Health Insurance Policy For A Foreign Employee

AYALON Insurance Company LTD

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In the event that this insurance policy was purchased and it is so stated in the insurance policy particulars sheet, as provided below, then the insurer shall indemnify the insured for the medical services expenses and/or shall pay the service providers and/or the medical institute that provided the health services for the Insurance Event and/or shall compensate the insured, subject to the provisions and the restrictions as defined and detailed in the insurance policy, throughout the insurance period and within the framework of the liability of the company, in accordance with the terms and conditions of the insurance policy and provisions thereof.

Wherever the male and/or singular language form is used, the meaning shall refer, respectively, to the female and/or the plural form.

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

Chapter A - Definitions And General Terms And Conditions

1. Definitions

In this policy, the following terms shall be interpreted as follows:

1.1	**"The Company / The Insurer"**	Ayalon – Insurance Company Ltd.
1.2	**"The Insured"**	those who reside in Israel as a foreign employee, employed by the policyholder, and whose name is specified in the policy particulars sheet.
1.3	**"The Policyholder"**	an employer or a corporation engaging with The Company in an insurance agreement, the name of which is stated in the insurance policy as The Policyholder, and who is interested in insuring the foreign employee whose name is stated in the policy particulars sheets of the said insurance policy.
1.4	**"The Insurance Policy"**	this insurance agreement, including the proposal, the Insurance Policy Particulars Sheet and any annex or addition attached thereto,
1.5	**"Insurance Proposal"**	a proposal form in the form to be determined by The Insurer, where it is complete and includes all the details, including a declaration of health, a declaration of the date of entry to Israel and a waiver of medical confidentiality executed by The Insured and by The Policyholder, where applicable.
1.6	**"Declaration of Health"**	a declaration of health form and a waiver of medical confidentiality executed by The Insured.
1.7	**"Insurance Policy Sheet"**	a sheet enclosed to The Insurance Policy, which comprises an integral part thereof, which includes, among others, the personal details of The Insured and the conditions required for the adjusting of The Insurance Policy to the terms and conditions of the insurance agreement for The Insured.
1.8	**"Insurance Fees"**	the amounts that The Policyholder is required to pay to The Insured for the insurance coverage according to this insurance policy, pursuant to the terms and conditions of the insurance policy.

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1.9	**"Insurance Event"**	an event where The Insured is in need – within the insurance period – for medical treatment in Israel, which is included in this insurance policy, and medical treatment for which is provided within the framework of the insurance period and/or within 90 days from the termination of the insurance policy, at most, all in accordance with the terms and conditions, restrictions and exceptions as detailed in this insurance policy.
1.10	**"Public General Hospital"**	an institution in Israel, acknowledged by the competent authorities to be a public general hospital, which serves only as a hospital, excluding an institution that further serves as a sanitarium and/or rehabilitation institute.
1.11	**"The Customary Payment"**	a payment, including a guarantee or deposit, which applies to The Insured, against providing the medical service in practice, and which is stipulated in the second or the third addition to the Health Insurance Law at the date of commencement of the insurance period or in the notice of the terms and conditions and payments which the State provided to the individual on the effective date pursuant to the Health Insurance Law or within the health fund proposal according to Section 8(1) of the Health Insurance Law, which was approved according to Section 8(2a) of the said law, and in the event that the different provisions included different payments for the same medical service – the higher of them.
1.12	**"Overseas / Outside of Israel"**	any place outside of Israel, including any means of transportation on their way from Israel or to Israel.
1.13	**"Israel"**	the areas of Israel, excluding any means of transportation on their way from Israel or to Israel, including the areas under the control of the IDF, but excluding the areas possessed by The Palestinian Authority,
1.14	**"Health Insurance Law"**	National Health Insurance Law, 1994.
1.15	**"Foreign Employees Law"**	Foreign Employees Law (Illegal Employment and Ensuring Fair Conditions, 1991.
1.16	**"Insured Card"**	a card issued by The Insurer in addition to issuance of the insurance policy, which shall state the personal details of The Insured, and which shall be presented by The Insured before any medical institute, in order to be provided a medical service.
1.17	**"A Medical Institute"**	a hospital or a clinic, including a medical institute, a lab, a diagnostic center, a pharmacy.
1.18	**"Current State"**	disability, congenital disease including hereditary diseases and/or a health condition and/or a medical condition and/or a disease, whether it is treated or not, and/or consequences thereof, whether direct or indirect, caused and/or exacerbated by the health condition that existed prior to the commencement of the insurance, subject to the declaration of The Insured and/or an approval of a physician, all subject to the provisions of section 3.1.4. below.
1.19	**"Service Providers"**	a Public General Hospital, as well as doctors and/or medical institution that are engaged in an agreement with The Insurer, from which alone The Insured shall be entitled to be provided the health services detailed in this insurance policy, all subject to the terms and conditions of the insurance policy.
1.20	**"Health Services Basket"**	within the definition of the terms in the Health Insurance Law.
1.21	**"A Foreign Employee"**	a person employed in Israel, who is not an Israeli citizen or resident.
1.22	**"Order of Foreign Employees"**	Order of Foreign Employees (Prohibition of Illegal Employment and Ensuring Fair Conditions) (Health Services Basket for an Employee), 2001.
1.23	**"Physician"**	holder of a medical certificate that is duly authorized to work as a physician in Israel.

1.24	**"General Physician"**	a general Physician, who is not a specialist, as well as a specialist in family medicine and/or internal medicine and/or gynecology.
1.25	**"Health/Medical Services"**	all the medical services to which the foreign employee is entitled under the terms and conditions of this insurance policy.
1.26	**"Primary Care Services"**	services to be provided by a General Physician.
1.27	**"Primary Care Services"**	services to be provided by a General Physician.
1.28	**"The Insurance Period"**	the period stated in the Insurance Policy Particulars Sheet enclosed to the insurance policy, which shall not exceed 12 months from the insurance commencement date.
1.29	**"A Single Employment Period"**	the entire period of work of The Insured, even if not continuous, during which employer-employee relations existed between a particular employer and a particular foreign employee.
1.30	**"Health Services at Work Regulations"**	Parallel Tax Regulations (Labor Health Services), 1973.

2. General Terms And Conditions

2.1 Duty of disclosure

2.1.1 In the event that The Insurer presented to The Insured, prior to the conclusion of the agreement, whether within the insurance proposal form or in any other written form, a question concerning a matter that may affect the willingness of a reasonable insurer to conclude the agreement in general or to conclude it under the terms and condition specified therein (Herein: **"Material Matter"**), then The Insured is required to respond it in full and justly. A comprehensive question, which includes various matters, without differentiating them, does not require response as provided above, unless it was reasonable upon the conclusion of the agreement.

2.1.2 A concealment of fraudulent intent on the part of The Insured of a matter that he knew to be a Material Matter is tantamount to providing an answer that is not complete and just.

2.1.3 In the event that a Material Matter is not responded completely and justly, then The Company is entitled, within 30 days from the date that it was made aware of that and as long as no Insurance Event has occurred, to annul the insurance policy by giving a written notice to The Insured.

2.1.4 In the event that The Company annulled the insurance policy by virtue of this section, then The Insured shall be entitled to repayment of the Insurance Fees that he has paid for the period after the annulment, after deducting the expenses of The Company, unless The Insured acted with fraud intent.

2.1.5 In the event that an Insurance Event occurred prior to cancellation of the insurance policy by virtue of this section, then The Company is solely liable to pay reduced insurance rewards at a relative rate, equaling the ratio between the Insurance Fees that would have been paid by The Company according to the real situation and the agreed Insurance Fees, and The Company shall be completely exempt in each of these:

2.1.5.1 The response was given with fraud intent.

2.1.5.2 A reasonable insurer would not have engaged in such an agreement, even for higher Insurance Fees, had it been aware of the real situation; in such case The Insured is entitled to repayment of the Insurance Fees he paid for the period after the occurrence of the Insurance Event, less The Company expenses.

2.1.6 The Insurer is not entitled to any of the aforesaid remedies in any of the following cases, unless the incomplete and unjust response was given with fraud intent.

2.1.6.1 The Insurer was aware or was supposed to be aware of the real situation at the conclusion of the agreement or in the event that he caused the response not to be complete and just.

2.1.6.2 The fact in response for which the incomplete and unjust response was given ceased to exist prior to the occurrence of the Insurance Event, or did not affect the event, the liability of The Insurer or scope thereof.

2.1.7 In the event of insurance rewards of the kind of compensation, The Insurer is not entitled to the

aforesaid remedies after three years have passed from the conclusion of the agreement, but in the event that The Insured acted with fraud intent.

2.2 The Validity Of The Insurance Policy

The entering of this insurance policy into effect is subject to payment of the first premium in practice. This term shall not apply in the event that means of payment was received by The Insured from which is it is possible to charge the insurance premium. In the event that The Company was paid Insurance Fees, prior to the consent of The Insurer to provide the insurance, then such payment shall not be considered as consent of The Insurer to provide the insurance. In such case, The Insurer shall send, within 90 days from the date of first receipt of the Insurance Fees, a decision regarding the acceptance or unacceptance of the candidate for insurance, and shall send him, as applicable, an insurance policy, including a policy particulars sheet, or a notice of rejection according to which The Insured is not accepted for insurance and has no effective insurance coverage or request for completion of datum or a counter insurance proposal. In the event that The Insurer failed to send, within 90 days from the first receipt of the Insurance Fees, a notice of rejection as provided above, or a request for completion of datum or a counter insurance proposal, then The Insured shall be considered to have been joined the insurance under the terms and conditions stipulated in the insurance proposal. In the event that an Insurance Event occurred to the candidate for insurance during the period between the first receipt of Insurance Fees and the decision of The Insurer concerning his acceptance or unacceptance for insurance, and if according to the provisions of medical underwriting held by The Insurer regarding candidates for insurance with similar characteristics, The Insurer would have notified the candidate for insurance, at the end of the underwriting procedure, of his acceptance for insurance (had the Insurance Event not occurred), then the candidate for insurance would be entitled to coverage within the framework of the insurance policy for the Insurance Event, all subject to all the other provisions of the insurance policy and terms and conditions thereof.

2.3 Declaration Of Health

2.3.1 The Policyholder shall provide The Insurer a Declaration of Health and a waiver of medical confidentiality, executed by The Insured, instructing his physicians and/or any medical entity or institution, whether in Israel or overseas and/or the National Insurance Institute and/or the Ministry of Defense and/or any other government office and/or insurance company and/or health fund, to transfer to The Insurer any reasonable information regarding The Insured that is in their possession.

2.3.2 The Policyholder shall arrange execution by The Insured of a Declaration of Health form and a waiver of medical confidentiality, which shall be provided by The Insurer in a language understood by The Insured, and shall provide to The Insurer the form in such language that is understood by The Insured, together with the declaration by The Policyholder, stating that the form was executed by The Insurer after he has been explained its content in the language understood by him and/or that The Insured executed the Declaration of Health form after reading it in such language that is understood by him.

2.4 Claims

2.4.1 Upon the occurrence of an Insurance Event, The Insured or The Policyholder shall notify the service center of The Insurer accordingly, and as soon as possible. In cases where an advance approval of The Insurer is required, The Insured and/or The Policyholder shall obtain a written approval.

2.4.2 In the event that the Insurance Event is a hospitalization due to an emergency medical condition, which prevented from The Insured and/or The Policyholder an advance notice to The Insurer as required by the insurance terms and conditions, then The Insured and/or The Policyholder shall ensure that the notice of directly addressing the hospital be transferred as soon as possible to the service center of The Insurer.

2.4.3 In the event that The Insured has not approached The Insurer for the receipt of the advance approval, then the insurance benefits shall be reduced to the amount that The Insurer would have paid had it been provided an advance notice.

2.4.4 The Insured shall provide The Insurer a waiver of medical confidentiality, instructing all his physicians and/or any medical entity or institution, whether in Israel or overseas to transfer to The Insurer any medical information that is in their possession, and which relates to The Insured.

2.4.5 The Insured or The Policyholder, as the case may be, shall provide The Insurer details concerning the claim, as well as medical or other documents required by The Insurer for the purpose of inquiring his liability.

The documents may be provided digitally too, at least by e-mail, a test message or by means of the personal account of The Insurer with The Company.

2.5 A Medical Examination

The Insurer shall be entitled to require The Insured, reasonable under the circumstances, to undergo medical examinations with a Physician on behalf of The Insurer and at the expense of the Insurer or by a Physician on behalf of The Insured.

* It shall be clarified that The Insured shall, at any time, be entitled to request to exhaust all the rights that are granted thereto by virtue of the insurance policy in court.

2.6 Annulment Of The Insurance

2.6.1 In the event that The Insured and/or The Policyholder has/have failed to pay the Insurance Fees regularly, then The Insurer is entitled to annul the insurance policy in accordance with the provisions of the Insurance Contract law, 1981 (Herein: “Insurance Contract Law”).

2.6.2 In the event that The Policyholder annulled the insurance policy before the end of the insurance period due to termination of the employment period of The Insured with The Policyholder, then The Insurer shall repay The Policyholder a proportion of the Insurance Fees for such period during which The Insured was no longer insured, subject to its liability under the Insurance Contract Law.

2.6.3 In respect of Section 2.6.2: the proportional Insurance Fees shall be repaid to The Policyholder for the after the returning of The Insured Card to The Insurer and in the case of annulment within less than two months from the date of commencement of the insurance period, processing fees equaling the amount of two months for this insurance policy shall be deducted from the proportional repaid Insurance Fees.

2.6.4 In the event that The Insured concealed from The Insurer a material fact as provided in Section 2.1 above, as stipulated in Insurance Contract Law.

2.6.5 In the event that The Insured did something with the intention to prevent from The Insurer the inquiry of the liability thereof, or form a burden, The Insurer shall not be liable to pay insurance benefits, unless he would have been liable to pay then had such thing not been done.

2.6.6 The Policyholder and/or The Insured shall be entitled to annul the insurance policy by a written notice to The Insurer at any time.

2.7 Extending The Insurance Period

2.7.1 The Insurer undertakes to extend the insurance period of The Insurer, continuously, upon the termination of the insurance period upon request of The Policyholder or of The Insured received by The Insurer, provided that Insurance Fees were paid for the period between the termination of the original insurance period and the insurance extension, as long as The Insured continues to work as a foreign employee in Israel for the employer.

2.7.2 The Insured or The Policyholder shall be entitled to renew the insurance policy without re-underwriting, within 90 days.

2.7.3 An Insured that is not entitled to extension without underwriting, as provided in Section 2.7.2 shall be applied the provisions of Sections 2.7.4-2.7.5 below. The provisions of Sections 2.7.5-2.7.6 below shall apply to any type of extension.

2.7.4 In any other case that does not fall under the cases listed in Sections 2.7.2 through 2.7.2 – The Policyholder is entitled to request The Insurer to extend the insurance period for an additional period. The extension of the insurance period shall be subject to an underwriting procedure as is customary by The Insurer, and subject to approval of The Insurer in advance and in writing. It is hereby clarified that upon termination of the insurance period, as defined within the insurance policy, the insurance will not be extended without consent, as provided in this section, within the period specified in Section 2.7.4.2 below, even if The

Policyholder and The Insured have offered The Insurer to extend it in any type and at any date.

2.7.4.1 The Policyholder is entitled to request to extend the insurance period (Herein: **"Request for Extension"**). The Request for Extension shall be sent to The Insurer by mail at least 30 days prior to the termination of the insurance period.

2.7.4.2 In the event that The Insurer consents to extend the insurance period, then The Insurer shall notify The Policyholder of its consent in writing. The letter shall be sent to The Policyholder within 20 days from the date of receipt of the Request for Extension. In the event that The Insurer gave his consent to extend the insurance period, then the insurance continuity of The Insured shall be kept, including the first date, within the definition of the terms below, within the existing state.

2.7.5 The calculation of the Insurance Fees for the additional period shall be carried out in accordance with the number of extension days, according to The Insured's Insurance Fees tariff, which will be in effect at the date of commencement of the extension.

2.7.8 The Insurer shall be entitled to amend the Insurance Fees at the date of commencement of any extension of this insurance policy.

2.8 Changes In The Health Services

2.8.1 The Insured shall be entitled to the services included in the Health Services Basket and the work services basket within the definition of the terms below, and as these shall be emended from time to time.

2.8.2 In the event that changes are made in the Health Services Basket and/or in the health basket and/or in the work services basket and/or the Health Law and/or in any order and/or provision subsequently to the commencement of the insurance period (Herein: "The New Health Basket"), then The Insurer shall notify The Policyholder and/or The Insured's of the changes that apply to the Health Services Basket and/or the Health Basket and/or in the Work Services Basket and/or in the Health Law and/or in any order and/or provision subsequently to the commencement of the insurance period, and shall be entitled to make changes in the insurance policy and in the Insurance Fees, including payment of an addition to the Insurance Fees, which may be required as a result of the said change.

2.9 Payment Of The Insurance Fees, Taxes And Levies

The Policyholder is bound to pay The Insurer the Insurance Fees and the governmental and other taxes that apply to this insurance policy or such imposed to the Insurance Fees and to all other payments that The Insured is bound to pay according to the insurance policy, whether such taxes exist at the date of preparing the insurance policy or imposed at a later date thereafter.

2.10 Notices

The Policyholder is required to notify The Insurer of any change in his address in writing. A notice sent by The Insurer to the last address of The Policyholder known thereto, shall be considered a notice duly delivered.

2.11 The Insurer's Absence Of Liability For The Actions And/Or Omissions Of The Service Providers

The Insurer shall have no liability whatsoever for the nature of the medical and/or other services provided to The Insured within the framework of this insurance policy. The Insurer is not liable for any damage that may be caused to The Insured and/or to any person other than him, whether directly or indirectly, due to the choice of The Insured and/or his referring by The Insurer to medical and/or other service providers and/or due to professional negligence of the service providers.

2.12 Limitation

The limitation period of a claim for the payment of insurance benefits for an Insurance Event according to this insurance policy is 3 years from the date of occurrence of the Insurance Event. In the event that the cause of the claim is disability caused to The Insured due to an accident, as provided in chapter D below, then the limitation period shall be counted from the date on which The Insured has become entitled to claim insurance benefits under the terms and conditions of the insurance agreement.

2.13 Insurance Contract Law

The provisions of Insurance Contract Law, 1981, shall apply to this insurance policy.

2.14 Jurisdiction

The exclusive and sovereign jurisdiction in all respects related to and deriving from this insurance policy shall be the competent courts in Israel, in accordance with the Israeli law, and no other court whatsoever shall have any jurisdiction.

The Israeli law shall apply to claims deriving from and/or related to this insurance policy.

Chapter B - The Health Services

1. Subject to the provisions of this insurance policy, The Insured shall be entitled to The Health Services, all as detailed below:

1.1 Treatments basket

1.1.1 All the services listed in the second addition to the Health Insurance Law at the date of commencement of the insurance period, as they may be amended from time to time.

1.1.2 Hospitalization services at a psychiatric hospital or at a psychiatric department in a general hospital, in a medical emergency condition, for a period that shall not exceed 60 days for a single employment period.

1.1.3 The services detailed below –

1.1.3.1 Amniocentesis for women aged 35 and more, at the beginning of their pregnancy.

1.1.3.2 Vaccines against tetanus, rabies and diphtheria.

1.1.3.3 Mantu tests and lung imaging.

1.1.3.4 Wheelchairs and walkers.

1.2 Health Basket

All the services listed in National Health Insurance Order (Medications in the Health Basket Services), 1995, at the date of commencement of insurance period.

1.3 Work Services Basket

All the services listed in Regulations 2 and 5 of The Work Services Regulations, pursuant to the manner provided in said Regulations, with the necessary changes, at the date of commencement of insurance period.

1.4 One-Time Compensation For An Employee In The Long-Term Care Sector

1.4.1 During the period start of which is on October 1, 2017 and through September 30, 2019:

After the passage of thirteen years since the employee first received a permit for a visitation stay for the purpose of working in the long-term caregiving sector - coverage for a one-time special compensation of NIS 80 thousand (linked to the CPI), which is intended for an employee who is found unfit to perform his work for medical reasons as stated in Section 4 below, provided that he had realized his right to fly back to his country, as provided in Section 2 below; The right to compensation shall apply to an employee who, at the time of the determination by the Physician, as stated in Section 4 below, is unfit for his work, had a valid license for a valid staying permit for work purposes in the long-term caregiving sector or had such a license at any time during the 12 months preceding the aforesaid doctor's determination.

1.4.2 During the period start of which is on October 1, 2019 onwards:

After the passage of ten years since the employee first received a permit for a visitation stay for the purpose of working in the long-term caregiving sector - coverage for a one-time special compensation of NIS 80 thousand (linked to the CPI), which is intended for an employee who is found unfit to perform his work for medical reasons as stated in Section 4 below, provided that he had realized his right to fly back to his country, as provided in

Section 2 below; The right to compensation shall apply to an employee who, at the time of the determination by the Physician, as stated in Section 4 below, is unfit for his work, had a valid license for a valid staying permit for work purposes in the long-term caregiving sector or had such a license at any time during the 12 months preceding the aforesaid doctor's determination.

An employee shall be entitled to a one-time compensation under this Section only if the determination of the Physician according to Section 4 below was not before the commencement date, but it shall further apply to the working period before the commencement date.

2. Additional undertakings of The Insurer

2.1 Subject to the provisions of this insurance policy, The Insurer shall bear the expenses detailed below, all subject to the terms, restrictions and exceptions as provided in this insurance policy below –

2.1.1 **Customary payment:** for medical services covered by this insurance policy, which The Insured shall bear against the receipt of the customary payment, The Insurer shall bear the customary payment. **The Insurer shall not bear customary payment where the medical services in respect of which the customary payment was paid is not covered under this insurance policy.**

2.1.2 Providing the coverage of all the expenses related to the flight of The Insured from Israel back to the country of origin of The Insured, including accompaniment or other special arrangement throughout the flight, which are the result of the medical state of the employee.

2.1.3 **Expenses of transportation of the corpse of The Insured:**

2.1.3.1 In the event of the death of The Insured, under circumstances entitling him to medical care pursuant to the terms and conditions of this insurance policy, The Insurer shall bear the expenses of transporting his corpse from Israel to his country of origin.

2.1.3.2 Notwithstanding the provisions of Section 2.1.3.1 above, and Section 3.1.7 below, in the event that The Insured passed as a result of an injury at work, within the definition of the term in Section 3.1.7 below, then The Insurer shall bear the expenses of transferring the corpse of The Insured from Israel to his country of origin.

2.1.3.3 **Liability of The Insurer pursuant to Section 2.1.3.1 and 2.1.3.2 is subject to receipt of an advance approval from The Insurer and execution of the aforesaid flight by means of The Insurer alone.** In the event that The Insured or anyone acting on its behalf did not address The Insurer for the purpose of receipt of his approval, prior to the flying of The Insured from Israel back to his country of origin, as provided above, then The Insurer shall be entitled to reduce the amount of the insurance benefits to which The Insured shall be entitled to such amount which The Insurer would have paid him had The Insured approached him with the request to receive the aforesaid approval prior to carrying out the air transport.

2.1.4 Emergency Air Transportation For A Close Family Member To Israel:

2.1.4.1 In this section, **"A Close Family Member"**: wife, husband, son, daughter, brother, sister.

2.1.4.2 In the event that The Insured is hospitalized under circumstances entitling him **to receive medical services under the terms and conditions of this insurance policy,** for the purpose of executing a surgical invasive procedure that involves hospitalization for more than 10 days, or in the event that the General Physician determines that the life of The Insured is in danger, then The Insurer shall pay to the close family member the cost of purchasing a flight ticket and travel to the place of hospitalization in Israel of The Insured up to a total amount of NIS 5,500, and the cost of staying in a hotel for up to 10 days, up to a maximum total amount of NIS 150 per day.

Undertaking of The Insurer pursuant to this section shall be subject to pur-

chasing the plane ticket and the arrangements of staying in a hotel via The Insurer and having been approved in writing by The Insurer in advance and in writing. In the event that The Insured has not approached to The Insurer for the purpose of receipt of his approval for the said expenses, then The Insurer shall be entitled to reduce the amount of insurance benefits to which The Insured shall be entitled to such amount which The Insurer would have paid him had The Insured approached him with the request to receive the aforesaid approval prior to carrying out the air transport.

2.1.5 Air Transportation Expenses In The Event Of Inability To Work:

In the event that a physician specializing in occupational medicine determines that The Insurer is not able to carry out the work, for which he was accepted to work for The Policy-holder, and that he shall not be able to carry it out within a time period of 90 days from the date on which he was examined thereby, even he is provided the medical care that he is required to (Herein: **"Inability to Work"**), all within the period of the insurance, then The Insurer shall bear the cost of the plane ticket to the country of origin of The Insured, up to a maximum total of NIS 7,200.

The Insurer shall not bear the plane ticket expenses as provided in Section 2.1.5 above, where the Inability to Work derived from circumstances that do not entitle The Insured of medical services pursuant to the terms and conditions of this insurance policy, excluding circumstances as provided in Section 2.1.5 above and 3.1.5 below.

2.1.6 First aid services in dentistry:

2.1.6.1 The Insured shall be entitled to receive emergency first aid services in dentistry, as specified below, and only said services, all by means of dentist clinics across the country, as shall be determined from time to time by The Insurer, particulars of which will be available at the service center of The Insurer –

a) Extensive dental caries, temporary filling.
b) Tooth cavity, temporary filling.
c) Exposed neck of tooth, substance for preventing sensitivity.
d) Severe inflammation, uprooting of a nerve or embalming material.
e) Dental abscess, abscess drainage and/or treating malocclusion.
f) Compression of food, treating the gums.
g) Peri-coronitis, washing and/or medication.
h) Pain after uprooting, pain relief.
i) Pressure damages under existing prosthesis, release of pressure injuries.
j) Any additional treatment deriving from tooth pain – treatment shall be given to relief of to seize the pain.
k) Examination and imaging of the painful teeth.
l) Providing suitable prescription to release the pain in the event that treatment is not given to the tooth at the time.

2.1.6.2 Notwithstanding the provisions of Section 3.1.4 below, The Insured shall be entitled to the emergency and first aid services detailed in Section 2.1.6.1 above, even if required due to an existing state.

3. Exceptions To Chapter B

3.1 Notwithstanding the provisions of Section 1 and 2 above, The Insurer shall not bear the expenses and/or the medical expenses for the services listed below, and The Insured shall not be entitled to these expenses and/or services within the framework of this insurance policy –

3.1.1 Within the framework of the treatments basket

3.1.1.1 Psychological services.

3.1.1.2 Treatments for psoriasis patients in Dead Sea.

3.1.1.3 Genetic tests.

3.1.1.4 Long-term care hospitalization or other long-term care services.

3.1.1.5 Services for treating impotency problems, difficulties in sexual functioning, fertility of the male or the female, as well as artificial fertilization or artificial insemination.

3.1.1.6 Services provided outside of Israel.

3.1.1.7 If the Insurance Event has occurred after the termination of the insurance period and/or consecutive insurance periods, as provided in the insurance period extension services.

3.1.2 Within the framework of the Health Basket

3.1.2.1 Medication for treating the Alzheimer disease.

3.1.2.2 Medications intended for treating impotency problems, difficulties in sexual functioning, fertility of the male or the female, as well as artificial fertilization or artificial insemination.

3.1.3 Pregnancy

Health services related to pregnancy throughout the first 9 months, cumulatively, during which employee-employer relations existed between the female employee and one or more employer in Israel, excluding emergency medical condition.

3.1.4 Existing condition

Medical services required by The Insured, due to a medical condition that derives from a medical condition that existed before such date on which any employee in Israel arranged for a medical insurance, within the first three years from the commencement of Foreign Employees Order – October 17, 2001, or from the first date on which a medical insurance was arranged for The Insured, whichever is the later (Herein: "The First Date"), if any of the following two is fulfilled:

3.1.4.1 The Insured himself has confirmed that the medical condition for which he was required the service derives from an existing condition.

3.1.4.2 A Physician has confirmed, according finding before him, that the medical problem for which the employee requires the services derives from an existing condition.

3.1.4.3 In the event that The Insured stayed outside of Israel, after the first date, for a period or periods exceeding 90 consecutive days with numerous employers, or for a period exceeding 120 consecutive days – if such staying separated between the employment periods with the same employer – The First Date in respect of paragraph 3.1.4 shall be considered The First Date after the staying during which the employee shall be covered by medical insurance.

3.1.4.4 Health services in emergency medical state due to existing condition: notwithstanding the provisions of Section 3.1.4 above, The Insurer shall bear the medical expenses for the medical services that The Insurer required at the time of emergency medical condition deriving from an existing condition, for the purpose of stabilizing his medical condition up to such condition that allows to continue giving him care outside of Israel, as well as expenses for other medical services that The Insured requires due to such existing condition, which The Insurer required throughout the 30 days following such determination of a Physician or the determination concerning the stabilization of his said medical condition.

3.1.5 Inability to Work

3.1.5.1 Medical services that The Insured requires after a specialist in occupational medicine determined that The Insured is not qualified to perform the work for which he was hired by The Policyholder and that he will not be fit to

perform it within 90 days from the date on which he was examined by him, even if he is provided the medical treatment that he requires.

3.1.5.2 Notwithstanding the provisions of Section 3.1.5.1 above, The Insured shall me entitled to medical services which he requires at medical emergency condition for the stabilization of his medical condition, up to reaching such condition that allows him treatment outside of Israel, as well as other medical services which he required throughout the 30 days period after the aforesaid determination of the Physician or the determination concerning the stabilization of his medical condition as provided above.

3.1.6 Road accidents and hostile acts

Medical services that The Insured requires following:

3.1.6.1 Road accidents, within the definition of the term in The Compensation for Road Accident Victims Law, 1975.

3.1.6.2 Hostile Acts, within the definition of the term in The Compensation for Victims of Hostilities Law, 1970, if he is injured pursuant to the definition of the term in said law.

3.1.7 Health services due to injury at work

3.1.7.1 The Insurer shall not bear the expenses for the health services of The Insured, where The Insured required them due to an injury at work, within the definition of the term in The National Insurance Law [Consolidated Version], 1995 (Herein: "Injury at Work"), provided that the employer confirmed, within a form determined by the National Insurance Institute designated for this purpose (Herein: "The Injury Form") that the said injury is an Injury at Work.

3.1.7.2 In the event that the employer provided The Injury Form and the National Insurance Institute did not determine, within three months from the date of the Injury at Work, that this is an Injury at Work, then The Insurer shall bear the expenses of the Health Services provided to The Insured following said Injury at Work, within three months, even if not provided by the service providers, and after three months, if provided by the service providers of The Insurer.

3.1.7.3 In the event that the injury derived from Injury at work, then The Policyholder undertakes to approve the injury as provided in Section 3.1.7.1 above, over The Injury Form to the National Insurance Institute, with a copy to The Insurer within 7 days from the date of The Injury at Work. The Policyholder who has failed to approve as provided above, and was found that the injury was an Injury at Work, within the definition of the term above, then he shall bear all the expenses borne by The Insurer and shall pay them in addition to linkage differentials and maximum interest as prescribed by law, within 7 days from the requirement to do so by The Insurer.

3.1.8 Receiving services by a service provider that has no arrangement with The Insurer.

4. Rules For The Approval Or Determination Of A Specialist Physician – An Existing Condition And Inability To Work

4.1 Approval that the medical condition for which The Insured is required a medical service derives from an existing condition, that an employee reached stabilization of his medical condition – shall be provided by a specialist physician.

Determination of a physician concerning the Inability to Work of The Insured, even if medical care is given thereto – shall be provided by a specialist occupational physician.

4.2 The 30 days specified in paragraphs 3.1.4 and 3.1.5 shall be counted as of the date of the final approval or the final determination provided pursuant to the provisions of Section 4.3 below, but determination concerning the stabilization of the medical condition of an employee shall not be considered final determination, unless the head of department of the hospital in which The Insured was hospitalized,

or the deputy manager – in the absence of the head of the department – determined that at the date on which the entitlement of The Insured for Health Services should be resolved in accordance with the provisions of this insurance policy, he has not reached stabilization of his medical condition. Such determination shall be effective as long as no other determination is provided, by the head of the department or his deputy – as provided above.

4.3 The rules for the approval or determination as provided in Section 4.2 above, are as follows:

4.3.1 The Insurer shall be entitled to require The Insured to undergo an examination by a specialist physician acting on his behalf, at the expense of The Insurer. The opinion of the Physician shall be provided to The Insured in addition to a notice concerning the entitlement of The Insured to a counter opinion as provided in Section 4.3.2 below, and in addition to the details of the bodies or organizations that may assist him to realize it, and who have provided him their consent.

4.3.2 The Insured shall be entitled to a counter opinion from a specialist Physician to his choice, which shall be provided to The Insurer within 21 days from the date of receipt of by The Insured of the opinion on behalf of The Insurer. The Insurer shall bear the expenses of the counter opinion up to the maximum amount, which shall be determined by the general manager of the Ministry of Health and the Commissioner of Insurance and the Capital Market at the Ministry of Finance (Herein: **"The Effective Wages"**).

4.3.3 In the event that the opinions of the two Physicians as provided above are divided, then the parties shall appoint a Physician which they agree upon, financed by The Insurer, the opinion of which shall be the determining opinion. In the event that the parties fail to agree on a Physician, then a determining specialist Physician shall be appointed by the Head of the Association of the Israel Medical Association (Herein: **"The Association"**), who engages in the medical sector that concerns the disease of The Insured, and in respect with the Inability to Work – even if medical care is provided – [the opinion shall be provided] by the Head of the Association of Occupational Medicine of The Association (Herein: **"The Determining Physician"**), whose opinion shall be the determining opinion. In the event that such said Head of the Association failed to appoint The Determining Physician within 15 days from the day of being approached by The Insurer, then The Determining Physician shall be appointed by the general manager of The Ministry of Health or anyone appointed thereby for said purpose. The wages of The Determining Physician shall be The Effective Wages and it shall be paid by The Insurer.

Chapter C - The Service Providers And The Health Services

5. The Service Providers

5.1 The health services included in this insurance policy shall solely be provided by the service providers, subject to any change on which The Insurer shall notify in writing to The Policyholder. In the event that the service provider ceased to work with The Insurer, then The Insured shall contact The Insurer's center in order to obtain a referral to another service provider.

5.2 The health services that are included in this insurance policy shall be provided to The Insured according to a medical discretion, at reasonable quality, within a reasonable time frame and within a reasonable distance from the place of residence of The Insured.

5.3 Notwithstanding the provisions of Section 5.1 above, The Insured shall be entitled to receive medical services listed below funded by The Insurer, under the following circumstances:

5.3.1 Emergency room services in any of the general hospitals across the country, in any of the following cases:

5.3.1.1 Any new fracture.

5.3.1.2 Acute discharge of shoulder or elbow.

5.3.1.3 Injury requiring fusion by sewing or alternative fusion.

5.3.1.4 Exhaustion of a foreign body to the respiratory system.

5.3.1.5 Penetration of a foreign body into the eye.

5.3.1.6 Treatment of cancer.

5.3.1.7 Treatment of Hemophilia.

5.3.1.8 Treatment of cystic fibrosis.

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

5.3.1.10 The referral ended in non-elective hospitalization.

5.3.1.11 Emergency medical condition.

5.3.2 Hospitalization services given to The Insured frequently after referral to emergency room, if [such referral was] made in the cases specified in Section 5.3.1 above.

6. Receiving Health Service

6.1 The access to the various health services shall be subject to an advance approval from The Insurer and/or subject to the approval of the General Physician and/or shall be free, all as provided below:

6.1.1 The access to the first aid medical services included in this insurance policy shall be free, and The Insured shall not be required to receive the advance approval of The Insurer prior to receiving health service of the said type.

6.1.2 The access to the non-first aid medical services, excluding the cases specified in Section 5.3 above, shall be subject to receiving an advance approval from the General Physician of the first aid health services. In the event that The Insured has not approached The Insurer for the purpose of receipt of his approval for the expenses, as provided above, then The Insurer shall be entitled to reduce the reduce the amount of insurance benefits to which The Insured shall be entitled to such amount which The Insurer would have paid him had The Insured approached him with the request to receive the aforesaid approval.

6.1.3 The access to examinations at the imaging institutes, the diagnostic institutes, the gastroenterology Institute, the labs and the elective hospitalization services, shall be subject to consent of The Insurer in advance and in writing.

The Insured shall submit a request in writing for the approval of the services listed in

this section to The Insurer, together with the approval of the General Physician, that The Insured requires this health service.

The requested approval or the notice of the rejection to issue it shall be granted within 7 days from the date of determination of the General Physician in respect of the requirement to conduct an examination or hospitalization, as applicable, and/or from the date on which The Insurer received the request of The Insured, whichever is the later, and in any case shall not be postponed to such date that may form a risk to The Insured or damage the reasonability of the care that he is entitled to under this insurance policy.

In the event that The Insured did not approach The Insurer for the receipt of his approval for the expenses as provided above, The Insurer shall be entitled to reduce the reduce the amount of insurance benefits to which The Insured shall be entitled to such amount which The Insurer would have paid him had The Insured approached him with the request to receive the aforesaid approval.

6.1.4 Apart from the cases listed in Section 5.3 above, The Insurer shall not beat the expenses of the Health Services of The Insured in the emergency room, unless The Insured has received the approval of the General Physician in advance.

Chapter D – Compensation For Death And Disability As A Result Of An Accident

7. For Insureds who have not yet reached the age of 18 and/or who have reached the are of 65 shall not have insurance coverage under this chapter. The total undertakings of The Insurer under this chapter shall not exceed a total maximum of NIS 50,000 per insured, [amount] to which The Insured shall be entitled only once.

7.1 In this chapter –

7.1.1 "The Insured" - any person staying in Israel on the basis of a foreign employee, provided that such employee is over the age of 18 and under the age of 65.

7.1.2 "Accident" - unexpected physical injury which was caused throughout the insurance period by external violent visible means, which is the only, direct and immediate reason for the death or the disability of The Insured, excluding an injury caused due to verbal violence and/or mental pressure and/or accumulation of tiny repeated injuries over a period, which cause disability – shall not be considered an "accident", and excluding if the damage is caused as a result of hostile action, within the definition of the term in The Compensation for Victims of Hostilities Law, 1970.

7.1.3 "Disability" - permanent medical disability, which is the direct and decisive result of an accident (an accident that has occurred throughout the insurance period).

7.1.4 "Absolute Disability" - an absolute loss of an organ due to its separation from the body or total loss of the functioning of an organ.

7.1.5 "Death of The Insured" - the death of The Insured due to the Accident.

7.2 In the event that damage was caused to The Insured, within the insurance period, the cause of which is an Accident, then the insurance benefits shall be paid as follows:

7.2.1 In the event of Death of The Insured, aged 18 and less than 65 at the date of his death, the beneficiary stated in the proposal, or in the absence of a beneficiary - the legal heirs of The Insured or estate manager or the executors shall be paid a total of NIS 50,000.

7.2.2 In the event of Absolute Disability: in the event of Absolute Disability to an insured aged 18 and less than 65, which is caused after the date of the Accident, which occurred after the date of commencement of insurance, The Insurer shall pay insurance amount according to the rate detailed below: (the amount for payment shall be calculated as a percentage of the full insurance amount stated in Section 7.2.1 above). Example: in the event that Absolute Disability of The Insureds foot is determined, and the stated maximum insurance rate is NIS 50,000 – The Insured shall receive:

40% X NIS 50,000 = NIS 20,000

The nature of the disability/absolute loss of:	Disability percentage
Vision in both eyes	100%
Ability to use both hands or both legs	100%
The right arm or the right arm	60% *
Left arm or left hand	50% *
One leg	40%
Vision in one eye	25%
The thumb in one hand	16%
The index finger in the right hand	14% *
The index finger in the left hand	12% *
The little finger in the right hand	12% *
The little finger in the left hand	10% *
The middle finger in the right hand	8% *

The middle finger in the left hand	6% *
The ring finger in one of the hands	6%
Foot toe	5%
Any other finger on foot	3%
Hearing in both ears	40%
Hearing in one ear	10%

* In respect a left-handed person – the opposite: the left hand shall be given the percentage states in respect of the right hand, and in the case of disability in the right hand – according to the percentage of the left hand.

7.2.3 A disability that exists prior to the insurance commencement date and/or a disability determined in accordance with this annex shall be deducted from disability percentage entitling to payment according to this annex.

7.2.3.1 Organs that are not stated in the list – in any case where disability is caused to an organ that is not included in the list provided in Section 7.2.2 above, the disability percentage shall be determined in accordance with the determination of a medical specialist in the relevant disability field, and shall be paid as a percentage of the full insurance amount. Example: in the event that Absolute Disability in the back is determined for The Insured, and the General Physician determined that the disability rate is 70%, and the amount of maximum insurance amount provided in the Insurance Policy Particulars Sheet is NIS 50,000, then in such case The Insured shall receive:

70% X NIS 50,000 = NIS 35,000.

7.2.3.2 Non-absolute disability (in cases where the nature of the disability is provided in the list) – in any case of non-absolute disability in the organs specified in the list, adjusted disability percentage shall be determined as defined in Section 7.2.6 below.

7.2.3.3 Adjusted disability percentage – shall equal the disability percentage of the Accident, multiplied by the Absolute Disability rate provided in the list, which related to such organ and multiplied by the full insurance amount. Example: the determined non-absolute disability rate of The Insureds foot is 20%, and the maximum insurance amount as provided in the Insurance Policy Particulars Sheet is NIS 50,000. The rate of the Absolute Disability in the list according to the table above, in relation to the foot is 40%.

In such case, The Insured shall receive:

20% X 40% X NIS 50,000 = NIS 4,000.

7.2.4 It shall be stressed that a plastic disability shall not be covered under this insurance policy.

8. Special Exceptions For Chapter D – Compensation For Death And Disability As A Result OF AN Accident

The Insurer shall not pay insurance benefits under this policy if the death or the disability are caused directly or indirectly by or following:

8.1 An earthquake, volcanic explosion, nuclear fission, nuclear fusion, radioactive contamination.

8.2 Active participation of The Insured in a military, policy, uprising, revolution, rebellion, riots, disturbance, sabotage, terrorism action or an insurance incident during military service, resulting directly from activities of a military nature, including military or pre-military exercises or training of any kind.

8.3 Participation by The Insured in any act of sabotage or terrorism of any kind and/or in the war and/or a war action of hostile, regular or irregular forces.

8.4 The Insured's flight in an aircraft, other than The Insured's flight as a passenger in a civilian aircraft having a certificate of qualification for transporting passengers, subject to The Insurer's liability in Israel only.

8.5 Intentional self-injury or suicide or an attempt to make a suicide, whether or not The Insured is sane.

8.6 Amateur sport within the framework of a sports association registered under the Sports Law, 1988, and/or professional sports activity (which is his main occupation or has a monetary remuneration).

8.7 Participation of The Insured in extreme sports according to the list provided on The Company's website. In this regard, extreme sports refer to sports that are considered dangerous and which include/require, among others, those who are engaged in such extreme sports high levels of difficulty and/or physical exertion. The list of extreme sports will be updated from time to time, according to the list appearing on The Company's website - www.ayalon-ins.co.il

8.8 Use of explosives.

8.9 Intentional self-risk, other than self-defense and saving lives.

8.10 Alcoholism or drug use by The Insured or the commission of a crime, misdemeanor, drug trafficking, activity without a valid license suitable for the activity, if required (i.e. driver's or flight license, or sports activity requiring a license) or opposition to arrest.

8.11 Death or disability resulting from medical or surgical treatment.

8.12 Work accident as defined in the National Insurance Law.

8.13 A road accident as defined in the Compensation to Victims of Road Accidents Law, 1975.

8.14 Plastic disability.

Chapter E – A Table Of The Limits Of Liability Of The Insurer

A summary of the coverages	Limits of liability
Medical expenses during hospitalization	Full coverage
Medical expenses during hospitalization in a psychiatric hospital	Up to 60 days of hospitalization
Medical expenses not during hospitalization - including a family doctor, a specialist, diagnostic tests, imaging services, pharmaceuticals	Full coverage
Emergency room - subject to the criteria stipulated in the order	Full coverage
Special one-time compensation for an employee holding a license in the nursing sector who was found unfit to perform his work for medical reasons, subject to the specified conditions	NIS 80,000
Medical Flight - accompanying medical staff and equipment as required by The Insured's medical condition to the extent that he is not fit for work	Full coverage
Extensions (no extra charge)	
Emergency dental care	Full coverage
Expenses for the transfer of a corpse	Full coverage
Personal accidents death/disability	NIS 50,000
Emergency flight for a close family member and expenses for stays in Israel for up to 10 days	NIS 5,500 NIS 150 for a hotel per day
Flight ticket back to the country of origin in case of loss of work ability	NIS 7,200

Only the full terms and exclusions of the insurance policy shall bind The Insurer.