Appendix 530
Health Insurance Policy For Foreign Workers

AYALON INSURANCE COMPANY LTD.

TRANSLATION

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

If this policy has been arranged and as stated in the policy schedule attached hereto, the insurer will indemnify the insured for the costs of medical services and/or shall pay the service providers and/or medical institutions providing the health services and/or shall compensate the insured due to an insured event which occurs during the period of insurance, up to the limits of liability of the company, subject to the terms, conditions and exclusions of the policy.
Any use of the masculine and/or the singular will have the same meaning, respectively, in the feminine and in the plural.

SECTION A – DEFINITIONS AND GENERAL CONDITIONS

1. DEFINITIONS:

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

1.1	**The company / the insurer**	.Ayalon Insurance Company Ltd
1.2	**The insured**	A person staying in the State of Israel as a foreign worker, who is employed by the .policyholder and whose name is stated in the policy schedule
1.3	**The policyholder**	The employer or company arranging the insurance policy with the company, and whose name appears in the policy as the policyholder, and who wishes to insure the foreign .worker whose name is stated in the policy schedule under this policy
1.4	**The policy**	This insurance contract including the proposal form, the policy schedule and any .endorsement or appendix thereto
1.5	**The proposal form**	The proposal form issued by the insurer, being fully completed including the health questionnaire, declaration of the date of entry into Israel and a waiver of medical .confidentiality, signed by the insured and by the policyholder in the appropriate place
1.6	**The heath questionnaire**	A health questionnaire and a waiver of medical confidentiality in favour of the insurer, .signed by the insured
1.7	**The policy schedule**	The page attached to the policy and constituting an integral part thereof, containing amongst other things, the personal details of the insured and specific details of the insurance cover for the insured. In the event of any discrepancy between the policy wording and the conditions shown in the policy schedule – that stated in the policy .schedule will prevail
1.8	**The premium**	The amount that the policyholder pays the insurer for the insurance cover under this .policy, subject to the terms and conditions of the policy
1.9	**The insured event**	An event occurring during the period of insurance in which the insured needs medical care in Israel which is covered under this policy, provided that the medical care is provided during the period of insurance and/or within 90 days of the expiry date of the .period of insurance, all subject to the terms, conditions and exclusions of this policy
1.10	**General-public hospital**	An institution in Israel recognised by the competent authorities as a general / public hospital and operating solely as a hospital, other than any institution which is a .sanatorium and/or hospice and/or rehabilitation centre
1.11	**The usual payment**	The payment, including a bond or deposit, incurred by the insured, plus linkage, for providing the actual medical service, which is stated in the second and third amendment to the National Health Insurance Act applying on the inception date of the period of insurance or notice from the State of Israel concerning terms and payments on the decisive date in accordance with the National Health Insurance Act or as proposed by the health maintenance organisations in accordance with article 8 (A1) of the Health Insurance Act, which has been approved in accordance with article 8 (A2) of the said act, and if the different directives contain different payments for the same medical service – .the higher of the two

1.12	**Abroad / Outside of Israel / Overseas**	.Anywhere outside of the State of Israel including whilst in transit to and from Israel
1.13	**Israel**	The borders of the State of Israel other than any transportation means to and from Israel, including the disputed territories but excluding the territories under the control of the .Palestinian Authority
1.14	**National Health Insurance Act**	.The National Health Insurance Act – 1994
1.15	**The Foreign Workers Act**	The Foreign Workers Act (Unlawful Employment and Assurance of Fair Conditions) – .1991
1.16	**Insurance certificate**	A card issued by the insurer in addition to the policy containing the personal details of the insured, which the insured should present to the medical institution in order to .obtain the medical service
1.17	**Index**	The Consumer Price Index published by the Central Bureau of Statistics from time to .time
1.18	**Base index**	.The known index on the first of the month of the inception of the period of insurance
1.19	**Decisive index**	The known index on the date of paying the premium to the insurer or payment of the sum insured to the insured or to the service suppliers, as aforementioned, subject to the .policy conditions
1.20	**Medical institution**	A hospital or a clinic including a medical institute, laboratory, diagnostic centre or .pharmacy
1.21	**Call centre**	A call centre operated by the insurer which provides service to insureds in connection with the policy including pre-approved service suppliers from whom the insured can .obtain service
1.22	**Emergency medical situation**	Circumstances in which a person's life is in immediate danger or whether there is an .immediate risk of severe and irreversible disability if urgent medical care is not provided
1.23	**Existing condition**	Impairment, birth defect, including hereditary illnesses and/or a health condition and/or medical condition and/or disease, either if treated or not, and/or their consequences, either directly or indirectly, which is caused and/or is worsened by a health condition that existing before the inception of the insurance, subject to the insured's health questionnaire and/or medical certificate, all subject to that stated in clause 3.1.4 .hereunder
1.24	**The pre-approved service providers**	A general / public hospital and a private hospital which has been approved in advance by the insurer, as well as doctors and/or medical institutions having an arrangement with the insurer from who the insured shall be entitled to receive the medical services detailed in this policy and from them only, all subject to the terms and conditions of the .policy
1.25	**National Health Basket**	.As defined in the National Health Insurance Act
1.26	**Foreign worker**	.A person who works in Israel but is not an Israeli citizen or resident
1.27	**Foreign Workers Ordinance**	The Foreign Workers Ordinance (Prohibition of Unlawful Employment and Assurance of .Fair Conditions) (Health Services Basket for Employees) – 2001
1.28	**Doctor**	A person holding a qualification in medicine and who is legally authorised to work as a .doctor in Israel
1.29	**General practitioner**	A general practitioner, who is not a specialist, including a specialist in family medicine .and/or internal medicine and/or gynaecology
1.30	**Health / medical services**	All of the medical services which the foreign worker is entitled to receive in accordance .with the conditions of this policy
1.31	**Primary healthcare services**	.Services provided by a general practitioner as defined above
1.32	**The period of insurance**	The period stated in the policy schedule attached to the policy, with a maximum of 12 .months from the inception date of the period of insurance
1.33	**Single period of employment**	The entire period of work of the insured, even if not consecutive, during which .employment relations exist between a specific employer and a specific foreign worker
1.34	**Health Services at Work Regulations**	.The Dual Tax Regulations (Health Services at Work) – 1973

2. GENERAL CONDITIONS:

2.1 Duty of disclosure

2.1.1 Duty of disclosure

If before arranging the policy the insurer presents a question to the insured either in a proposal form or in any other written manner concerning a matter which would influence the willingness of a prudent insurer to arrange the policy at all, or to apply special conditions (hereinafter: “material fact”), the insured shall provide an honest and complete reply in writing. A general question involving various matters without distinction between them is not subject to the requirement to provide a reply as aforementioned other than if it was reasonable at the time of arranging the policy.

2.1.2 Intentional non-disclosure by the insured of a fact which they knew to be a material fact with fraudulent intent is tantamount to providing a dishonest and incomplete reply.

2.1.3 If a dishonest and incomplete reply is provided to a question concerning a material fact, the company may, within 30 days of becoming aware of this and provided that an insured event has not yet occurred, cancel the policy by written notice to the insured.

2.1.4 If the company cancels the policy by virtue of this clause, the premiums paid to the company for the period after the cancellation will be refunded to the policyholder, less the insurer’s expenses, other than if the insurer acted with fraudulent intent.

2.1.5 If an insured event occurs before the policy is cancelled by virtue of this clause the insurer is only liable to make proportionately reduced indemnity payments at the ratio between the premium that would have been paid based on the true facts situation and the premium paid, and the insurer will be completely exempt in any of the following cases:

a. The reply was provided with fraudulent intent.

b. A prudent insurer would not have entered into such a contract, even at a higher premium if it would have been aware of the true facts; in such a case the insured is entitled to a return premium paid for the period after the occurrence of the insured event less the insurer’s expenses.

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

a. It was aware or should have been aware of the true situation at the time of arranging the policy or if it caused the reply to be incomplete and dishonest.

b. The fact in respect of which the incomplete and dishonest reply was provided no longer applied before the occurrence of the insured event, or did not affect the insured event, the liability of the insurer or its scope.

2.1.7 In the case of a claim for benefits rather than indemnity – the insurer is not entitled to the aforementioned remedies after three years have passed after the policy was taken out, other than if the insured acted with fraudulent intent.

2.2 The validity of the policy

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

2.3 Health questionnaire

2.3.1 The policyholder shall send a health questionnaire and a waiver of medical confidentiality form to the insurer, signed by the insured, instructing its doctors and/or any medical entity or institute either in Israel or abroad and/or the National Insurance Institute and/or the Ministry of Defence and/or any other government ministry and/or insurance company and/or health funds to provide the insurer with all reasonable medical information concerning the insured in its possession.

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

2.4 Claims

2.4.1 In the case of an insured event, the insured or the policyholder shall notify the insurer's call centre as soon as possible. In cases where the prior approval of the insurer is required, all of the information and the documents concerning the event shall be attached to the notice and the insured and/or the policyholder shall obtain written approval thereof.

2.4.2 If the insured event involves hospitalisation due to a medical emergency in a case where the insured and/or the policyholder is unable to notify the insurer in advance subject to the policy conditions, the insured and/or the policyholder shall notify the call centre of their direct admission to the hospital as soon as possible.

2.4.3 If the insured does not contact the insurer to obtain prior approval, the indemnity payments shall be reduced by the amount that the insurer would have paid if prior notice would have been given.

2.4.4 The insured shall provide the insurer with a waiver of medical confidentiality permitting all doctors and/or any medical or other institution in Israel or abroad to provide all of the medical information in their possession relating to the insured, to the insurer.

2.4.5 The insured or the policyholder, as applicable, shall send the information concerning the claim to the insurer together with medical or other documents required by the insurer to process the claim. The documents can be submitted digitally, by e-mail, text message or via the website of the insurer.

2.4.6 If the insured acts intentionally to prevent the insurer from processing the claim or obstructs it, the insurer shall be exempt from paying indemnity other than if it would have been liable to do so if nothing had been done.

2.5 Medical examination

The insured will be reasonably required according to the circumstances and at the request of the insurer to attend a medical examination by a doctor appointed by and paid for by the insurer, and the insured agrees to attend the medical examinations requested by the insurer. **It is hereby clarified that the insured may at any time exercise the rights conferred on them under the policy in a court of law.**

2.6 Cancellation of the policy / expiry of the period of insurance

2.6.1 The insurer is entitled to cancel the policy if the insured and/or the policyholder do not pay or have not paid the premium on time, in accordance with the provisions of the Insurance Contract Act - 1981 (hereinafter: "the Insurance Contract Act").

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

2.6.3 Concerning clause 2.6.2: The proportional share of the premium will be refunded to the policyholder for the period after the insured's certificate of insurance has been returned to the insurer and in the event of cancellation within less than two months from the inception date of the period of insurance – handling fees will be deducted from the proportional share of the premium which is refunded, equivalent to the premium for two months covered under this policy.

2.6.4 The insurer is entitled to cancel the policy if the insured breaches the duty of disclosure as stated in clause 2.1 above, in accordance with the provisions of the Insurance Contract Act.

2.6.5 The policyholder and/or the insured may cancel the policy by written notice to the insurer at any time.

2.7 Extension of the period of insurance

2.7.1 The insurer agrees to extend the period of insurance for the insured, consecutively, at the request of

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

2.7.2 The insured or the policyholder is entitled to renew the policy with continuity of cover from the expiry date of the policy, without repeating the underwriting process, within 90 days.

2.7.3 In the case of an insured who is not entitled to an extension without repeating the underwriting process as stated in clause 2.7.2; the provisions of clauses 2.7.4 and 2.7.5 hereunder will apply. The provisions of clauses 2.7.5 and 2.7.6 will apply to any type of extension.

2.7.4 In any case other which is not included in clauses 2.7.1 and 2.7.2 – the policyholder is entitled to request the insurer to extend the period of insurance for a further period. Extension of the period of insurance will be subject to the standard underwriting process of the insurer and subject to the prior written confirmation of the insurer. It is hereby clarified that at the expiry of the period of insurance, as defined in the policy, the policy will not be automatically extended without its agreement as stated in this clause within the period of time stated in clause 2.7.6 hereunder, even if the policyholder and the insured offered the insurer to extend it in any other manner.

2.7.5 Without derogating from the right of the insured to extend the policy as stated in the above clause, the policyholder is entitled to request an extension of the period of insurance (hereinafter**: "the extension request"**). The extension request will be sent to the insurer by post at least 30 days before the expiry of the period of insurance.

2.7.6 If the insurer agrees to extend the period of insurance – the insurer will notify the policyholder in writing of its agreement. The letter will be sent to the policyholder within 20 days of the date of receiving the extension request. If the insurer agrees to extend the period of insurance, the continuity of insurance for the insured will be maintained including "the first date" as defined hereunder as part of the existing condition of the insured.

2.7.7 The premium for the additional period will be calculated in accordance with the number of days extension according to the applicable premium tariff of the insurer on the inception date of the extension.

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

2.8 Changes to the health services

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

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

2.9 Payment of the premium, indexation, taxes and levies

2.9.1 The premium shall be paid in advance by the policyholder and/or the insured, whoever has agreed to pay it, before the inception of the period of insurance and during the entire period of insurance, other than if the insurer has given prior written agreement to pay it is any other manner.

2.9.2 If the premium is paid by standing order or by credit card details which have been provided by the policyholder and/or the insured to the insurer before the inception of the period of insurance, or by cheques, the premium will be considered to have been paid when the bank account of the insurer has been credited.

2.9.3 If the premium is not paid in advance, the premium shall be paid in New Israeli Shekels and shall be linked to the index at the rate by which the decisive index increases / decreases on the actual payment date in relation to the base index.

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

2.10 Notices

The policyholder shall notify the insurer in writing of any change of address. Notice which is sent by the insurer to the last known address of the policyholder will be considered as notice which has been duly delivered.

2.11 The insurer is not liable for the errors and/or omissions of the service providers

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

2.12 Legal prescription

The prescription period in respect of a claim for indemnity payments due to an insured event covered under this policy is 5 years from the occurrence date of the insured event.

2.13 Situate and legal action

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

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

SECTION B – THE INSURANCE COVER

1. The insured will be entitled to the following health services:

1.1 Basket of treatments

1.1.1 All of the services detailed in the second amendment to the National Health Insurance Act, which may be amended from time to time.

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

1.1.3 The following services –

a. Amniotic fluid tests for women over the age of 35 at the beginning of the pregnancy, subject to the conditions concerning pregnancy as shown in clause 3.1.3 hereunder.

b. Vaccinations against tetanus, rabies and diphtheria.

c. Mantoux tests and lung x-rays.

d. Wheelchairs and walking frames.

1.2 Basket of medication

All of the services detailed in the National Health Insurance Act (Medication in the National Health Basket) – 1995, which may be amended from time to time in accordance with a medical prescription and on the instructions of a doctor.

1.3 The basket of services at work

All of the services detailed in regulations 2 and 5 of the Health Services at Work Regulations, in the manner stated in these regulations, mutatis mutandis and anything in the said regulations referring to “health maintenance organisation”, shall apply to the insurer.

1.4 Special lump-sum compensation for workers in the care sector

Ten years or more after the employee first received a B-1 visa to work in the care sector – special lump-sum compensation of NIS 80,000 (linked to the US Dollar) for an employee who is incapacitated due to medical reasons as stated in clause 3.1.5 hereunder, provided that they have exercised their right to a flight back to their home country as stated in clause 2.5 hereunder; the entitlement to this compensation will apply to an employee who, at the time when a doctor determined that they are unable to work as stated in clause 3.1.5 hereunder, held a valid B-1 visa to work in the care sector or held a license as aforementioned at any time in the 12 month period that preceded the determination of the doctor as aforementioned.

2. Extensions to the cover

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

2.1 Cover will be provided for all of the expenses related to flying the insured from Israel to their home country

including accompaniment or other special arrangements for the flight where deemed necessary due to the health condition of the employee.

2.2 Corpse repatriation costs

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

2.2.2 Notwithstanding that stated in clause 2.2.1 above and in clause 5.1.7 hereunder, if the insured dies in a work accident as defined in clause 5.1.7 hereunder, the insurer will pay the expenses for repatriating the corpse of the insured from Israel to their home country.

2.2.3 The liability of the insurer in accordance with clause 2.2.1 and 2.2.2 is subject to the prior approval of the insurer and strictly subject to arranging the flight via the insurer. If the insured or their representative does not contact the insurer to obtain its approval before the insured flies from Israel back to their home country, as aforementioned, the insurer will be entitled to reduce the payment to which the insured is entitled to the amount that the insurer would have paid if the insured would have contacted the insurer or its representative with a request for approval as aforementioned before arranging the flight.

2.3 Emergency flight for a close relative to come to Israel:

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

2.3.2 If the insured is hospitalised **under circumstances which entitle them to receive the medical services in accordance with this policy** for the purpose of undergoing an invasive surgical procedure with hospitalisation for more than 10 days or where the general practitioner determines that the life of the insured is in danger, the insurer will pay for a close relative the cost of purchasing a flight ticket to come to the place where the insured is hospitalised in Israel, up to NIS 5,500 and the cost of accommodation for up to 10 days in a hotel for up to NIS 150 per day.

The agreement of the insurer in accordance with this clause is subject to the flight ticket and the hotel accommodation being arranged via the insurer and approved in writing by the insurer in advance. If the insured or their representative does not contact the insurer to obtain its approval for the aforementioned expenses, the insurer will be entitled to reduce the payment to which the insured is entitled to the amount that the insurer would have paid if the insured would have applied to the insurer for approval as aforementioned.

2.4 Flight expenses in the event of incapacity to work

If a specialist doctor in the field of occupational medicine determines that the insured is unable to perform the work for which they were accepted to work by the policyholder, and that they are unable to work for a period of 90 days from the date when they were examined by the said doctor, even if they obtain the medical care they need (hereinafter: **"incapacity to work"**), and all of this during the period of insurance, the insurer will pay the costs of the insured to from Israel ticket to their home country. **The insurer will not pay the costs for a flight ticket as aforementioned in this clause if the incapacity to work arises from circumstances which do not entitle the insured to the medical services under this policy.**

2.5 First aid dental treatment

2.5.1 The insured will be entitled to receive the following emergency services and first aid dental treatments and these alone, in any nationwide dental clinic from the list which may be updated from time to time by the insurer, whose details can be obtained from the call centre or from the website of the insurer:

a. Extensive dental caries, temporary filling.
b. Open cavity in a tooth, temporary filling.
c. Exposed tooth neck, material for preventing sensitivity.
d. Acute infection – extraction of the nerve or embalming material.
e. Abscess from the source of the tooth, incision of the abscess and/or closure treatment.
f. Impacted food – gum treatment.
g. Infection under crown, rinsing and/or medication.
h. Pain following an extraction, pain relievers.
i. Pressure wounds underneath existing dentures, releasing pressure wounds.
j. Any other treatment provided due to tooth pain – pain relief treatment will be provided.
k. Examination and x-ray of painful teeth.
l. Issuing a prescription for pain relief medication if it is not possible to treat the tooth at the same time.

2.5.2 Notwithstanding that stated in clause 3.1.4 above, the insured will be entitled to the emergency services and first aid detailed in clause 2.5.1 above even if they are required due to an existing condition.

3. Exclusions to Section B

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

3.1.1 In the framework of the basket of treatments

a. Psychological treatments.

b. Dead Sea treatments for psoriasis patients.

c. Genetic testing.

d. Hospitalisation in a nursing home or other long-term care type treatments.

e. Services for treating impotence or sterility problems, sexual functioning disorders, male or female fertility as well as artificial insemination or artificial fertilisation.

f. Services provided outside of Israel.

g. An insured event which occurs after expiry of the period of insurance and/or consecutive periods of insurance as stated in clause 2.7 in Section A above.

3.1.2 In the framework of the basket of medication –

a. Medication for the treatment of Alzheimer's disease.

b. Medication designated to treat impotence or sterility problems, sexual functioning disorders, male or female fertility or which is provided in the context of artificial insemination or artificial fertilisation treatment.

3.1.3 Pregnancy – Health services in connection with pregnancy during the first 9 months, accumulatively, in which there are employment relations between the employer and one or more employees in Israel, other than in the event of a medical emergency.

3.1.4 Pre-existing medical condition: Medical services which the insured needs due to a medical problem arising from a medical condition which preceded the first date when any employer in Israel arranged medical insurance for them, and this for the first three years from the commencement date of the Foreign Workers Ordinance – 17.10.2001, or from the first date when medical insurance was arranged for the insured, the latter of the two (hereinafter: the first date) if either of the following two conditions apply:

a. The insured themselves confirmed that the medical problem for which they need the service arises from a pre-existing medical condition.

b. A doctor confirms, in accordance with his findings, that the medical problem for which the insured needs the service arises from a pre-existing medical condition.

c. If the insured spends time outside of Israel after the first date, for a period or periods exceeding 90 consecutive days for several employers, or for a period exceeding 120 consecutive days if the stay separates between periods of employment with the same employer – the first date, for the purpose of clause 3.1.4, will be considered to be the first date following the stay when the employee was covered under medical insurance.

d. Medical services in the event of an emergency due to a pre-existing medical condition: Notwithstanding that stated in clause 3.1.4 above, the insurer will pay medical expenses for health services the insured needs in the event of a medical emergency arising from a pre-existing medical condition, in order to stabilise their medical condition until it is possible to continue to treat them outside of Israel as well as costs for other medical services the insured needs due to the same pre-existing medical condition, which the insured needs for a period of 30 days after the determination of the doctor as aforementioned or the determination of the medical condition as aforementioned.

3.1.5 Incapacity to work –

a. Medical services that the insured needs after a specialist doctor in occupational medicine has determined that the insured is unable to perform the work for which they were accepted to work for the policyholder, and that they are unable to work for a period of 90 days from the date when they were examined by the said doctor, even if they obtain the medical care they need.

b. Notwithstanding that stated in clause 3.1.5.a above, the insured will be entitled to the

medical services they need in a medical emergency to stabilise a pre-existing medical condition until their condition enables them to be treated outside of Israel, as well as other medical services they need for a period of 30 days after the determination of the doctor as aforementioned or the determination of the medical condition as aforementioned.

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

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

b. Hostile acts, as defined in the Compensation for Victims of Hostile Acts Law – 1970, if the insured was injured in the way defined in the same law.

3.1.7 Health services due to work accidents

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

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

c. If the injury arises from a work accident, the policyholder agrees to confirm the injury as stated in clause 3.1.7 a. above on the National Insurance Institute injury form with a copy to the insurer within 7 days of the date of the work accident. If the policyholder does not provide the said confirmation and it is found that the injury was a work accident, as defined above, the policyholder will reimburse all of the costs incurred by the insurer with the addition of indexation increments and interest per legal provisions within 7 days of the demand by the insurer.

3.1.8 Obtaining services from an approved service provider as defined above who does not have an agreement with the insurer.

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

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

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

4.3 The rules for approval or determination in accordance with clause 4.2 will be as follows:

4.3.1 The insurer will be entitled to ask the insured to undergo a medical examination by an expert it appoints, at the cost of the insurer. The report of the doctor will be submitted to the insured together with a notice regarding the entitlement of the insured to a counter-expert report as stated in clause 4.3.2 hereunder, together with details of entities or organisations that can assist them in obtaining such a report, who have given their agreement to do so.

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

4.3.3 If the two specialist doctors as aforementioned disagree, the parties will appoint a doctor mutually

agreed on; this will be paid for by the insurer and his or her opinion will prevail. If the parties do not reach an agreement on the doctor as aforementioned, an arbitrating doctor will be appointed by the Head of the Israeli Medical Federation (hereinafter: **"the Federation"**) who engages in the medical field related to the insured's illness and in respect of determining incapacity to work including the provision of medical care – by the Head of the Occupational Medicine Association of the Federation (hereinafter: **"the arbitrating doctor"**) and his or her opinion will prevail. If the Head of the Association does not appoint an arbitrating doctor within 15 days of the date when the insurer contacts him or her, the arbitrating doctor will be appointed by the General Manager of the Health Ministry or by a party agreed upon. The fees of the arbitrating doctor will be the set fee and will be paid by the insurer.

SECTION C – THE SERVICE PROVIDERS AND THE MEDICAL SERVICES

5. The service providers

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

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

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

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

a. Any new fracture.
b. Severe dislodgement of a shoulder or elbow.
c. An injury which needs to be unified by stitches or alterative unification means.
d. Breathing a foreign matter into the respiratory system.
e. The penetration of a foreign matter into an eye.
f. Treatment of cancer.
g. Treatment of haemophilia.
h. Treatment of cystic fibrosis.
i. Transfer in an ambulance to an emergency room from the street or other public place, due to a sudden event.
j. Referral concluding in non-elective hospitalisation.
k. A medical emergency.

5.3.2 If the insured is hospitalised immediately from the accident and emergency room, in the cases detailed in clause 5.3.1 above.

6. Obtaining the medical service

6.1 Access to the various medical services will be subject to the prior confirmation of the insurer and/or approval by the general practitioner and/or on a discretionary basis, as follows:

6.1.1 The access to primary medical services covered under this policy will be free, and the insured will not be required to obtain the prior confirmation of the insurer before obtaining medical service of this type.

6.1.2 The access to non-primary medical services, other than in the cases detailed in clause 5.3 hereunder, will be subject to the prior approval of the general practitioner in the primary medical services framework. If the insured or their representative does not contact the insurer to obtain its approval for the aforementioned expenses, the insurer will be entitled to reduce the payment to which the insured is entitled, to the amount that the insurer would have paid if the insured would have applied to the insurer for confirmation as aforementioned.

6.1.3 The access to imaging institutes, diagnostic institutes, gastroenterology clinics, elective hospitalisation laboratories and services, will be subject to the prior written agreement of the insurer.

The insured shall submit a written request for approval for the services detailed in this clause to the insurer, together with certification from the general practitioner that the insured is in need of this medical service.

The approval or notice of declinature to provide it will be issued within 7 days of the date when the general practitioner determines the need for the test or the hospitalisation, as applicable and/or from

the date when the insurer receives the request from the insured, the latter of the two, and in any case will not be delayed in a way which may endanger the insured or affect the feasibility of the treatment which they may receive under this policy.

If the insured or their representative does not contact the insurer to obtain its confirmation for the aforementioned expenses, the insurer will be entitled to reduce the payment to which the insured is entitled, to the amount that the insurer would have paid if the insured would have applied to the insurer for confirmation as aforementioned.

6.1.4 Other than the cases detailed in clause 5.3 above, the insurer will not pay the cost of medical services in an accident and emergency room, other than if the insured obtains prior approval from the general practitioner.

Due Diligence And Disclosure
Summary Of The Policy Conditions – Health Insurance Policy For Foreign Workers (2022 Edition)

SUMMARY OF THE POLICY CONDITIONS	
The name of the policy	Health Insurance Policy for Foreign Workers
The type of insurance	Health insurance for foreign workers
The period of insurance	The period stated in the policy schedule with a maximum of 12 months from the inception .date of the period of insurance as stated in clause 1.32 of the policy
Description of the cover	Health insurance for foreign workers in Israel including health services in accordance with the National Health Insurance Act, the basket of medications and the basket of services at work. The services shall be provided by a pre-approved service supplier other than if stated otherwise. The policy also covers emergency dental treatment and pay benefits for .incapacity to work for people working in the care sector
The policy does not cover the insured in the following cases ((policy exclusions	In the case of an event arising from pre-existing medical conditions and other cases as stated in clause 3 in Section B of the policy. For detailed information concerning this matter please .contact the company
After how long is it possible to make a claim under the policy ?((eligibility period	.There is no eligibility period
Deductible	In the case of medical services covered under this policy for which the insured is required to .obtain a payment receipt, the insured shall pay the amount as defined in the policy
The amount of monetary compensation I will obtain	• Basket of treatments in accordance with the second amendment to the National Health Insurance Act, including medical costs for in-patients and out-patients care with a pre-approved service supplier. Medication and other services as detailed in the policy – as defined in the National Health Insurance Act. • Hospitalisation in a psychiatric hospital or psychiatric department of a general hospital in the case of a medical emergency – up to 60 days per since period of employer. • Lump-sum compensation for a licensed care worker who is unable to work for medical reasons and who has worked for more than 10 years, up to NIS 80,000 subject to the policy conditions. • Cover for expenses to fly the insured from Israel to their home country in the case of a medical event as stated in the policy conditions, as well as cover for additional expenses for the emergency flight of a family member and accommodation expenses in Israel in the case of a special medical emergency involving the insured as defined in the policy conditions – up to NIS 5,500, and the cost of hotel accommodation for up to 10 days subject to a daily limit of NIS 150. • Flying back to the home country of the insured in the event of incapacity to work.
Do any of the covers overlap top-up covers of the health ?maintenance organisations	No.
Insurance premium	As stated in the policy schedule.

The full terms and conditions appear in the policy wording.