TRANSLATION

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

HEALTH INSURANCE POLICY FOR TOURISTS

If this policy has been arranged and as stated in the policy schedule attached hereto, the insurer shall pay the service providers and/or medical institutions providing the health services in respect of an insured event occurring during the period of insurance, up to the limits of liability of the insurer, 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 insurer / the insurer**	Ayalon Insurance Company Ltd.
1.2	**The insured**	A person staying temporarily in the State of Israel who is not a resident or citizen of the State of Israel and whose name is stated in the policy schedule.
1.3	**The policy**	This insurance contract including the proposal form, the policy schedule and any appendix or endorsement attached thereto.
1.4	**The proposal form**	The proposal form which is an application to arrange this policy, fully completed and signed by the insured or their legal representative. The proposal form shall also include a health questionnaire signed by the insured (or their legal representative) and the payment means.

1.5	**The policy schedule**	The page attached to the policy and constituting an integral part thereof, containing amongst other things, personal details of the insured and the conditions required to tailor the insurance policy to the conditions of the insurance contract for the insured. In the event of any discrepancy between the policy conditions and the conditions stated in the policy schedule – that stated in the policy schedule will prevail.
1.6	**The premium**	The payment for this policy that the insured makes to the insurer in accordance with the conditions of the policy as stated in the policy schedule.
1.7	**The insured event**	An event occurring during the period of insurance due to which the insured needs medical care in Israel which is covered under this policy, and provided that the medical care is provided during the period of insurance and/or within 30 days of the expiry date of the period of insurance, all subject to the terms, conditions and exclusions detailed in this policy.
1.8	**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.
1.9	**Abroad / Overseas**	Any place or country outside of the State of Israel including whilst in transit to and from Israel.
1.10	**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.

1.11	**The period of insurance**	The period of insurance as stated in the policy schedule. The period of insurance shall not exceed the following maximum periods: **Maximum period:** If the age of the insured is between 3 months and 65 years – up to 365 days. If the age of the insured is between 66-75 years – up to 60 days.
1.12	**Additional period**	An additional period of insurance beyond the original period of insurance. It is hereby clarified that an extension of the period of insurance beyond the period of insurance stated in the policy schedule (either at its expiry or during the maximum period) is subject to the agreement of the insurer and completion of a new health questionnaire. Such renewal will constitute a new policy to all intents and purposes and will be subject to the applicable premium, terms and conditions of the insurer at the time (subject to the provisions of clause 2.6 hereunder).
1.13	**Medical institution**	A hospital or a clinic including a medical institute, laboratory, diagnostic centre or pharmacy.
1.14	**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.
1.15	**Emergency medical situation**	Circumstances in which a person's life is in immediate danger or where there is an immediate risk of severe and irreversible disability if urgent medical care is not provided.
1.16	**Pre-existing medical condition**	A set of medical circumstances, which the insured was diagnosed with before the date when they arranged the insurance, including due to an illness or accident. In this context, "**which the insured was diagnosed with**"

		means by way of a documented medical prognosis, or by a process of a documented medical diagnosis which took place in the six months before the date of arranging the insurance.
1.17	**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.
1.18	**National Health Basket**	As defined in the National Health Insurance Act.
1.19	**Health Insurance Act**	The National Health Insurance Act – 1994.
1.20	**Doctor**	A person holding a qualification in medicine and who is legally authorised to work as a doctor in Israel.
1.21	**General practitioner**	A general practitioner, who is not a specialist, including a specialist in family medicine and/or internal medicine and/or gynaecology.
1.22	**Health / medical services**	All of the medical services which the insured is entitled to receive under the policy.
1.23	**Primary healthcare services**	Services provided by a general practitioner as defined above.
1.24	**Accident and emergency department**	A place designated to provide urgent medical care which has been approved by the competent authorities in Israel to operate as an accident and emergency department.
1.25	**Hospitalisation expenses**	Medical expenses involved in the hospitalisation of the insured which are incurred during the period of insurance for a maximum period of 90 days, as stated in the policy.

1.26	**Out-patients medical expenses**	Payment for medical care, diagnostic tests or medication which is provided to the insured other than in the framework of hospitalisation in Israel for up to the maximum amount stated in the policy.
1.27	**Medication**	A chemical or biological substance which is designated to treat the medical condition of the insured, to prevent its worsening (including to prevent the onset of further medical conditions) or to prevent relapse of the medical condition of the insured, as a consequence of an illness or an accident, which is approved by the competent authorities in Israel and is included in the list of approved medications and/or by the competent authorities in one or more of the recognised countries.
1.28	**Accident**	Bodily injury occurring solely due to the application of physical force, as a consequence of a sudden, one-off and unforeseen event, which is caused directly by an external and visible cause, constituting the sole, direct and immediate cause of the occurrence of the insured event. For the sake of avoidance of doubt, verbal abuse and/or emotional pressure and/or the gradual accumulation of microinjuries which leads to disability shall not be considered as an accident.
1.29	**Excess**	The share of the insured in the payment due to an insured event as stated in the policy schedule. It is hereby clarified that the insurer shall only be liable to make payment for the costs which exceed the excess.
1.30	**The payer**	The person or company which arranges this policy with the insurer and agrees to pay the premium, whose name is stated in the policy schedule and in the proposal form.

1.31	**Index**	The Consumer Price Index published by the Central Bureau of Statistics from time to time.
1.32	**Base index**	The known index on the first of the month of the inception of the period of insurance.
1.33	**Decisive index**	The known index on the date of paying the premium to the insurer or payment of the claim to the insured or to the service suppliers, as aforementioned, subject to the policy conditions.
1.34	**Insurance Contract Act**	The Insurance Contract Act - 1981.

2. GENERAL POLICY CONDITIONS:

2.1. 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.

2.1.1. 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.

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

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

2.1.4. 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:

2.1.4.1. The reply was provided with fraudulent intent.

2.1.4.2. 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.

2.1.5. 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:

2.1.5.1. 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.

2.1.5.2. 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.

2.2. **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**

The insured shall send a signed health questionnaire and a waiver of medical confidentiality form to the insurer.

2.4. **Claims**

2.4.1. In the case of an insured event the insured shall notify the call centre of the insurer 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 is unable to notify the insurer in advance subject to the policy conditions, the insured 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 form permitting all doctors and/or any medical or other institution in Israel or abroad to supply all of the medical information in their possession relating to the insured to the insurer.

2.4.5. The insured shall submit 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. The insured shall not be entitled to indemnity payments which exceed the policy limit.

2.4.7. If the insured is entitled to cover for expenses covered under this policy which are fully or partially covered under any other insurance, or if they receive indemnity from any other source, the insurer shall only pay the amount which the insured is not indemnified for, up to the policy limit. The insured shall notify the insurer immediately after arranging any double insurance.

2.4.8. 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, depending on 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.

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 payer do not pay the premium on time, subject to the provisions of the Insurance Contract Act.

2.6.2. The insurer is entitled to cancel the policy if the insured breaches the duty of disclosure as stated in clause 2.1 above, subject to the provisions of the Insurance Contract Act. If the policy is cancelled before the expiry of the period of insurance under circumstances which entitled the insured to a return premium, the insurer shall pay refund the premium respect of the period for which the insured is not covered to the extent that they are obliged to in accordance with the Insurance Contract Act and in the case of cancellation within less than two months from the inception of the period of insurance, administrative

fees equivalent to the premium for two months' cover under this policy shall be deducted from the return premium. For the purpose of this clause – administrative fees means the costs of the insurer for issuing the insurance policy, issuing a certificate of insurance and associated costs involved in issuing the policy.

2.6.3. The insured may cancel the policy by written notice to the insurer at any time.

2.7. **Extension of the period of insurance**

The insured may apply to the insurer to extend the period of insurance for a further period. Any such extension shall be subject to the approval of the insurer, subject to the premium and policy conditions applying at the time and subject to completion of a new health questionnaire before the extension is confirmed. It is hereby clarified that at the expiry of the period of insurance as defined in the policy, the policy shall not be automatically extended and any extension shall be arranged as part of a new policy. It is hereby clarified that the period of insurance shall not exceed the maximum period of insurance stated in clause 1.1 above.

2.7.1. The insurer shall be entitled to change the premium for the additional period of insurance. The premium for the additional period shall be calculated according to the number of days' extension multiplied by the daily premium tariff of the insurer applying at the time of the extension.

2.8. **Amendments**

The insurer shall be entitled to revise the list of pre-approved service suppliers from time to time.

2.9. **Taxes and levies**

The insured or the payer, as applicable, shall 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 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. **Changes to the premium and the policy conditions**

2.10.1. The premium for this policy shall be determined in accordance with the age of the insured at the time of arranging the policy as stated in the policy schedule.

2.10.2. The insurer may amend the premium and the conditions of this policy for new insureds provided that the Commissioner of Insurance has confirmed the amendment.

2.10.3. Any change to the premium as stated in clause 2.10.2 above shall not take into account any change to the health condition of the insured (if there is any such change) during the period before the said amendment.

2.11. **Notices**

The insured 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 insured will be considered as notice which has been properly delivered.

2.12. **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.

2.13. **Payment of the premium and indexation**

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

2.13.2. If the premium is paid by standing order or by credit card details which have been provided by the payer 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.

The premium, the excess and the limits of liability shall be linked to the index.

2.14. **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.

2.15. **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

3. The insurer shall pay the following costs for treating the insured with a pre-approved service supplier:

Hospitalisation expenses and out-patients expenses as detailed hereunder:

3.1. Costs incurred in a public-general hospital in Israel

If the insured is admitted to a public-general hospital in Israel, the insurer shall pay for these costs for a maximum period of 90 days.

3.2. Costs in respect of hospitalisation including x-rays, medication, doctors, surgeons, intensive care treatment, anaesthetics, angiogram, general services including nursing services (hereinafter: "**hospitalisation costs**").

It is hereby clarified that the insurer shall pay the hospitalisation expenses to the public-general hospital or to a hospital which is recognised by the competent authorities in Israel as a public hospital. **In no case shall the insurer indemnify the insured and/or make payment to a service supplier for hospitalisation if the insured is hospitalised in a private hospital and/or receives and/or pays for private medical care during the course of such hospitalisation.**

3.3. Accident and emergency services at any general hospital in Israel, in any of the following cases and these only:

3.3.1. A doctor's referral;

3.3.2. Any new fracture;

3.3.3. Severe dislodgement of a shoulder or elbow;

3.3.4. An injury which requires stitches or alterative means;

3.3.5. Breathing a foreign matter into the respiratory system;

3.3.6. The penetration of a foreign matter into an eye;

3.3.7. Babies up to two months with fever over 38.5 °C;

3.3.8. Snake bite;

3.3.9. Transfer in an ambulance to an accident and emergency department from the street or other public place, due to a sudden event;

3.3.10. Anything confirmed by the insurer;

3.3.11. Non-elective admission to hospital.

The insured shall not be entitled to indemnity from the insurer in respect of accident and emergency department services arising from any other cause which is not stated in this clause.

3.4. Medical expenses other than during hospitalisation, with a pre-approved service supplier

The insurer shall make payment directly to the service suppliers for medical care the insured needs other than during hospitalisation, as follows:

3.4.1. **Medical care / advice:** Medical care / advice with a pre-approved service supplier subject to the excess stated in the policy schedule.

3.4.2. **Laboratory tests, x-rays and bandages:** Tests and examinations on the insured in a laboratory and/or clinic of a pre-approved service supplier.

3.4.3. **First aid:** First aid given to the insured by a first aid station of Magen David Adom in Israel only in the case of an emergency.

3.4.4. **Medication:** Up to NIS 800 for the entire period of insurance. This amount shall be paid for medication prescribed by a pre-approved doctor in a pre-approved pharmacy, subject to the excess stated in the policy schedule.

Ambulance transfer costs: The insurer shall pay the costs for ambulance transfer in the event of a medical emergency following which the insured is hospitalised, once only during the entire period of insurance **and provided that the insured is not entitled to coverage of such costs from any other source.**

3.4.5. **Emergency dental treatment:** Up to NIS 800 for the entire period of insurance. The insured will be entitled to receive the emergency services and first aid dental treatments detailed hereunder for emergency dental treatment provided in a clinic of a pre-approved service supplier, and only as first aid, if the treatment is required due to an accident and/or sudden pain, as detailed hereunder:

3.4.5.1. Extensive dental caries, temporary filling.

3.4.5.2. Open cavity in a tooth, temporary filling.

3.4.5.3. Exposed tooth neck, material for preventing sensitivity.

3.4.5.4. Acute infection – extraction of the nerve or embalming material.

3.4.5.5. Abscess from the source of the tooth, incision of the abscess and/or closure treatment.

3.4.5.6. Impacted food – gum treatment.

3.4.5.7. Infection under crown, rinsing and/or medication.

3.4.5.8. Pain following an extraction, pain relievers.

3.4.5.9. Pressure wounds underneath existing dentures, releasing pressure wounds.

3.4.5.10. Any other treatment provided due to tooth pain – pain relief treatment will be provided.

3.4.5.11. Examination and x-ray of painful teeth.

3.4.5.12. Issuing a prescription for pain relief medication if it is not possible to treat the tooth at the same time.

3.5. Corpse repatriation costs

3.5.1. In the event of the death of the insured, the insurer will pay the costs of repatriating the corpse from Israel to the home country of the insured, up to the sum of NIS 20,000 and **provided that this cost is not paid by any other source.**

3.5.2. For the sake of avoidance of doubt the liability of the insurer for medical expenses due to an insured event which occurs during the period of insurance where the treatment is not completed by the expiry of the period of insurance, shall continue for a further 30 days after the expiry of the period of insurance. It is hereby clarified that the cover provided by the insurer under this clause does to constitute any extension or renewal of the period of insurance (as defined in clause 1.1 above).

The liability of the insurer under this section (Section B) is limited to NIS 400,000 for the entire period of insurance (the limit of liability does not accumulate if the period of insurance is extended).

4. General exclusions to the policy

The insurer shall not be liable to make any payment for any event which is connected directly or indirectly to any of the following:

4.1. An insured event which occurs before the inception date of the period of insurance.

4.2. Pre-existing medical condition: An insured event whose actual cause was the regular course of a pre-existing medical condition which the insured suffered from in the period when the exclusion applied. The pre-existing medical condition exclusion in the case of an insured whose age on the inception date of the period of insurance is as follows:

4.2.1. **Under 65 – The exclusion shall apply for a period of not more than one year from the inception of the period of insurance.**

4.2.2. **65 or over – The exclusion shall apply for a period of not more than six months from the inception of the period of insurance.**

4.3. An insured event which occurs after the expiry of the period of insurance.

4.4. **Psychiatric treatments, psychological treatments or mental health treatments.**

4.5. **Suicide or attempted suicide, intentional or unintentional self-injury, alcohol addiction, the use of drugs other than the use of medical drugs on the instructions of a doctor;**

4.6. **Participation of the insured in extreme sports in accordance with the list appearing on the website of the insurer. In this regard, extreme sports refers to branches of sport which are considered especially hazardous and which demand, amongst other things, high levels of difficulty and/or physical effort by the participants. The updated list of extreme sports which is revised from time to time can be found on the website of the insurer at www.ayalon-ins.co.il**

4.7. **Sports activities in the framework of a registered sports association in accordance with the Sports Act – 1988 and/or professional sports and/or competitive sports activities for payment.**

4.8. **Sexually transmitted diseases.**

4.9. **Road accidents, as defined in the Compensation for Victims of Road Accidents Act – 1975.**

4.10. **Work accidents, as defined in the National Insurance Act (Combined Version – 1995.**

4.11. **Any insured event which occurs or is a consequence of the insured serving in any security forces, other than army and including police, as well as any insured event during military service arising directly from activities of a military nature including military or pre-military exercises or training of any type.**

4.12. **Passive involvement of the insured in sabotage or terrorism of any type, or war or belligerent actions of organised or unorganised enemy forces, provided that the insured is not entitled to cover of the medical expenses arising from such an event from any other source.**

4.13. **Costs relating to pregnancy and/or childbirth and/or ectopic pregnancy and/or costs for route treatments / tests or pregnancy monitoring and/or genetic consulting and/or pregnancy complications including pregnancy bed resting and/or childbirth.**

4.14. **Fertility and/or sterility treatments.**

4.15. **Costs relating to preterm birth and/or new born babies.**

4.16. Welfare treatments for babies and/or children, infant welfare centre treatments, vaccinations, routine check-ups and examinations of children.

4.17. Child development costs including for learning disabilities, speech therapy or occupational therapy and the like.

4.18. Periodic, routine or monitoring tests which do not arise from an active medical condition, cosmetic or rehabilitative surgery, clinical trials, vaccinations, periodontics, dental treatment (other than first aid provided under the extension for emergency dental treatment).

4.19. Organ transplants.

4.20. Rehabilitation, physiotherapy, mechanotherapy, hydrotherapy, complementary medicine, homeopathy, alternative medicine, therapeutic touch, acupuncture, chiropractic, optometry.

4.21. Medical accessories other than those which are loaned due to an accidental event.

4.22. Spectacles or contact lenses, hearing aids and dentures of any type.

4.23. Medical expenses arising from the active participation of the insured in any of the following activities: civil war, underground or undercover activity, mutiny, riots, sabotage, fights, violence, terrorism, crime or misdemeanour, drug trading, any unlicensed activity where a license is required (such as a driving or flying license or licensed sports activities) or opposition to arrest.

4.24. An insured event caused by nuclear fission, nuclear fusion or radioactive pollution.

4.25. Experimental medicine – Any medication which has not been approved or indicated by the competent authorities in Israel or by the competent authorities in the recognised countries for treating the medical condition of the insured.

4.26. Experimental medical treatments of any type.

4.27. Treatments, examinations and surgery outside of the State of Israel.

4.28. Consequential loss of any type.

4.29. Actions of any type in respect of which the insured is liable to pay compensation to a third party in accordance with the Torts Ordinance.

4.30. Accident and emergency department costs – other than as stated in clause 3.3 above.

4.31. The insurer shall not be liable or make any payment for an insured event which occurs during the period of insurance whose treatment continues after the expiry of the period of insurance other than in the following cases.

4.32. Hospitalisation which starts during the period of insurance defined in clause 1.11 above.

4.33. Medical expenses other than during hospitalisation for a period of up to 30 days as defined in Section B.

4.34. Expenses for hospitalisation and/or for out-patients treatment which can be postponed until the insured returns to their home country in accordance with the opinion of a specialist doctor in the relevant field of medicine.

4.35. Where the insured is medically fit in accordance with the opinion of a specialist doctor in the relevant field of medicine to return to their home country to obtain the medical care.

4.36. Medical services provided to the insured other than by the pre-approved service suppliers.

DUE DILIGENCE AND DISCLOSURE

SUMMARY OF THE POLICY CONDITIONS – HEALTH INSURANCE POLICY FOR TOURISTS (2022 EDITION)

SUMMARY OF THE POLICY CONDITIONS	
The name of the policy	Health Insurance Policy for Tourists
The type of insurance	Health insurance for tourists
The period of insurance	The period stated in the policy schedule subject to the maximum period as stated in clause 1.11 of the policy.
Description of the cover	Cover for medical services with a pre-approved service supplier for hospitalisation and out-patient care as stated in the policy wording, including accident and emergency department, examinations, emergency dental treatment and the like.
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 4 of the policy. For detailed information concerning this matter please contact the insurer.
After what period it possible to make a claim under the policy (eligibility period)?	There is no eligibility period.
Excess	As stated in the policy schedule.
Do any of the covers overlap top-up covers of the health maintenance organisations?	No.
Insurance premium	As stated in the policy schedule.

SUMMARY OF THE INSURANCE COVERS AND LIMITS		
Medical services	Clause 3 of the policy – Payment of costs for medical care during hospitalisation and on an out-patients basis including consultancy, examinations, medication, laboratory tests, bandages and x-rays, ambulance transfer, first aid treatment in a Magen David Adom in Israel station and emergency dental treatments with a pre-approved service supplier.	**Clause 3 –** Up to NIS 400,000 for a period of 90 days in the event of hospitalisation. **Medication** – Up to NIS 800. **Emergency dental treatment** – Up to NIS 800.
Corpse repatriation	Payment for repatriating the corpse of the insured from Israel to their home country.	Up to NIS 20,000.

N.B.: The insurance company shall pay the actual expenses up to the policy limit. Please note that if you hold any identical insurance cover under any other policy you shall not be entitled to double indemnity or any payment exceeding the actual expenses, all subject to the terms and conditions of the policy.

The full terms and conditions appear in the policy wording.