign worker provided that they are over the age of 18 and under the age of 65.

7.1.2. **“Accident”**: Unforeseen bodily injury which occurs during the period of insurance by an external visible violent cause and which is the sole, direct and immediately cause of the death or disability of the insured, other than damage occurring as a consequence of verbal abuse and/or psychological pressure and/or the accumulation of recurrent minor injuries over time leading to disability will not be considered as an “accident”, other than if the injury occurred as a consequence of hostilities as defined in the Compensation for Victims of Hostilities Act – 1970.

7.1.3. **“Disability”**: Permanent medical disability which is caused as a direct and decisive result of an accident (an accident that occurs during the period of insurance).

7.1.4. **“Permanent disability”**: The total loss of an organ due to its separation from the body or the total loss of the functional capacity of a bodily organ.

7.1.5. **“Death of the insured”**: The death of the insured due to the accident, which occurs within 6 months of the date of its occurrence.

- 7.2. If the insured suffered bodily injury during the period of insurance, whose direct cause is an accident, indemnity payments will be paid as follows:**

7.2.1. In the event of **the death of the insured** whose age at the time of their death was more than 18 and less than 65 – the beneficiary stated in the proposal form, or if there is no

beneficiary, the legal heirs of the insured or the executors of the estate or probate order of the insured, will be paid the sum of US\$ 10,000.

7.2.2. In the event of total disability: In the event of total disability which occurs after the date of the accident which occurs after the inception date of the period of insurance, the insurer will pay a sum insured to the insured according to the following percentages: (The amount payable will be calculated as a percentage of the capital sum insured stated in clause 7.2.1 above). For example: If the insured is determined totally disabled in their leg and the capital sum insured is US\$ 10,000 – the insured will receive, in such a case:

$$40\% \times \text{US\$ } 10,000 = \text{US\$ } 4,000.$$

Type of disability / total loss of	Disability rate:
Ability to see in both eyes	100%
Ability to use of both arms or both legs	100%
Of an arm or the right hand	60% *
Of an arm or the left hand	50% *
One leg	40%
Sight in one eye	25%
Thumb of one of the hands	16%
Right forefinger	14% *
Left forefinger	12% *
Right little finger	12% *
Left little finger	10% *
Right middle finger	8% *
Left middle finger	6% *
Ring finger on one of the hands	6%
A big toe	5%
Any another toe	3%
Hearing in both ears	40%
Hearing in one ear	10%

\* For a left handed person – vice-versa. The percentages stated for the right hand will apply to the left hand, and those stated for the left will apply to the right hand.

- 7.2.3. **Disability which exists prior to the inception of the period of insurance and/or disability which was determined in accordance with this clause due to a previous insured event will be deducted from the disability in respect of which payment is due in accordance with this clause.**
- 7.2.4. **Limbs which are not stated in the table** – In any case in which disability is caused to a limb which does not appear in the table in clause 7.2.2 above, the disability rates will be determined by a specialist doctor in the applicable field of the disability and will be paid as a percentage of the capital sum insured. For example: If the insured suffers total disability in their back and a specialist doctor determines that the disability rate is 70% and the capital sum insured stated in the policy schedule is US\$ 10,000, the insured will receive, in such a case:  $70\% \times \text{US\$ } 10,000 = \text{US\$ } 7,000$ .
- 7.2.5. **Disability which is not total (in cases where the disability is stated in the table)** – In any case of disability which is not total to the limbs stated in the table, a modified disability rate will be determined as defined in clause 7.2.6 hereunder.
- 7.2.6. **Modified disability rate** – Will be equivalent to the disability rate from the accident, multiplied by the total disability rate in the schedule relating to the same limb and in turn multiplied by the capital sum insured. For example: If a disability which is not total is determined in a leg of 20% and the capital sum insured stated in the policy schedule is US\$ 10,000, the total disability rate in the table for a leg is 40%, the insured will receive, in such a case:  
 $20\% \times 40\% \times \text{US\$ } 10,000 = \text{US\$ } 800$ .
- 7.2.7. **It is clarified that cosmetic disability will not be covered under this policy.**

**8. SPECIAL EXCLUSIONS TO SECTION D – COMPENSATION FOR DEATH AND DISABILITY AS A CONSEQUENCE OF AN ACCIDENT**

The insurer will not pay benefits under this policy if the death or disability or any claim is caused directly or indirectly by or due to:

- 8.1. Earthquake, volcanic eruption, nuclear fission, nuclear fusion, radioactive pollution.**
- 8.2. The active participation of the insured in armed conflict or military or police or underground activity, revolution, revolt, riots, civil commotion, sabotage, terrorism, strikes, illegal acts.**
- 8.3. The participation of the insured in acts of sabotage or terrorism of any type and/or war and/or belligerent acts of enemy forces, whether regular or not.**
- 8.4. The insured flying in any aircraft other than if the insured flies as a passenger in a civil aircraft with a certificate of worthiness to carry passengers subject to the liability of the insurer in Israel only.**
- 8.5. Intentional self-injury suicide or attempted suicide regardless of whether the insured was sane or not.**
- 8.6. Amateur sports in the framework of a registered sports association in accordance with the Sports Act – 1988 and/or professional sports activity (which constitutes the main occupation of the insured or involves payment).**
- 8.7. Participation of the insured is extreme sports in accordance with the list appearing in the internet site of the company. In this regard – extreme sports relates to branches of sport which are considered hazardous and involve / demands, amongst other things, from the participants a high level of difficulty and/or bodily effort. A list of the branches of extreme sports is updated from time to time and appears in the internet site of the company at [www.ayalon-ins.co.il](http://www.ayalon-ins.co.il)**
- 8.8. The use of explosives.**
- 8.9. Mental illness, intentional self-endangerment other than for the purpose of self-defence and lifesaving.**
- 8.10. Alcohol addiction or the use of drugs by the insured.**
- 8.11. Death or disability as a consequence of surgery.**
- 8.12. A work accident as defined in the National Insurance Institute Act.**

- 8.13. Road accidents as defined by law in the Compensation of Victims of Road Accidents Act - 1975.**
- 8.14. Cosmetic disability.**

## SECTION E – TABLE OF LIMITS OF LIABILITY OF THE INSURER

Summary of the covers	Limit of liability
Medical expenses during hospitalisation	Full cover
Medical expenses during hospitalisation in a psychiatric hospital	Up to 60 days hospitalisation
Out-patient medical expenses including general practitioner, special doctors, diagnostic tests, imaging services and medication	Full cover
Accident and emergency room – subject to the criteria laid out in the Ordinance	Full cover
Special lump-sum compensation for a worker with a B-1 work visa who is unable to work for medical reasons subject to the conditions laid out in the policy	NIS 80,000
Medical ambulance – Accompaniment by a medical team with suitable equipment for the condition of the insured if they are unable to work	Full cover
<b>Extensions (without additional premium)</b>	
Emergency dental treatment	Full cover
Corpse repatriation costs	Full cover
Personal accident – death / disability (capital sum insured)	US\$ 10,000
Emergency flight for a close family member and accommodation expenses in Israel for up to 10 days	US\$ 1,500 US\$ 40 per day in a hotel
Return flight to the country of origin in the event of incapacity to work	US\$ 2,000

**Only the full terms, conditions and exclusions of the policy in Hebrew will bind the insurer.**