1/2021

MenoMedic TOP

Medical Insurance for Foreign Workers

Due to the fact that the policy holder whose name is indicated below, contacted Menora Mivtachim Insurance Ltd. with the request to take out insurance, the details of which are hereby specified, and undertook to pay the insurance premiums as agreed with such policy holder and which are stipulated in the list of this policy.

Therefore, this policy attests to the fact that, subject to the cover, expansions, terms and conditions, reservations and provisions specified therein and / or which will be added and / or attached to the policy with the consent of the parties, the insurer agrees to indemnify the policy holder upon the occurrence of an insurance event that occurred during the insurance period specified therein, in accordance with the cover as specified in the chapters of this policy.

It would be prudent to emphasize that the list page attached to the policy and the health declaration attached to it, are the basis of insurance and form an integral part of the policy.

For the elimination of doubt, this policy has been specially adapted to the provisions of the Foreign Workers Order (Range of Health Care Services for Employees) 5761 - 2001, (hereinafter: "The Order") and also to the Foreign Workers Order (Range of Health Care Services for a Worker) (Amendment) - 2016. In order to eliminate doubt, it would be prudent to clarify that in any case of contradiction between the order and the policy, the wording of the order will prevail.

General Terms and Conditions

Preface

1. Definitions

In this policy:

1.1 **The Policy Holder** – The person, a member of an association or corporation, who is an employer who enters into an agreement with the insurer by means of the insurance contract that is the subject of the policy and whose name is stipulated in the list and / or in the insurance proposal as the owner the policy.

The Insured: Any person working in Israel, whose name is stipulated in the list, **provided that he / she holds foreign citizenship and his / her permanent domicile is outside of the borders of Israel** and who signed up for the insurance under the provisions of this policy.

1.2 **The Insurer** – Menorah Mivtachim Insurance Ltd.

1.3 **The Insurance Proposal or The Proposal** – The proposal form that constitutes an application to take out the insurance under this policy, it being filled out with all required details and signed by the candidate for the insurance and / or by his / her spouse on his / her behalf and on behalf of each of his / her family members. The proposal will also include the health statement that was completed and signed by the insurance candidate.

1.4 **The Policy** – An individual insurance contract between the policy holder and the insurer for the insurance of the policy holder's employees, including the insurance proposal, the health declaration, and any appendix or supplement attached to it.

1.5 **The List / The Insurance Details Sheet** – A page attached to the policy, which is an integral part of the policy, and which includes, inter alia, the policy number, personal details of the policy holder, details of the insured, the date of commencement of the insurance period and the insurance period of the insured, insurance premiums, the name of the insurance agent, if any, **restrictions on the scope of the insurance cover of a particular insured, including exclusions due to a medical condition, if any, underwriting addendums, if any, etc. This insurance details sheet constitutes the insurer's written consent to insure the insured whose details are recorded on the sheet, with the insurance cover recorded in their name and all in the reservations listed on the insurance details page and subject to the terms and conditions of the policy.**

1.6 The Insurance Event: An event as defined in each of the sections of the policy, as the case may be, for which the insured is entitled to receive insurance benefits from the insurer, all subject to the terms and conditions, exclusions and reservations in the policy.

1.7 Date of Commencement of the Insurance – The date specified in the list as the date of commencement of the insurance or the date on which the insured's sojourn in Israel commenced – the chronologically later of the two.

1.8 **The Insurance Period** – The period that began on the date of commencement of the insurance and lasted the entire period of the insured's employment in Israel, but in any case the insurance period will not exceed 60 months from the date of commencement of the insurance according to the policy.

Notwithstanding the above, in the case of the issue of an extension to the insured's visa on the part of the Ministry of the Interior, beyond a period of 60 months, the insurance period will be extended, but in any case it will conclude, at the latest, on the expiration date of the visa. The insurance period will be extended sequentially at the end of the insurance period, at the request of the employer or the employee, that was received by the insurer, provided that the insurance premiums have been paid also in respect of the interim period between the end of the original insurance period and the extension of the insurance policy period.

In the event of a transfer between employers, the insured or the policy holder will be entitled to renew the insurance, without re-underwriting, within a period of 90 days.

1.9 **Israel** – The State of Israel, including the territories under Israeli rule, Judea, Samaria and the Gaza Strip, excluding the territories held by the Palestinian Authority.

1.10 **Abroad** – Any country outside of the borders of Israel, except enemy countries.

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

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

1.13 **The Second Addendum** – The Second Addendum to the Health Insurance Law, which includes and provides details of the range of health care services provided under the Health Insurance Law.

1.14 **The Order** – The Foreign Workers Order (Range of Health Services for Workers), 5761 - 2001.

1.15 **The National Insurance Law**: The National Insurance Law [Integrated Version], 5755 - 1995.

1.16 **The Commissioner** – The Commissioner of the Capital Market, Insurance and Savings Authority.

1.17 **Legislative Arrangement** – The Financial Services Overseeing Law (Insurance), 5741 - 1981, The Insurance Contract Law, 4741 - 1981, as well as the regulations and the orders legislated and / or which will be legislated by virtue of these laws and the directives and circulars issued by the Commissioner, which will arrange the terms and conditions applicable to the policy holder, the insured and the insurer within the context of this policy.

1.18 **Hotline Service Center** – A hotline operated by the insurer or by any entity acting on behalf of the insurer and accredited by the insurer, which operates 24 hours a day throughout the year, used for obtaining and providing information, the options available for obtaining the medical services required by the policy – including the locations and the times, authorization of hospitalization at hospitals, handling of the return of injured patients and bodies of deceased persons to their country of origin and the provision of any other assistance necessary in accordance with the insurance under this policy.

1.19 **Index** – The Consumer Price Index (including Fruit and Vegetables) published by the Central Bureau of Statistics or any other index specific to health care services, which will replace it, whether it is based on the same data on which the existing index is based or not. Should another index replace the existing Index, the Central Bureau of Statistics will determine the ratio between it and the replaced index. The index is adjusted to the basic index of 100.0 points as at January 1959, it being divided by 1000.

1.20 **Basic Index** - The latest index known on the 1st of the month of the date of commencement of insurance.

1.21 **Determining Index** – The last index known on the day of payment of the insurance premium to the insurer or payment of the insurance amount to the insured or to providers of medical service to the insured, in accordance with the terms of the policy.

Everything stated in this policy in the singular refers to the plural in meaning, and also everything stated in the masculine gender refers to the feminine gender and vice versa

2. The Validity of the Policy

2.1 Signing up for the Insurance

2.1.1 The insured signing up for the insurance will be effected after the insurer's written consent to accept the insured to the insurance.

2.1.2 The insurer will submit its consent to accept the insured for insurance after receiving the sign up application form, signed by the insurance candidate and a filled out health declaration and after undergoing an underwriting procedure which will determine the conditions of acceptance for the insurance, to the satisfaction of the insurer and upon the insurer's consent. It would be prudent to clarify that the non-fulfillment of one of the conditions listed above will not affect the insured's right to insurance coverage after having been accepted for insurance.

2.2 The policy will take effect from the date of commencement of the insurance, after arranging the means of payment for the policy.

2.3 Should advance payments have been paid to the insurer against the insurance premiums, without the insurer's demand and before the insurer has agreed to insure the insurance candidate, such payment will not be considered as being the insurer's consent to entering into the insurance contract. The insurer will refund those monies paid plus lawful linkage discrepancies and interest, should the insurance not come into effect, within a period of one month at the latest.

2.4 Rejection of the insurance offer or contacting the insured with a counter-offer for insurance cover will be made within a maximum of three months from the date of the insurer receiving the initial deposit, or if the insurer contacted the insured with a request to provide supplemental information, within six months from the date of receipt of the first deposit by the insurer. Should the insurer not reject the insurance offer and not offer the insured a counter proposal for insurance cover, or if the insurer informed the insured regarding the insured being accepted to the insurance according to the terms of the insurance proposal within the dates as stated, the insurer will not be entitled to change the conditions laid down in the insurance proposal until the end of the insurance period, subject to the terms of the policy. Should an insurance event occur prior to the insurer responding to the insured with a counter proposal, or rejected its offer for insurance, the insured will be entitled to insurance cover, provided that according to the medical underwriting provisions existing with the insurer regarding insureds with similar characteristics, the insurer would have notified the insured, of the insured having been accepted for insurance, were it not for the occurrence of the insurance event.

3. The Insurance Period

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

3.2 The maximum age for signing up the policy is age 65. It would be prudent to clarify that that stated should not detract from the rights of an insured person whose insurer has approved his acceptance for insurance, even if when attached to the insurance when his age is over the maximum age listed above.

3.3 The insurance cover for each and every insured person will terminate upon his death or at the end of the insurance period or on the date of termination of the employer - employee relationship – the chronologically earlier of the options, subject to the provisions of Section 8.2 below.

4. Obligation of Disclosure

4.1 The insurance under this policy is effected based upon the written information, the responses to questions and written statements provided to the insurer by the insured and / or by the policy holder.

4.2 Should the insurer have posed, to the insured, before the policy has been taken out, in the insurance proposal form or in another written manner, a question regarding a matter that may influence the willingness of a reasonable insurer to draw up the policy in general or to draw it up under the terms and conditions therein (hereinafter – "Essential Interest"), the insured must provide a full and truthful response in writing. A sweeping question involving various matters, without distinction between them, does not require an answer as stated, unless it was reasonable to assume at the time of drawing up the contract, there a fraudulent attempt to obscure, on the part of the insured, a matter which he knew to be an essential matter, and will be considered as having provided a response that is neither truthful nor complete.

4.2.1 Should a question of an essential matter have been given a response that was neither complete nor truthful, the insurer is at liberty, within 30 days from the day it became aware of the matter and as long as the insurance event did not occur, to cancel the policy, by written notice to the insured and to the policy holder. The insurance premiums paid for the period after the cancellation, will be reimbursed after the deduction of the insurer's expenses, unless the insured acted with fraudulent intent.

4.2.2 Should the insurance event occur prior to the insurance being canceled by virtue of this section, the insurer is only liable for reduced insurance benefits at a proportional rate which is as the ratio between the insurance premiums that would have been paid as is customary at the insurer, according to the actual situation and the agreed insurance premiums. Despite the above stated, the insurer will be exempt from any obligation in any of the following cases:

4.2.2.1 The response was given with intent to defraud.

4.2.2.2 A reasonable insurer would not have issued such insurance, even with higher insurance premiums, should such insurer had known the true situation. In this case, the policy holder is eligible for the reimbursement of the insurance premiums that were paid for the period after the insurance event occurred, less the insurer's expenses.

4.3 Sections 4.2.1 and 4.2.2 will not apply in the following cases, unless the response that was incomplete and untruthful, was given with intent to defraud:

4.3.1 The insurer either knew or should have known the true situation at the time the contract was signed, or the insurer caused the response to be incomplete and not truthful.

4.3.2 The fact for which a response was given that was not complete and truthful, ceased to exist before the insurance event occurred, or did not affect the insurance event, and neither affected the liability of the insurer nor the extent of the liability.

4.4 Furthermore, the insurer is not entitled to the remedies referred to in section 4.2.2 after three years have elapsed from the conclusion of the contract, except if the insured or the person whose life was insured acted with intent to defraud.

5. Insurance Premiums and How to Pay Them

5.1 The insurance premiums will be paid to the insurer in advance by the policy holder and / or by the insured who undertook to pay them, prior to the commencement of the insurance period and for the duration of the entire insurance period, unless the insurer has agreed to another method of payment, in advance and in writing.

5.2 If the insurance premiums were paid by a bank standing order or through a credit card which will be submitted by the policy holder and / or the insured to the insurer at the beginning of the insurance period, only the crediting of the insurer's bank account or credit card company account will constitute the payment of the insurance premiums.

5.3 The insurance premiums will be paid in New Shekels, being linked to the index as detailed below: The insurance premiums that the policy holder is obligated to pay will be paid in addition to the linkage discrepancies in the rate of increase / decrease of the determining index, compared to the basic index, on the actual date of payment.

6. Claims and Insurance Benefits

6.1 Upon the occurrence of an insurance event, the insured or the policy holder must notify the insurer's hotline center as soon as possible.

6.2 In cases where the prior approval of the insurer is required, the insured and / or the policy holder must obtain written approval to this extent.

6.3 Should the insurance case have lead to hospitalization due to a medical emergency which prevented the insured and / or the policy holder from giving prior notice to the insurer, as required under the terms and conditions of the insurance policy, the insured and / or the policy holder will ensure that the notification of the patient's direct evacuation to the hospital will be notified to the hotline center service of the insurer, as soon as possible.

6.4 Should the insured not have applied to the insurer for prior approval, the insurance benefits will be reduced up to the amount that the insurer would have paid, should the insurer have been notified in advance.

6.5 The insured will provide the insurer with a waiver of medical confidentiality, that permits all the insurer's doctors and / or any medical organization or other institution in Israel or abroad to submit, to the insurer, all the medical information in its possession and concerning the insured.

6.6 The insured or the policy holder, as the case may be, will provide the insurer with details relating to the claim, as well as medical or other documents required of the insurer to clarify the insurer's liability.

6.7 **Medical Confidentiality**

6.7.1 **Any medical information relating to the insured's physical condition or mental health, or the treatment thereof and any medical record, including the insured's medical file (hereinafter: "Medical Information"), will be submitted by the insurer to the insured. The insurer will not provide medical information to the**

employer of the insured or to any other party related, directly or indirectly, to the insured's employment with an employer, such as a private bureau as defined in Section 62 of the Employment Service Law, 5719 - 1959 (hereinafter: "The Entity Related to the Employment") unless the insured provided an informed consent. The insurer will take steps to ensure the observance of this provision.

6.7.2 The insurer will not accept a waiver form for the confidentiality of medical information of an insured, which concerns consent to the transfer of the said information to the employer of the same insured or to any entity related to the employment. An insurer is at liberty to accept such informed consent, if given in other ways, provided that the insurer will verify in each and every case that obtaining such consent was not done in an across the board manner.

6.7.3 An insurer in need of medical information from a foreign worker will not contact the employer of that worker or the entity related to the employment with a request to obtain, for the insured, the stated medical information, except in cases of a medical emergency.

6.8 The insured will, if required by the insurer, undergo a medical examination conducted by a doctor / doctors acting on behalf of the insurer and at the expense of the insurer, provided that the examination will be reasonable. The insured may, in time, seek to exhaust his rights, granted to him by virtue of the policy, in court.

6.9 The insurer will pay the insurance benefits directly to the service provider.

6.10 The insured is entitled to receive, from the insurer, at his request, a letter of financial commitment to the service provider, which will enable the insured to obtain medical service as detailed in the chapters of the policy, provided that the insured's eligibility under the policy is not in dispute.

6.11 An insurance event covered under the provisions of the law and / or by an insurance company and / or by a third party

6.11.1 Should, in the vase of the insurance event, the insured also had a right to indemnification vis-à-vis a third party, not by virtue of an insurance contract, this right is transferred to the insurer from the time the insurer paid the insured insurance benefits and at the rate of benefits paid by the insurer and without prejudice to the insured's right to collect first, from the third party, indemnification for insurance benefits received under this policy.

Should the insured have received from the third party and / or according to the law of indemnity that would have been owing to the insurer, the insured will have to transfer it to the insurer. Should the insured have reached a compromise, agreed to a waiver or carried out any other action that infringes on a right transferred to the insurer, the insured must compensate the insurer for such.

The provisions of this section will not apply if the insurance event was caused unintentionally by a person from whom a reasonable insured would not have claimed indemnity, on the grounds of a family relationship or due to an employer - employee relationship between them.

6.11.2 Should the insured be entitled to cover of expenses of the indemnity type paid under this insurance by another insurer or by another insurance policy, the insurer will be liable to the insured, jointly and severally with the other insurer, regarding the amount of the

overlapping insurance and the provisions of Section 59 of the Insurance Contract Law will apply.

7. Cancellation of the Policy

7.1 The policy holder is at liberty, at any time, to cancel the policy by means of written notice to the insurer and the cancellation will take effect, in accordance with the provisions of the Legislative Arrangement, upon the receipt of the notice by the insurer.

7.2 Should the insurance premiums not have been paid on time as stated in Section 5 above, the insurer will be entitled to cancel the insurance subject to the provisions of the Insurance Contract Law.

7.3 The insurer is at liberty to cancel the policy in any case in which the insurer is granted this right under the Insurance Contract Law.

7.4 Insurance premiums, which were not paid on time, will accrue, on the date of payment, in addition to the linkage differences, interest according to the Interest and Linkage Ruling Law 5721 - 1961, from the date of the accrual of the arrears until the actual payment thereof by the policy holder.

7.5 Should the employee - employer relationship between the policyholder and the insured have terminated, the policy holder will notify the insurer without delay and the insurance will be canceled from the date of the termination of this relationship and subject to the provisions of Section 8.2 below.

7.6 Notwithstanding the provisions of this section, should an insurance event have occurred, that involves the actual provision of treatment, in accordance with the provisions of Chapter 1, prior to the cancellation of the policy, the insured will be entitled to obtain the service in respect of the insurance event up to 90 days after the cancellation of the policy.

8. Extending the Insurance Period and Insurance Continuity

8.1 The insurer will extend the insurance period, for additional fixed periods, without re-underwriting, beyond the period specified in the list, if requested to do so by the policy holder and / or the insured, prior to the end of the current insurance period, but, in any case, the extended insurance period will not exceed the insurance period as defined in Section 1.8 above.

8.2 Should the employee - employer relationship between the policy holder and the insured have been terminated, in a transition between employers, the insured will be entitled, either by himself or through another policy holder, to renew the insurance, for an additional fixed period, with insurance continuity and without re-underwriting, provided that the insured notifies [the insurer] to this effect within 90 days from the date of termination of such relationship and will pay the premium debt for this period.

The insurance period for the insured will not, in any event, exceed the insurance period as defined in Section 1.8 above

9. The Level of Medical Service

The insurer undertakes to provide the insured, under this policy, with the medical services for which the insured is entitled to obtain cover for his expenses, at medical discretion, of reasonable quality, within a reasonable period of time and at a reasonable

distance from his place of residence or from the place of occurrence of the insurance event, as is customary in the State of Israel.

10. Insured Individual's Card

The insurer will issue, to the policy holder, for each insured employee, an insured individual's card that will include identifying details of the insured and the policy holder, as well as the telephone number of the insurer's hotline center service. This card, together with a passport or official certificate bearing the insured's photo, will serve as a means of identifying the insured and of checking his eligibility when obtaining the service.

11. Telephonic Hotline Center Service

The insurer undertakes to establish and operate a hotline center which will operate 24 hours a day throughout the year and will provide the insured and the policy holder with all the information and the assistance as required from the cover under this policy and the definition of the term "Telephonic Hotline Center Service" in the introductory chapter.

11.1 Obtaining Medical Treatment

An insured person in need of medical treatment is entitled to contact the hotline center, which will take care of referring the insured to a service provider near his location.

11.2 In the event of a medical emergency, the insured may contact the hospital directly and ensure that a notification is sent to the hotline center as soon as possible

12. Proof of Age

The insured must prove his date of birth by means of a certificate to the satisfaction of the insurer. The date of birth of the insured is an essential matter to which the obligation of disclosure applies. As stated in Section 4 above and in the case of giving an incomplete and untruthful response or omitting a fact in this regard, the provisions of Section 4 above will apply.

13. Irrevocable Determination of a Beneficiary

The irrevocable determination of a beneficiary regarding rights in this policy is conditional upon the unequivocal consent of the insurer, in advance and in writing.

14. Statute of Limitations

The statute of limitations period of a claim for insurance benefits is 3 years from the date the insurance event occurred. A pretext of a claim that is a disability from an accident, will be tallied from the date the insured has the right to claim insurance benefits under this policy.

15. Applicability of the Insurance Contract Law

The provisions of this policy are subject to the provisions of the Insurance Contract Law, 5741 - 1981. In any case of a contradiction between that stipulated in the policy and the provisions of The Insurance Contract Law, the provisions of the Insurance Contract Law will apply, unless otherwise stipulated in favor of the policy holder and the insured in this policy.

15.1 Double Insurance

15.1.1 The insurer will be liable, separately, to the insured for the full amount of the insurance benefits up to the level of the ceiling set on the insurance details page, even if the insured was entitled to cover for the expenses paid for an insurance event also with respect to a different health insurance policy, whether with the same insurer or with another insurer.

15.1.2 In policies in which insurance benefits are paid in accordance with the rate of damage sustained, the insurers will bear the burden of the charge amongst themselves, according to the ratio between the ceilings of the insurance benefits relating to the insured event as laid down in the insurance policies.

15.1.3 If, due to the insured event, the insured had a right to indemnification with respect to a third party, which is not by virtue of an insurance contract, this right passes to the insurer from the time the insurer paid the insured insurance benefits and at the rate of benefits paid in this section by a third party, including the health care funds.

15.1.4 The insurer may not use the right transferred to it under this chapter in a manner that infringes on the insured's right to collect indemnification from the third party, over and above insurance benefits received from the insurer.

15.1.5 Should the insured have reached a compromise, agreed to a waiver or carried out any other action that infringes on a right transferred to the insurer, the insured must compensate the insurer for this.

15.1.6 If the insured has received indemnification from a third party in respect of expenses covered by this policy, whether by virtue of an insurance contract or not by virtue of an insurance contract, the insurer is entitled to deduct the indemnity amount from the total insurance benefits of the indemnity type, to which the insured is entitled under this policy.

15.1.7 The insured will not be entitled to additional insurance benefits of the indemnity type due to other similar or identical policies, with the insurer, due to the same insurance event. Should the insurer have drawn up additional policies for the insured as stated above, the insurer will reimburse the insured with the insurance premiums for the additional policies from the date on which the double insurance was discovered.

16. <u>Notices From the Parties</u>

16.1 The insurer's notice to the insured and / or the policy holder will be given according to their last address known to the insurer.

16.2 The notice on the part of the policy holder and / or the insured to the insurer will be given to the office of the insurer as specified by it in the insurance documents or to any other address to which the insurer has requested to send the policyholder's and / or the insured's messages.

Chapter 1 – Cover for Health Care Services

Provided Pursuant to the Health Care Insurance Law

1. **Preface**

This chapter provides the insured with all the health care services included in the order, within the scope of eligibility and while excluding defined services that will be specified below:

All the services included in the range of treatments detailed below, the scope of which is anchored in the Second Addendum to the Health Insurance Law, as amended from time to time.

Psychiatric Hospitalization Services.

Examinations and additional health care services.

The Range of Medicines.

The range of services at work – all the services listed in Regulations 2 and 5 of the Parallel Tax Regulations (Occupational Health Services), 5733 - 1973, however, wherever "Health Care Fund" is stated, it should be read as "Medical Insurer".

For the elimination of doubt, it would be prudent to emphasize that in addition to that stipulated in the general exceptions in the preface chapter, the provision of health care services, which will be detailed in this chapter below, will be subject to restrictive conditions relating to a pre-existing state of health, to an injury at work, to the inability of the insured to carry out the job for which he was hired by his employer – the policy holder, as well as the additional conditions and procedures detailed below, so that the policy holder and the insured are aware of the scope of the insurer's liability and to the rights of the insured under this policy.

The Insurer will indemnify the insured for expenses incurred for obtaining the medical services listed below in this policy, **at service providers contracted in by means of an agreement with the insurer and with them only, unless unequivocally stated otherwise.**

For the elimination of doubt, it would be prudent to clarify that obtaining the insurer's approval in cases where the approval is required, is a material condition for the insurer's liability under this policy.

The insurer will be at liberty, at its discretion, to pay the insurance benefits, or part thereof, directly to whoever provided the insured with the medical service, **or to pay** the benefits to the insured against receipts. The documents and receipts can also be submitted digitally.

2. Definitions for this Chapter

2.1 Hospital – A medical institution recognized by the competent authorities in Israel and operating as a general hospital only.

2.2 **Hospital in the Agreement** – A hospital related to the agreement with the insurer to provide services under this policy.

2.3 **Emergency Room** – a ward attached as an integral part of a general hospital where the insured resides before being hospitalized and / or released to his home.

2.4 **Hospitalization Expenses** – All expenses for hospitalization in a hospital for a period exceeding 24 hours, for the medical treatment provided during the hospitalization period, including the fees of a surgeon, the fees of an anesthesiologist, the costs of intensive care, as well as for tests and medications performed and administered during the course of the hospitalization period.

2.5 **Non-hospitalization Expenses** – All expenses for the medical services provided to the insured not during hospitalization, by service providers contracted in an agreement with the insurer for the provision of services under this policy and laid down in the Second Addendum to the Health Law, except for all expenses excluded by the Order and the terms and conditions of this policy.

2.6 **Physician** – A person who has been authorized by the competent authorities in Israel or abroad to practice medicine in Israel, both as primary medicine and as secondary medicine (Specialist Medicine).

2.7 **Primary Health Care Physician** – A general practitioner, who is not a specialist, or a family doctor who specializes in family medicine or an internal medicine doctor or gynecologist, who is contracted in an agreement with the insurer to provide services under this policy.

2.8 **Specialist Physician** – A doctor who has been recognized as a specialist by the health authorities in the State of Israel, provided that his area of expertise is in the relevant field required for medical treatment (other than family medicine or internal medicine or gynecology), who is contracted in an agreement with the insurer to provide services under this policy.

2.9 **Contract Physician** – A doctor contracted in an agreement with the insurer to provide services under this policy.

2.10 **Medical Event** – An illness or accident that the insured sustained during the insurance period, except for an illness or accident that was excluded and / or limited in this policy. To an extent that the case in point is a pre-existing medical condition, the provisions of Section 6 below will apply.

2.11 **Medical Emergency** – Circumstances in which the insured is in immediate life threatening danger or there is an immediate danger that the insured will sustain a serious irreversible disability, if he is not given urgent medical attention.

2.12 **Elective Hospitalization** – A hospitalization period that was anticipated and for which the insured's admission to the hospital for the purpose of performing the operation is not effected by a referral from an emergency room as an urgent case, rather that the insured was referred to hospital by a specialist doctor from a clinic (including a hospital outpatients clinic).

2.13 **Diagnostic Institute** – An institute that performs EG, EMG, audiometry, and ergonometric examinations, that are contracted in an agreement with the insurer to provide services under this policy.

2.14 **Imaging Institute** – X-ray Institute, Ultrasound (US), Nuclear Medicine, Computed Tomography (CAT) and Echo-gradiography [sic], contracted in an agreement with the insurer for the provision of services under this policy.

2.15 Insurance Event – <u>an event or medical condition following which the insured requires the services included in Section 4.</u>

2.16 **The Range of Drugs** – All drugs included in the National Health Insurance Order (Drugs in the Health Services Range), 5755 - 1995, as amended from time to time, in the case of the occurrence of a medical event defined as an insurance event under the policy.

2.17 **Pharmacy** – An institution legally authorized to sell and market drugs to the general public, contracted in an agreement with the insurer to provide services under this policy.

2.18 **The Customary Payment** – A payment, including a guarantee or deposit, which the insured must pay, in exchange for obtaining a medical service / services as laid down in this policy and determined in the Second or Third Addendum to the Health Insurance Law, or in a notice regarding conditions and payments given by the State to the individual on the determining date under the Health Insurance Law or in a health care fund proposal under Section 8 (a 1) of the Health Insurance Law approved under Section 8 (a 2) of the same law, and if there were different payments for the same service in the above stated provisions – the higher of the two.

3. <u>Guidelines for Obtaining the Services Under the Policy</u>

3.1 Primary Medicine

An insured who needs a general practitioner, who is not a specialist, or a specialist in family medicine or an internal medicine doctor or gynecologist, will be able to contact any doctor contracted in an agreement with the insurer to provide services under this policy without the need for the Insurer's approval.

3.2 Non-primary Medicine

An insured who needs a specialist doctor will be able to contact any specialist doctor contracted in an agreement with the insurer to provide services under this policy, provided that he is referred in writing by a primary care physician or is referred by the telephone hotline center.

3.3 Medical Institutes

An insured who needs tests at an imaging institute and / or a diagnostic institute as defined above and / or at a gastroenterological institute and / or laboratory tests will contact the Telephone Hotline Center service to obtain approval for the undergoing of the above stated procedure and / or procedures at the institutes contracted in an agreement with the insurer for the provision of services under this policy, after being referred to them in writing by a primary care physician or by a specialist physician.

The notification of confirmation or of a refusal shall be given within a reasonable time, but not more than 7 days from the date of the request by the attending physician (primary or specialist). In any case, the duration of the approval will not endanger the insured and / or impair the likelihood of the treatment to which he is entitled according to the order.

3.4 **Elective Hospitalization** –

Determining the need for elective hospitalization will be done by a primary care physician and / or a specialist physician who is treating the insured.

The confirmation or notification of the refusal will be given within a reasonable period of time but not more than 7 days from the date of the request by the attending physician (primary or specialist) and, in any case, the duration of the approval will not endanger the insured.

3.5 **Emergency Room** –

An insured person who needs emergency room services in one of the general hospitals in Israel, as specified in Section 4.2 below, will be entitled to contact one of the emergency rooms without any need for any prior approval.

The insured's arrival at the emergency room in any other case will require the insured to present a prior authorization from the doctor treating him (whether primary or specialist).

3.6 **Pharmacies** –

An insured who needs medication covered under this policy will be able to obtain the medication against a medical prescription issued to him by a primary care physician and / or a specialist contracted in an agreement with the insurer to provide services under this policy and to pharmacies contracted in an agreement with the insurer.

3.7 **Deductible Amount** –

The insurer is entitled to condition the provision of the services according to this policy on the payment of a deductible amount by the insured of an amount of the customary payment as defined in Section 2.17 above. The deductible amount will be the same as the customary payment applicable on the day of receipt of the relevant service.

The deductible amount will be indicated on the insured individual's card, and, to the extent possible, will be paid before obtaining the service and will be a precondition for obtaining the service.

4. <u>The insurer undertakes to bear expenses related to a medical event defined as the insured event as follows:</u>

Hospitalization expenses in a hospital contracted in an agreement in Israel as defined above.

4.1 **Emergency room services in each of the general hospitals in the country (and not only in hospitals contracted in an agreement) in each of the following cases:** Any new fracture; acute dislocation of shoulder or elbow; injury that requires healing treatment by suturing or an alternative means of unification; inhalation of a foreign body into the airways; penetration of a foreign body into the eye; cancer treatment; treatment of hemophilia; treatment of cystic fibrosis; evacuation by ambulance to the emergency room from the street or other public place, due to a sudden event; the referral ended in a non-elective hospitalization; medical emergency.

4.2 **Hospitalization services** provided to the insured in a hospital as stipulated in Section 4.1 above are valid after referral to the emergency room of that hospital, if effected in the cases listed in section 4.1 above.

4.3 **Hospitalization services** in a psychiatric hospital or in a psychiatric ward at a general hospital.

4.4 **Non-hospitalization expenses**:

These services will be provided to the insured only in the case of a medical emergency as defined above and for a period not exceeding 60 days for one employment period.

In this matter, "one employment period" – the entire period, even if not continuous, in which an employee - employer relationship existed between a particular employer and the insured. Medical expenses for an examination by a doctor contracted in an agreement as defined above, laboratory tests, images taken at a diagnostic institute as defined and / or in an imaging institute, including a range of services at work and medications as defined which were provided to the insured not during the course of hospitalization and including the other medical services contained in the order, through service providers contracted in an agreement with the insurer and in accordance with its guidelines.

4.5 Additional Medical Services

4.5.1 Amniocentesis for women over the age of 35 at the beginning of pregnancy, subject to the provisions of pregnancy in Section 4.7 below.

4.5.2 Vaccines against scabies, rabies, diphtheria.

4.5.3 Mantoux tests and pulmonary imaging.

4.5.4 Wheelchairs and treadmills.

4.6 Medications

The range of medicines – all the services listed in the National Health Insurance Order (Medicines in the Range of Health Care Services), 5755 - 1995, as amended from time to time; medicines purchased according to a doctor's instructions and according to a medical prescription, except for the medicines that were excluded from this policy and provided that they were purchased at a pharmacy contracted in an agreement with the insurer as defined above.

4.7 Health Care Services for a Pregnant Woman

An insured who requires the services listed above in respect of being pregnant, will be entitled to obtain them only if one of the following conditions exists and / or has existed for her:

4.7.1 The insured was employed by the policy holder and / or another employer for a period that in total exceeds 9 months.

4.7.2 The insured needs the medical services included in this policy due to a state of medical emergency as defined above.

5. Exclusions for this Chapter

The insurer will not be liable and is not obligated to pay insurance benefits according to one or more sections of the policy if the insurance event is a direct result of and / or an insurance event arising from:

5.1 The insurance event occurred after the end of the insurance period. This reservation will apply to each insured once during consecutive insurance periods (at the time at which the insurance coverage for it has recently ended) and will re-apply each time an insured person signs up again for the insurance, during periods of non-consecutive insurance.

5.1.1 Road accident as stipulated in the Compensation for Ro

ad Accident Victims Law, 5735 - 1975.

5.1.2 Hostile action and / or actions, as defined in the Compensation for Victims of Hostilities Law, 5730 - 1970, if the insured is "Wounded" as defined in that law.

5.1.3 Provision of services of any kind outside Israel (whether the insurance event occurred within the borders of Israel or occurred outside of the country).

5.1.4 Loss of work capacity for a job for which the insured came to work at in Israel, subject to the provisions of Section 7 of this chapter.

5.1.5 Work injury subject to Section 8 of this chapter.

5.2 The insurer will not be liable and will not be obligated to pay insurance benefits under one or more sections of the policy if the insured event is:

5.2.1 Framework of the Range of Treatments:

5.2.1.1 Psychological services.

5.2.1.2 Dead Sea treatments given to psoriasis patients.

5.2.1.3 Genetic testing.

5.2.1.4 Frail care hospitalization or other frail care services.

5.2.1.5 Services for the treatment of impotence problems, sexual dysfunction, male or female fertility, as well as artificial fertility treatments or artificial insemination.

5.2.1.6 Services provided outside of the borders of Israel.

5.2.2 Within the Ambit of the Range of Medications:

5.2.2.1 Medications for the treatment of Alzheimer's disease.

5.2.2.2 Medications for the treatment of impotence problems, sexual dysfunction, male or female fertility, as well as given within the ambit of artificial fertility treatments or artificial insemination.

6. Pre-existing Medical Condition

6.1 The insured will not be entitled to health care services as specified in this policy if the medical event that constitutes an insurance event, for which he requires health care services, is derived from a medical condition that preceded the date of commencement of the insurance period under this policy (hereinafter: "pre-existing medical condition") and / or preceding the first date on which an employer in Israel arranged medical insurance for him (hereinafter: "the first date") and if one of the following two conditions is met:

a. The insured has confirmed that the insurance event which is a medical problem for which he requires the service is due to a pre-existing medical condition.

b. A doctor confirmed, according to the findings in his possession, that the medical problem due to which the insured required the service was due to a pre-existing medical condition.

If the insured sojourned outside of Israel, after the first date (hereinafter: "Sojourn"), for a period or periods exceeding 90 consecutive days, or 120 consecutive days if the sojourn separates the periods of employment with the same employer – the first date will be considered as being the first date after the sojourn in which the employee was insured with health care insurance.

6.2 Notwithstanding the provisions of section 6.1 above, if 3 years have elapsed from the date of commencement of the order or from the first date, the chronologically later of the two, the restrictions stipulated above will not apply to the case.

6.3 Notwithstanding the foregoing, the right of the insured to obtain health care services, as stipulated in this chapter, will not be restricted regarding services which he requires in a medical emergency resulting from a pre-existing medical condition, in order to stabilize his medical condition to a condition that allows him to continue treatment outside of Israel, or to restrict the provision of other health care services required by him due to a pre-existing medical condition within the period of 30 days after the authorization issued by the stated doctor or the determination regarding the stabilization of his medical condition as stipulated.

6.4 In the event that the insured's eligibility for health care services is restricted due to a pre-existing medical condition, the insurer will pay the insured full payment of the expenses related to his flight from Israel in any case where his medical condition requires an escort or other special arrangements required during the flight.

7. **The Insured's Fitness to Work**

7.1 Should a doctor determine that the insured is not fit to perform the job for which he was hired by his employer, and that he will not be fit to perform it within a period of 90 days from the date on which the insured is examined by the doctor, even if he is given the medical treatment he needs, the insured will not be entitled to medical services that he requires except for the services required in a medical emergency in order to stabilize his medical condition, to a situation that allows him to continue treatment outside of Israel, as well as other medical services that he requires within the 30 days following the determination of the stated physician or the determination regarding the stabilization of his stated medical condition.

7.2 In the event that the insured's eligibility for health services is restricted due to a loss of work capacity as stipulated in Section 7.1 above, the insurer will pay the insured the full payment of the expenses of his flight from Israel, including an escort or other special arrangements required during the flight.

8. Injury at Work

8.1 Should an insurance event have occurred, to the insured, that constitutes an injury at work within the meaning of the National Insurance Law [Combined Version], 5755 - 1995, the policy holder, the insured's employer, must fill out a form BL 250 intended for this and submit it to the National Insurance Institute without any delay.

If the policy holder has not filled out the above stated form, the insurer, if it bears payments for medical services due to an injury at work, is entitled to subrogation by the policy holder for any amount the policy holder paid due to not filling out the above stated form and the submission thereof to the National Insurance Institute.

8.2 The services included in the range of health care services under this order will not be provided to the employee, if he requires them due to an injury at work, within the meaning of the National Insurance Law [Combined Version], 5755 - 1995, except if the employer has authorized, by means of a form set by the National Insurance Institute and designated for this purpose (hereinafter - Injury Form) that the stated injury is an injury sustained at work.

8.3 Should the employer have submitted an injury form and the National Insurance Institute has not determined, within three months from the date of the injury, that it is an injury sustained at work, the medical insurance will apply to the services rendered to an employee due to the same injury, within the three month period, even if rendered not by a service provider acting on behalf of the medical insurer, and after the three months, subject to the provisions of Sections 8.2 and 8.3 above, as long as the National Insurance Institute has not determined that such is an injury sustained at work.

9. Claims Management and Payment of Insurance Benefits:

9.1 A doctor's certificate must be obtained stipulating that the medical problem for which the insured needs the service, due to a pre-existing medical condition and a doctor's certificate must be obtained stipulating that the insured's medical condition has been stabilized.

9.2 A doctor's determination regarding an insured's loss of work capacity, even if he is given medical treatment – will be effected by a doctor who specializes in occupational medicine.

9.3 If the insurer required the insured to undergo an examination by a specialist doctor acting on behalf of the insurer, the examination will be funded by the insurer, provided that the examination is reasonable. The insured can, in time, seek to exhaust the rights conferred on him, by virtue of the policy, in court.

9.4 The insurer will provide the insured with the professional considered opinion of the specialist doctor, together with a notice regarding the insured's eligibility to obtain a second opinion from a doctor of his choice, as stipulated in Section 9.4 [sic] below and together with details of bodies or organizations that are likely to be able to assist the insured in the implementation thereof, and who have given their consent to this.

9.5 The insured is entitled to receive a second opinion from a specialist doctor of his choice, which will be submitted to the insurer within 21 days from the date the insured received the professional considered opinion from the specialist doctor acting on behalf of the insurer.

9.6 The fees of the specialist doctor acting on behalf of the insured will be paid by the insurer, at a rate determined by the Director General of the Ministry of Health and the Commissioner (hereinafter – the fixed fees).

9.7 If the two specialist physicians, as stated, disagree in their professional considered opinions, the parties will appoint a physician agreed upon by them, financed by the insurer and such specialist's professional considered opinion will be final. Should the parties not consent regarding such a physician, a deciding specialist physician will be appointed by the head of the Israel Medical Association (hereinafter – the Association), dealing in the medical field pertaining to the insured's illness and regarding the matter of the determination of loss of work capacity even if medical treatment is provided – by the head of the Association of Occupational Medicine (hereinafter - the deciding physician), and his professional considered opinion is that which will be final. Should the head of the Association not have appointed such a deciding physician within 15 days from the date of the insurer requesting such, the deciding physician will be appointed by the Director General of the Ministry of Health or whoever he has authorized to do so; The fee of the deciding physician will be the fixed fee and it will be paid by the insurer.

9.8 Notwithstanding the above stated, if the Director of the Department at a hospital where the insured is hospitalized, or the Deputy Director of the Department – in the absence of the Director – determined that, at the time that the insured's entitlement to health care services is to be terminated due to a pre-existing medical condition as stipulated in Section 6 above, or loss of work capacity as stipulated in Section 7 above, the insured's medical condition has not yet been stabilized, his determination will prevail unless otherwise determined, either by the Director of the Department or his Deputy as stated above or by the provisions of this section.

9.9 Eligibility for services under Sections 6 and 7 above will not be terminated and the thirty days referred to in those paragraphs will not be tallied, except from the date of final approval or the final determination given under Section 9.6 above, however, such determination as stated will not be considered final regarding the stabilization of the medical condition of the insured, with a determination as stated in Section 9.7 having been given.

Chapter 2 – Special Expenditure

The cover in this chapter is in addition to the coverage in Chapter 1.

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

   1.1 **Transfer of a corpse**: In the event of the death of the insured, the expenses of transferring his corpse from Israel to his country of origin, up to a maximum amount of NIS 15,000.

   1.2 **Emergency dental care**: Emergency dental care performed at one of the dental clinics contracted in an agreement with the insurer, in the case the insured requires this treatment only as first aid and up to a maximum amount of NIS 800 per year of insurance

2. Exclusions to Chapter 2:

The Insurer will not be liable under this Chapter if the insurance event was caused directly or indirectly by or due to:

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

2.2 Alcoholism or narcotics use by the insured, unless given as directed by a physician.

2.3 The insurance event was caused directly or indirectly by violent activity of a type classified as a crime or misdemeanor in which the insured participated.

2.4 War or warring action perpetrated by regular or irregular hostile forces.

2.5 An act of sabotage or terrorism of any kind, if the insured is entitled to compensation from a Government entity.

2.6 The insured flying in any aircraft other than in a civilian aircraft with a certificate of competency for the carriage of passengers.

2.7 Active participation of the insured in underwater diving, parachuting, hunting.

2.8 Use of explosives.

2.9 Deliberate self-risk, other than self-defense and saving lives.

2.10 Accidents as a result of surgeries, including minor surgeries.

2.11 Road accident as defined in the Compensation for Road Accident Victims Law 5735 - 1975 or any other law that will supersede it.

2.12 A work accident within the meaning of the National Insurance Law (Combined Version) 5728 - 1968 or any other law that will supersede it.

Chapter 3 – Accidental Death and Disability Insurance

This chapter will be valid only if purchased and explicitly stipulated on the list page.

If the insured sustains one of the insurance events listed below, within the insurance period, the insurer will pay insurance benefits as follows:

1. **Accidental Death**:

   1.1 Definitions for this section:

   Accident: A bodily injury, which is the direct, immediate and exclusive result of a physical force that is an external and accidental factor, which occurred regardless of other causes.

   1.2 **The insurance event**: The death of the insured as a direct and decisive result of an accident, provided that the death occurred within the insurance period specified on the list page of the policy and the policy being in full force.

   If the death occurred other than as a direct, immediate and exclusive result of the accident (hereinafter: "External Causes"), the insurer will be liable only if these external causes did not constitute the decisive factor in the death of the insured.

   1.3 **Insurance benefits**: Upon the occurrence of an insurance event, the insurer will pay the beneficiary, and in the absence of a beneficiary, to the insured's legal heirs, compensation in the amount of NIS 50,000.

   1.4 If the insured was paid insurance benefits for disability due to an accident due to the same insured event, the insurer will pay, upon the death of the insured, only the difference, if any, between the amount under this section and the amount paid as stated above in respect of the disability.

2. **Disability Due to an Accident**:

   2.1 Definitions for this section:

   Accident – As defined in Section 1.1 of Chapter 3 above, provided that it did not cause the death of the insured.

   The insured event – Permanent disability of the insured, due to an accident and as a direct and decisive result of that accident, within the insurance period specified on the list page of the policy, provided that the insured is still alive 90 days after the date of the accident and provided that at the time of the accident, the premiums to the policy were paid up in full.

   2.2 If the disability event occurred not as a direct, immediate and exclusive result of the accident itself, the insurer will be liable only if this effect was not the decisive factor in the insurend's disability.

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2.3 **Insurance benefits**:

2.3.1 The insurer will pay the insurance amount of an amount of NIS 50,000 (hereinafter: "The Insurance Amount" or "The Full Insurance Amount") or part thereof, depending upon the rate of medical disability, which will be determined for the insured by a doctor who specializes in the relevant field in accordance with the provisions of the National Insurance Law and its regulations (Excluding Regulation 15), as a victim of a work injury, as defined in the National Insurance Law and subject to the exclusion stipulated in Section 5.12 below. In case of a medical disability which is not specified in the National Insurance Institute tests, the degree of disability will be determined by a doctor who specializes in the relevant field, and the payment will be effected as a percentage of the disability amount, that will be determined by the specialist doctor of the full insurance amount.

2.3.2 **Cumulative Disability Percentages**: An insured who has a number of disabilities, for each of which he is entitled to a disability rate according to this appendix, his disability rate will be determined in a cumulative manner.

2.3.3 For the elimination of doubt and in any case, a total amount exceeding 100% of the insurance amount in case of disability, will not be paid to the insured due to the insured event, whether it is paid at once fell swoop due to the full disability of the insured or whether it is paid in installments following a number of claims for partial or cumulative disability.

The amount to be paid will be calculated as a percentage of the full insurance amount for this appendix. When the total payments that the company has to pay according to an appendix total an amount equal to the full insurance amount, the expiration of this appendix will occur.

3. **Under no circumstances will the total amount to be paid in respect of the cover under this chapter exceed the sum of NIS 50,000.**

4. **The cover under this chapter will apply only from the time the insured alights from the aircraft when he arrives in Israel until his departure from Israel, subject to the definition of the insurance period in the definitions section in the preface chapter.**

5. **Exclusions to Chapter 3:**

The Insurer will not be liable under this Chapter if the insured event was caused directly or indirectly by or due to:

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

5.2 Alcoholism or narcotics use by the insured, unless given as directed by a physician.

5.3 The insurance event was caused directly or indirectly by violent activity of a type classified as a crime or misdemeanor in which the insured participated.

5.4 War or warring action perpetrated by regular or irregular hostile forces.

5.5 An act of sabotage or terrorism of any kind, if the insured is entitled to compensation from a Government entity.

5.6 The insured flying in any aircraft other than in a civilian aircraft with a certificate of competency for the carriage of passengers.

5.7 Active participation of the insured in underwater diving, parachuting, hunting.

5.8 Use of explosives.

5.9 Deliberate self-risk, other than self-defense and saving lives.

5.10 Accidents as a result of surgeries, including minor surgeries.

5.11 Road accident as defined in the Compensation for Road Accident Victims Law 5735 - 1975 or any other law that will supersede it.

5.12 A work accident within the meaning of the National Insurance Law (Combined Version) 5728 - 1968 or any other law that will supersede it.

Chapter 4 – Cover for Loss of Work Capacity

– for Workers Holding a Permit Only in the Field of Nursing

1. **Definitions for this Section**:

   An Eligible Insured – An insured in this insurance who is an employee in the nursing industry, when, as of October 1, 2017, more than 13 (thirteen) years have passed since he first received a visitor's permit to work in the field of nursing (hereinafter: The Permit). In this regard, it would be prudent to clarify that for an insured who, as of October 1, 2017, 13 years have not yet elapsed from the date he was granted the permit, his entitlement to the cover specified in this chapter, will commence from the date when he will have had the permit for 13 years.

2. The Insurance Event

An insured is entitled as defined in Section 1 of this chapter, who is found by a specialist in occupational medicine to be unfit to perform his job for medical reasons. In accordance with the provisions of section 7.1 in Chapter 1 (Coverage for health care services provided under the Health Insurance Law) will be entitled to receive insurance benefits as stipulated in Section 3 below, provided that he has exercised his right to fly back to his country of origin as stipulated in Section 7.2 in Chapter 1.

3. Insurance Benefits

3.1 The insurer will pay to an eligible employee who underwent an insurance event as specified in this chapter, a special one-time compensation in the amount of NIS 80,000 provided that he has exercised his right to fly back to his country of origin as stated as stated in Section 7.2 in Chapter 1. It would be prudent to clarify that the compensation will be transferred to the eligible employee only after exercising his right and returning to his country of origin.

3.2 Eligibility for compensation will apply only to an insured who, at the time of the expert's determination that he is unfit for work – in accordance with the provisions of Section 7.1 in Chapter 1, he had a valid permit for a visit sojourn in order to work in the field of nursing or he had such a license at some point during the 12 month period preceding the determination by the stated doctor.