



Harel SAFE STAY+

Extended Health Insurance for a foreign worker in Israel

May 2021

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SAFE STAY +
Extensive Medical Insurance for the Foreign Worker

If this Policy was purchased and this is noted on the Insurance Details Page, as said below, the Insurer will indemnify the Insured for expenses for medical services and/or will directly pay the service providers and/or medical institution that provides the health services for an insurance event and/or will compensate the Insured, all as defined and set forth in detail in the Policy, during the insurance period, within the limits of the liability of the Insurer, according to the terms, exclusions, and exceptions set forth in this Policy.

Chapter A: Definitions and General Terms

1. Definitions

- 1.1. **The Insurer:** Harel 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 specified on the Insurance Details Page.
- 1.3. **Foreign worker:** A person working in Israel who is not an Israeli citizen or resident of Israel.
- 1.4. **The Policyholder:** An employer or corporation who entered into the insurance contract with the Insurer and whose name is specified on the Policy as the owner of the policy, who requests to insure the foreign worker whose name is specified on the Insurance Details Page of this Policy.
- 1.5. **The Policy:** The insurance contract, including the proposal, the Insurance Details Page and any rider or appendix attached to it.
- 1.6. **The Insurance Proposal:** A proposal form in the version determined by the Insurer that has been fully completed with all details, a statement regarding the date of entry to Israel and a waiver of medical confidentiality, signed by the Policyholder in the place where his/her signature is required.
- 1.7. **Health Condition Statement:** The Health Condition Statement form and waiver of medical confidentiality of the Insurer, signed by the Insured.
- 1.8. **Insurance Details Page:** A page attached to the Policy, which constitutes an integral part thereof, which includes, among other things, the personal details of the Insured and the conditions required in order to adapt the insurance policy to the terms of the Insurance contract with the Insured. In the case of a conflict between the terms of the Policy and the terms specified on the Insurance Details Page, the terms on the Insurance Details Page shall prevail.
- 1.9. **Foreign country/outside of Israel:** Any place or country outside of Israel, including any means of transportation traveling to or from Israel.
- 1.10. **Israel:** The territory of the State of Israel, with the exception of any means of transportation traveling to or from Israel, including territories controlled by the IDF, but excluding the territories held by the Palestinian Authority.
- 1.11. **Insurance period:** The period specified on the Insurance Details Page attached to the policy, which shall not be more than 12 months from the date of commencement of the Insurance.
- 1.12. **One employment period:** The entire period of work of the Insured, even if it is not continuous, in which there existed employer-employee relations between a given employer and a given foreign worker.
- 1.13. **Insurance event:** A case in which the Insured has need, during the insurance period, of medical treatment in Israel that is included under this Policy and that is provided during the insurance period and/or at the latest within 90 days of the date of the end of the insurance period, all this according to the terms, exclusions and exceptions as set forth in this Policy.

- 1.14. **Medical institution:** A hospital or clinic, including a medical institute, laboratory, diagnostic centers, pharmacy.
- 1.15. **General-government hospital:** An institution in Israel that is recognized by the qualified authorities as a general-government hospital and that serves as a hospital only, with the exception of an institution that is also a sanitarium and/or a rehabilitation institution.
- 1.16. **Physician:** A person who holds a legal certificate of qualification to work as a physician in Israel.
- 1.17. **Attending physician:** A general physician who is not a specialist, as well as a specialist physician in family medicine and/or internal medicine and/or gynecology.
- 1.18. **Health/medical services:** All the medical services to which the foreign worker is entitled according to the terms of this Policy.
- 1.19. **Primary health services:** Services provided by an attending physician according to the terms of this Policy.
- 1.20. **Medical emergency:** Circumstances in which there is an immediate threat to a person's life or in which there exists an immediate risk that severe irreversible disability will be caused to a person if not provided with urgent medical treatment.
- 1.21. **Preexisting condition:** A defect, congenital disease, including hereditary diseases and/or a health condition and/or a medical phenomenon, and/or a disease, whether treated or not, and/or their consequences, whether direct or indirect, that were caused and/or worsened due to a health condition that existed prior to the date of commencement of the Insurance, subject to the Insured's Health Condition Statement and/or to the confirmation of a physician, all subject to the said in Section 5.1.4 below.
- 1.22. **Service providers:** A general-government hospital and in addition, physicians and/or a medical institution connected by agreement with the Insurer, **from which and solely from which the Insured will be entitled to receive the health services specified in this Policy, all this subject to the terms of the Policy.**
- 1.23. **Insurance fees:** The amounts that the Policyholder must pay the Insurer, according to the terms of the policy, for insurance coverage according to this Policy.
- 1.24. **Customary payment:** A payment, including a guarantee or deposit, that applies to the Insured, with the addition of linkage as specified on the Insurance Details Page, in return for the actual provision of the medical service, and that was determined in the Second or Third Schedule to the Health Insurance Law at the beginning of the insurance period or by notice regarding terms and payments issued by the state issued to the individual on the determining date according to the Health Insurance Law or in the proposal of the health fund according to Section 1)8a) of the Health Insurance Law, which was approved according to Section 2)8a) of that law, and if the different instructions included different payments for the same medical service – the highest among them.

- 1.25. **Insured card:** A card to be issued by the Insurer in addition to the Policy, on which the personal details of the Insured will be specified, which the Insured will present to any medical institution in order to obtain medical services.
- 1.26. **Health Insurance Law:** The National Health Insurance Law, 1994 - 5754.
- 1.27. **Foreign Workers Law:** The Foreign Workers Law (Illegal Employment and Assurance of Fair Conditions), 1991-5751.
- 1.28. **Health basket:** As defined in the Health Insurance Law.
- 1.29. **Foreign Workers Ordinance:** The Foreign Workers Ordinance (Prohibition of Illegal Employment and Assurance of Fair Conditions) (Worker's Basket of Health Services), 2001-5761.
- 1.30. **Regulations on Health Services at Work:** Parallel Tax Regulations (Health Services at Work), 1973-5733.
- 1.31. **Service call center:** A call center on behalf of the Insurer that provides a response to the Insured with regard to service providers, and operates 24 hours a day.

2. General Terms

- 2.1. **Duty of Disclosure:** If, prior to entering into the contract, the Insurer presented to the Insured, whether on the Insurance Proposal form or by any other means in writing, a question regarding a matter that could affect the willingness of a reasonable insurer to enter into a contract, in general, or to enter into the terms included in it (herein: an essential matter), the Insured must answer it in writing with a complete and honest answer. A general question that incorporates different matters, without differentiating among them, does not require an answer as said, unless it was reasonable at the time of entering into the contract.
 - 2.1.1. Deliberate deceptive concealment on the part of the Insured of a matter that he/she knew was an essential matter, shall be legally equivalent to providing an answer that is incomplete and dishonest.
 - 2.1.2. If an essential matter is answered incompletely and dishonestly, the Insured is entitled, within thirty days of the date on which this became known to it and as long as no insurance event has occurred, to cancel the Policy by written notification of the Insured.
 - 2.1.3. If the Insurer cancels the Policy by force of this section, the Insured is entitled to a refund of the insurance fees that he/she paid for the period after the cancellation, after deduction of the Insurer's expenses, unless the Insured acted with the intention of fraud.
 - 2.1.4. If the insurance event occurred before the Policy was cancelled by force of this section, the Insurer is not liable, with the exception of reduced insurance benefits at a proportional rate, which is the ratio between the insurance fees that would have been paid as customary in the company according to the true condition and the agreed insurance benefits, and the Insurer is completely exempt in any of the following:
 - 2.1.4.1. The answer was provided with the intention of fraud.

- 2.1.4.2. The Insurer believes that it would not have entered into the contract, even for higher insurance fees, if it had known the true situation; in this case, the Insured is entitled to a refund of the insurance fees he/she paid for the period after the occurrence of the insurance event with the deduction of the Insurer's costs.
 - 2.1.5. The Insurer is not entitled to the above-said remedies in each of these, unless the incomplete and dishonest answer was provided with the intention of fraud:
 - 2.1.5.1. It knew or should have known the true situation at the time of entering into the contract or it caused the answer to be incomplete and dishonest.
 - 2.1.5.2. The fact about which the answer provided was incomplete and dishonest ceased to exist prior to the insurance event, or did not affect its case, the liability of the Insurer or its scope.
 - 2.1.6. In the case of compensation-type insurance benefits, the Insurer is not entitled to the above-said remedies if three years have passed since entering into the contract, unless the Insured acted with the intention of deception.
- 2.2. **Validity of the Policy:** The entry of this Policy into effect is contingent upon actual payment of the first premium. This term shall not apply if the Insured provided a means of payment from which it is possible to collect the insurance premium. If insurance fees were paid to the Insurer before the Insurer gave its agreement draw up the insurance, the payment shall not be construed as agreement to of the Insurer to draw up the insurance. In this case, the Insurer will, within 90 days from the date of first receipt of insurance fees, send a decision regarding the acceptance or non-acceptance of the applicant for the insurance, and will send him/her, according to the case at hand, an insurance policy including an Insurance Details Page, or a rejection notice stating that the Insured was not accepted for the insurance and is not covered by valid insurance, or a request for completion of data or a counterproposal for insurance. If the Insurer does not, within 90 days from the date of receipt of the insurance fees for the first time, send a rejection notice as said above or a request for completion of data or a counterproposal for insurance, the Insured will be considered to have been accepted for the insurance under the terms specified in the insurance proposal. If the candidate for insurance has an insurance event during the period between receipt of the insurance fees for the first time and the Insurer's decision regarding his/her acceptance or non-acceptance to the insurance, and if, according to the instructions of the Insurer's medical underwriting regarding insurance candidates with similar characteristics, the Insurer would have notified the insurance candidate at the end of the underwriting process of his/her acceptance for insurance (were it not for the occurrence of the insurance event), the insurance candidate shall be entitled to coverage under the Policy for the insurance event, subject to all the other instructions and terms of the Policy.

2.3. Health Condition Statement:

- 2.3.1. The Policyholder shall provide the Insurer with a Health Condition Statement and Waiver Of Medical Confidentiality, signed by the Insured, which instructs his/her physicians and/or any other entity or medical institution, in Israel or abroad and/or the National Insurance Institute and/or the Ministry of Defense and/or another government ministry and/or insurance company and/or health fund to provide the Insurer with reasonable medical information regarding the Insured that it has in its possession.
- 2.3.2. The Policyholder will obtain the signature of the Insured on the Health Condition Statement and Waiver of Medical Confidentiality form issued by the Insurer in a language understood by the Insured, and will send the Insurer the form in a language understood by the Insured that is signed by the Insured, together with a statement of the Policyholder that the form was signed by the Insured after its contents were explained to him/her in a language he/she understands and/or that the Insured signed the Health Condition Statement form after he/she read its content in a language that he/she understands.

2.4. Claims:

- 2.4.1. A notice of any insurance event will be delivered to the Insurer within a reasonable amount of time, as quickly and as early as possible. The notice will be accompanied by the details of the insurance event, which will be sent to the Insurer in order to obtain all the facts it requires. The Insured may submit the documents, among other ways, by e-mail, text message or a personal online account.
 - 2.4.2. The Policyholder and/or the Insured shall attach to the form for notice of an insurance event all the relevant medical documents regarding the insurance event, including diagnoses, a history of the event (anamnesis) and, if payments were made by the Policyholder and/or by the Insured - receipts of payment.
 - 2.4.3. The Insured will cooperate with the Insurer before and after submission of the claim and will do all required in order to enable the Insurer to clarify its liability for payment according to the Policy and its scope.
- 2.5. **Medical examination:** The Company shall be entitled at any time to examine the medical condition of the Insured in any reasonable way it sees fit, and the Insured undertakes to undergo medical examinations as required by the Company and at its expense, provided that the examination is reasonable under the circumstances and at the expense of the Insurer. It is clarified that this does not detract from the ability of the Insured to fully utilize all the rights accorded him/her by force of the Policy at any time in court.

2.6. Extension of the insurance period:

- 2.6.1. The Insurer undertakes to extend the insurance period, continuously, at the end of the insurance period, in response to a request from the Policyholder or the Insured that is received by the Insurer and solely if insurance fees have also been paid for the interim period between the end of the original insurance period and the extension of the insurance, provided that the Insured continues to work for an employer as a foreign worker in Israel.
- 2.6.2. The Insured or the Policyholder are entitled to renew the insurance of the Insured consecutively from the date of termination of the Policy, without renewed underwriting, within 90 days.
- 2.6.3. An Insured who is not entitled to an extension without underwriting as said in Section 2.6.2 shall be subject to the instructions of Sections 2.6.4-2.6.5 below.
- 2.6.4. In any other case that is not included under the cases listed in Sections 2.6.1 to 2.6.2. - the Policyholder is entitled to ask the Insurer to extend the insurance period for an additional period of time. Extension of the insurance period shall be subject to a process of underwriting as customary for the Insurer and subject to the prior written approval of the Insurer. It is hereby clarified that at the end of the insurance period, as defined in the Policy, the insurance will not be extended automatically except by its agreement as said in this section, within the period of time specified in Section 2.6.4.2 below, even if the Policyholder and the Insured proposed its extension to the Insurer in any form and at any time.
 - 2.6.4.1. The Policyholder is entitled to request extension of the insurance period (herein: "request for extension"). The request for extension shall be sent to the Insurer by post at least 30 days before the end of the insurance period.
 - 2.6.4.2. If the Insurer agrees to extend the insurance period - the Insurer will notify the Policyholder in writing of its consent. The letter will be sent to the Policyholder within 20 days of receipt of the request for an extension. If the Insurer agrees to extend the insurance period, the insurance continuity of the Insured shall be maintained, including the first date as defined below regarding a preexisting condition.
- 2.6.5. The insurance fees for the additional period shall be calculated according to the number of days of extension at the rate of insurance fees in effect with the Insurer on the day that the extension begins.
- 2.6.6. The Insurer shall be entitled to change the insurance fees at the beginning of any extension of this Policy.

2.7. Cancellation of insurance:

- 2.7.1. In the case that the Insured and/or the Policyholder does/do not pay or did not pay the insurance fees as arranged, the Insurer is entitled to cancel the Policy according to the instructions of the Insurance Contract Law 5741-1981.

- 2.7.2. If the Policyholder cancels the policy before the end of the insurance period due to termination of the employment period of the Insured by the Policyholder, the Insurer will refund the Policyholder part of the insurance fees for the period in which the Insured is no longer insured, which will be linked to the Consumer Price Index, subject to the duty of the Insurer according to the instructions of the Insurance Contract Law.
- 2.7.3. In the matter of Section 2.7.2: The proportionate insurance fees will be returned to the Policyholder for the period after return of the Insured card to the Insurer.
- 2.7.4. In the case that the Insured concealed from the Insurer an essential matter as said in Section 2.1 above, as set forth in the Insurance Law.
- 2.7.5. In the case that the Insured deliberately did something that could prevent the Insurer from clarifying its duty or encumber it, the Insurer shall not be required to pay insurance benefits except insofar as it was required to do so had this not happened.
- 2.7.6. The Policyholder and/or the Insured are entitled to cancel the Policy by written notice to the Insurer at any time.
- 2.8. **Absence of Insurer liability for acts and/or failures of service providers - The Insurer shall not have any responsibility** for the quality of medical and/or other services provided to the Insured under this insurance. The Insurer is not responsible for any damage caused by the Insured and/or any other person directly or indirectly due to the choice by the Insured and/or his referral by the Insurer to medical and/or other medical services and/or for professional negligence of the service providers.
- 2.9. **Limitations:** The period of limitations of a claim for payment of insurance benefits for an insurance event according to this policy is 5 years from the date of incidence of the insurance event.
- 2.10. **The Insurance Contract Law:** The instructions of the Insurance Contract Law, 5741-1981 shall apply to this policy.
- 2.11. **Changes in insurance services:**
 - 2.11.1. **The Insured shall be entitled to the services included in the health basket, in the medications basket and in the services at work basket, as defined below, and as they are changed from time to time.**
 - 2.11.2. **Insofar as changes occur in the health basket and/or the medications basket and/or the services at work basket and/or in the Health Law and/or in any ordinance or instruction after the commencement of the insurance period (herein: "the new health basket"), the Insurer shall notify the Policyholder and/or the Insured parties regarding the changes that were made in the health basket and/or the medications basket and/or the services at work basket and/or the Health Law and/or in any ordinance and/or instruction after the commencement of the insurance period, and shall be entitled to make changes in the Policy and in the insurance fees, including payment of an addition for the insurance fees demanded because of the said change.**

- 2.12. **Notices:** The Policyholder must notify the Insurer of any change of its address in a letter.
- 2.13. **Payment of insurance fees, taxes and charges:** The Policyholder must pay the Insured the insurance fees and government and other taxes that apply to this Policy or that are charged on insurance fees, and on all other payments that the Insured is required to pay according to the policy, whether these taxes existed at the time of preparation of the policy or if they were instituted on a later date.
- 2.14. **Linkage (Insurance Fees, Amounts Insured):** The insurance fees and the amounts insured cited in New Israeli Shekels will be linked to the **Consumer Price Index** published by the Central Bureau of Statistics, and will be linked to the index monthly, where the base index is the index published in April 2021.
- 2.15. **Place of jurisdiction:** The sole and exclusive place of jurisdiction in all matters related to and arising from this policy shall be the authorized courts in Israel according to the law in Israel, and no other court whatsoever shall have any authority to judge. The law that applies to claims that stem from and/or are related to this policy is Israeli law.

Chapter B: The Health Services

3. The health services to be provided to the Insured subject to the said in this Policy, the Insured will be entitled to the health services in return for payment that will not exceed the customary payment, and in the absence of a customary payment – without payment, all according to the following details:

3.1.1. **The treatment basket -**

3.1.1.1. All the services listed in the Second Schedule to the National Health Insurance Law on the date of commencement of the insurance period, as changed from time to time.

3.1.1.2. Hospitalization services in a psychiatric hospital or in a psychiatric ward in a general hospital, in a medical emergency, for a period that shall not exceed 60 days for one period of employment.

3.1.1.3. The services set forth in the following -

3.1.1.3.1. Amniocentesis for women of the age 35 and older at the beginning of the pregnancy.

3.1.1.3.2. Vaccination against tetanus, rabies and diphtheria.

3.1.1.3.3. Mantous tests and chest X-rays.

3.1.1.3.4. Wheelchairs and walkers.

3.1.2. **Medications basket:** All the services listed in the National Health Insurance Ordinance (Medications in the Health Services Basket), 5755-1995 on the date of commencement of the insurance period.

3.1.3. **Services at work basket:** All the services listed in Regulations 2 and 5 of the Health Services at Work Regulations, mutatis mutandis on the date of commencement of the insurance period.

3.1.4. **Special one-time compensation for an employee in the nursing care sector:**

3.1.4.1. **In the period from 1 October 2017 to 30 September 2019**

After the passage of **thirteen years** since the employee first received a visiting resident permit for the purpose of work in the nursing care sector – coverage for one-time special compensation in the amount of ₪80,000, intended for an employee who is found unfit to perform his work for medical reasons as said in Section 6 below; and provided that he realized his entitlement to a flight back to his country as said in Section 4 below; the entitlement to compensation will apply to an employee who at the time of the doctor's determination as said in Section 6 below that he is unfit for his work held a valid visiting resident permit for the purpose of work in the nursing care sector or held a permit as said at any time during the period of 12 months prior to the said determination of the doctor.

3.1.4.2. **In the period beginning on 1 October 2019 and onwards:** After the passage of **ten years** since the employee first received a visitor's residence permit for the purpose of working in the nursing care sector – special one-time compensation in the amount of ₪80,000, intended for an employee who is found unfit to perform his job for medical reasons as set forth in Section 6 below, and provided that he executes his right to a flight back to his country as said in Section 4 below; the entitlement to compensation will apply to an employee who at the time of the physician's determination as said in Section 6 below that he is unfit for his job held a valid visitor's residence permit for the purpose of work in the nursing care sector or that he held a permit as said at any time during the 12-month period prior to the said determination of the physician.

An employee will be entitled to one-time compensation according to this section only if the determination of the physician according to Section 6 below did not precede the beginning date, but it will, however, also apply to a work period that preceded the beginning date.

4. Additional Undertakings of the Insurer

4.1. Subject to the instructions of this Policy, the Insurer shall bear the expenses specified below, all subject to the terms, exclusions, and exceptions specified in this Policy and below -

4.1.1. Payment of coverage for all expenses related to the flight of the Insured from Israel back to the country of the origin of the Insured, including accompaniment or other special arrangements, necessitated at the time of the flight by the medical condition of the employee.

4.1.2. **Expenses of transporting the mortal remains of the Insured:**

4.1.2.1. In the case of the death of the Insured, under circumstances that entitle him/her to medical service according to the terms of this Policy, the Insurer shall bear the expense of transporting his/her corpse from Israel to his/her country of origin.

4.1.2.2. The said in Section 4.1.2.1 above notwithstanding, in the case of the death of the Insured as the result of injury at work, as defined in Section 5.1.7 below, the Insurer shall bear the expense of transporting the corpse of the Insured from Israel to the country of origin of the Insured.

4.1.2.3. **The liability of the Insurer according to sections 4.1.2.1 and 4.1.2.2 above are conditional upon prior receipt of approval from the Insurer and upon the performance of the above air transport solely through the Insurer.** If the Insured or someone on his/her behalf did not apply to the Insurer for the purpose of obtaining its approval, prior to air transport

of the Insured from Israel back to his/her country of origin, as said above, the Insurer shall be entitled to reduce the amount of the insurance benefit to which the Insured is entitled to the amount that the Insurer would have paid if the Insured had applied to the Insurer with a request for approval as said prior to performance of the air transport.

4.1.3. Emergency flight of a close relative to Israel:

4.1.3.1. In this section, “**close relative**”: wife, husband, son, daughter, brother, sister.

4.1.3.2. If the Insured is hospitalized under circumstances that entitle him to receive health services according to this Policy for the purpose of an invasive surgical procedure involving hospitalization for more than 10 days or the attending physician determines that the life of the Insured is in danger, the Insurer will pay a close relative the cost of purchasing a ticket for flight and travel to the place of hospitalization of the Insured in Israel up to the amount of ₪6,000, the cost of staying up to 10 days in a hotel up to the maximum amount of ₪160 per day.

The undertaking of the Insurer according to this section is conditional upon the airline ticket and arrangements for the hotel stay being purchased through the Insurer and approved by the Insurer in writing and in advance. If the Insured did not apply to the Insurer for the purpose of obtaining its approval for the expenses as said above, the Insurer shall be entitled to reduce the amount of insurance benefits to which the Insured is entitled to the amount that the Insurer would have paid if the Insured had applied to the Insurer in advance and asked to receive the said approval.

4.1.4. **Flight expenses in the case of incapacity to work:** If a specialist in occupational medicine determines that the Insured is not fit to perform the work for which he/she was accepted for work by the Policyholder, and that he/she will not be fit to perform it within a period of 90 days from the date at which the physician performed the examination, even if provided the medical treatment that he/she needs (herein: “incapacity to work”), all this within the insurance period, the Insurer shall bear the cost of airfare to the country of origin of the Insured up to a maximum amount of ₪8,000.

The Insurer shall not bear the cost of airfare as said in Section 4.1.4 above if the incapacity to work derived from circumstances that do not entitle the Insured to health services according to this Policy, with the exception of circumstances as said in Sections 4.1.4 above and 5.1.5 below.

4.1.5. **First aid dental care**

4.1.5.1. The Insured shall be entitled to receive the dental emergency services and first aid specified below and these services only, through dental clinics throughout Israel, to be determined

from time to time by the Insurer, the details of which can be obtained from the Insurer's service call center.

- 4.1.5.1.1. Extensive caries, temporary filling.
- 4.1.5.1.2. Open space in a tooth, temporary filling.
- 4.1.5.1.3. Exposed neck of tooth, material to prevent sensitivity.
- 4.1.5.1.4. Acute inflammation, extraction of nerve or embalming material.
- 4.1.5.1.5. Abscess originating in a tooth, drainage of abscess and/or treatment by closure.
- 4.1.5.1.6. Compacted food, treatment of gums.
- 4.1.5.1.7. Inflammation under the crown, rinsing and/or drug treatment.
- 4.1.5.1.8. Pain following extraction, pain relief.
- 4.1.5.1.9. Pressure sores under an existing prosthesis, release of pressure sores.
- 4.1.5.1.10. Any additional treatment due to toothache, which will be provided to ease or end the pain.
- 4.1.5.1.11. Examination and X-ray of the painful teeth.
- 4.1.5.1.12. Provision of an appropriate prescription for pain relief in the case that treatment is not possible at the time.

4.1.5.2. The said in Section 5.1.4 below notwithstanding, the Insured shall be entitled to the dental emergency treatment and first aid specified in Section 4.1.5.1 above even if they are required due to a preexisting condition.

5. Exclusions to Chapter B

5.1. The said in Sections 3 and 4 above notwithstanding, the Insurer shall not bear the expenses and/or the medical expenses in regard to the services listed below and the Insured shall not be entitled to expenses and/or these services under this Policy -

5.1.1. In the healthcare basket -

- 5.1.1.1. Psychological services.**
- 5.1.1.2. Treatments at the Dead Seas for psoriasis patients.**
- 5.1.1.3. Genetic testing.**
- 5.1.1.4. Hospitalization in a nursing ward or other nursing services.**
- 5.1.1.5. Services to treat problems of impotence, sexual dysfunction, male or female fertility, and artificial fertilization or artificial insemination treatments.**
- 5.1.1.6. Services provided outside of Israel.**

- 5.1.1.7. An insurance event that occurred after the end of the insurance period and/or consecutive insurance periods as said in Section 2.6 above.
- 5.1.2. In the medications basket -
 - 5.1.2.1. Medications for treatment of Alzheimer's disease.
 - 5.1.2.2. Medications designed to treat problems of impotence, sexual dysfunction, male or female fertility, or medications provided as part of artificial fertilization or artificial insemination treatments.
- 5.1.3. Pregnancy - Health services related to pregnancy for a period of the first 9 months, cumulative, in which there were employer-employee relations between the employee and one or more employers in Israel, with the exception of a medical emergency.
- 5.1.4. Preexisting condition: Medical services that the Insured requires due to a medical problem deriving from a medical condition that preceded the first date on which any employer in Israel arranged medical insurance, this for the first 3 years from the date of effect of the Foreign Workers Ordinance - the date 12 October 2001 or from the first date on which medical insurance was arranged for the Insured, whichever comes later (herein: "the first date") if one of the following applies:
 - 5.1.4.1. The Insured himself/herself confirmed that the medical problem for which service is required derived from a preexisting condition.
 - 5.1.4.2. A physician confirmed, according to the findings available to him/her, that the medical problem for which the employee required service derived from a preexisting condition.
 - 5.1.4.3. The Insured was overseas after the first date for a period or periods exceeding 90 consecutive days with several employers, or for a period exceeding 120 consecutive days if the stay was between periods of employment with the same employer - the first date for the purpose of Section 5.1.4 shall be considered the first date after the stay in which the employee was insured under medical insurance.
 - 5.1.4.4. Health services in a medical emergency due to a preexisting condition: The said in Section 5.1.4 above notwithstanding, the Insurer shall bear medical expenses for health services that the Insured requires during a medical emergency due to a preexisting condition, for the purpose of stabilizing the Insured's medical condition to a condition that enables further treatment of the Insured outside of Israel and the expenses for other medical services that the Insured requires due to the same preexisting condition, for a period of 30 days from said determination by a physician or determination regarding stabilization of the medical condition as said.

- 5.1.5. Incapacity to work -
 - 5.1.5.1. Medical services that the Insured requires after a specialist in occupational medicine has determined that the Insured is unfit to perform the work for which he/she was accepted to work by the Policyholder, and that he/she will not be fit to perform it within a period of 90 days from the date that the physical examined him/her, even if he/she is given the medical treatment that he/she requires.
 - 5.1.5.2. The said in Section 5.1.5.1 above notwithstanding, the Insured shall be entitled to medical services that he/she requires in an emergency situation in order to stabilize his/her medical condition, to a condition that enables treatment outside of Israel, as well as other medical services that he/she requires for a period of 30 days from said determination by the physician or determination regarding stabilization of his/her medical condition as said.
- 5.1.6. Road accidents and acts of hostility - medical services required by the Insured due to:
 - 5.1.6.1. A road accident, as defined in the Road Accident Victims Compensation Law 1975 - 5735.
 - 5.1.6.2. Acts of hostility, as defined in the Benefits for Victims of Hostile Acts Law, 1970 - 5730, if he/she was injured as defined in that law.
- 5.1.7. Health services due to injury at work
 - 5.1.7.1. The Insurer shall not bear the expenses for health services of the Insured if the Insured requires them due to injury at work, according to its meaning in the National Insurance Law [Consolidated Version], 1995 - 5755 (herein: "injury at work"), provided that the employer confirmed, in a form determined by the National Insurance Institute and designed for this purpose (herein: "injury form"), that the said injury is an injury at work.
 - 5.1.7.2. If 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 it is an injury at work, the Insurer shall bear the expenses of the health services provided to the Insured due to that injury at work, within the three months, even if they were provided by other than the service providers, and after three months, if they were provided by the service providers of the Insurer.

5.1.7.3. If the injury derived from an injury at work, the Policyholder undertakes to confirm the injury as said in Section 5.1.7.1 above, on 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. In the case that the Policyholder has not confirmed as said and it is found that the injury was an injury at work as defined above, the Policyholder shall bear all expenses that the Insurer paid and shall pay them in addition to linkage differences and interest on interest according to law, within 7 days of the date this is demanded by the Insurer.

5.1.8. Receipt of services from a service provider that is not under agreement with the Insurer.

6. Rules for approval or determination of a specialist physician - preexisting condition and incapacity to work

- 6.1. A physician's confirmation that the medical problem for which the Insured requires medical service derives from a preexisting condition and a physician's determination that the Insured has reached stabilization of his/her medical condition - shall be made by a specialist physician.
- 6.2. The 30 days mentioned in sections 5.1.4 and 5.1.5 shall be counted only from the date of a final confirmation or a final determination as said in Section 6.3 below, but will not be considered a final determination as said regarding the stabilization of the medical condition of an employee if the director of the hospital ward in which the Insured is hospitalized or the deputy director of the ward - in the absence of the director - has determined that the date on which the entitlement of the Insured to health services according to the instructions of this policy was meant to end, the medical condition of the Insured had not yet been stabilized. This determination shall be decisive unless determined otherwise by the director or deputy director, of the ward, as said.
- 6.3. The rules for confirmation or determination as said in Section 6.2 shall be as specified below:
 - 6.3.1. The Insurer shall have the right to demand of the Insured to undergo examination by a specialist physician on its behalf, at the expense of the Insurer. The opinion of the physician will be presented to the Insured together with a notice regarding the entitlement of the Insured to a counter-opinion as said in Section 6.3.2 below and together with the details of entities or organizations that are likely to assist the Insurer in realizing this right, which have given their agreement to this.

- 6.3.2. The Insured is entitled to a counter-opinion from a specialist physician of his/her choice, which will be presented to the Insurer within 21 days of the insured's receipt of the opinion on behalf of the Insurer. The Insurer will bear the expenses of the counter-opinion up to a ceiling amount to be determined by the director-general of the Ministry of Health and the director of the Insurance and the Capital Market Department of the Ministry of Finance (herein: "**the determining wage**").
- 6.3.3. If the two said specialist physicians have different opinions, the parties will appoint a physician acceptable to them, financed by the Insurer, and his/her opinion shall be decisive. If the parties do not agree on the said physician, a specialist physician will be appointed by the head of the Israel Medical Association (herein: "the Association") that is engaged in the medical field related to the illness of the Insured, and for the matter of determining incapacity to work even if given medical treatment - by the head of the union of occupational medicine of the Association (herein: "**the deciding physician**") and his/her opinion shall be decisive. If the head of the Association has not appointed a deciding physician as said within 15 days of the day the Insurer requested he/she do so, the deciding physician will be appointed by the director general of the Ministry of Health or someone authorized for this purpose. The wages of the deciding physician will be the fixed wages and they will be paid by the Insurer.

Chapter C: The Service Providers and the Medical Services

7. The Service Providers

- 7.1. The medical services included in this Policy shall be provided solely by the service providers, subject to any change of which the Insured notifies the Policyholder in writing. If the service provider ceased to work with the Insurer, the Insured will contact the call center of the Insurer to obtain a referral to another service provider.**
- 7.2. The medical services included in this Policy shall be provided to the Insured according to medical judgement, at a reasonable quality, within a reasonable amount of time and within a reasonable distance from the place of residence of the Insured.
- 7.3. The said in Section 7.1 above notwithstanding, the Insured shall be entitled to receive, at the funding of the Insurer, the medical services listed below under the circumstances listed below:
 - 7.3.1. Emergency services in any of the general hospitals in Israel, in any of the following cases:
 - 7.3.1.1. Any new fracture.
 - 7.3.1.2. Severe dislocation of a shoulder or elbow.
 - 7.3.1.3. An injury requiring stitching by means of sutures or other means of stitching.
 - 7.3.1.4. Aspiration of a foreign object into the respiratory tract.
 - 7.3.1.5. Penetration of a foreign object into an eye.
 - 7.3.1.6. Cancer treatment.
 - 7.3.1.7. Treatment of hemophilia.
 - 7.3.1.8. Treatment of cystic fibrosis.
 - 7.3.1.9. Transportation by ambulance to an emergency room from the street or another public space due to a sudden event.
 - 7.3.1.10. A referral that ends in non-elective hospitalization
 - 7.3.1.11. A medical emergency.
 - 7.3.2. Hospitalization services provided to the Insured soon after referral to an emergency room, in the cases listed in Section 7.3.1 above.

8. Obtaining Medical Services

- 8.1. Access to the different medical services shall be contingent upon the prior approval of the Insurer and/or the approval of the attending physician and/or it shall be free, all as specified below:**
 - 8.1.1. Access to the primary medical services included in this Policy shall be free, and the Insured will not be required to obtain prior approval of the Insurer before obtaining a medical service of this type.**

8.1.2. Access to non-primary medical services, except in the cases listed in Section 7.3 above, shall be dependent upon obtaining prior approval of the attending physician in the primary medical services. If the Insured did not contact the Insurer in order to obtain its approval for expenses as said above, the Insurer shall be entitled to reduce the amount of the insurance benefits to which the Insured is entitled to the amount that the Insurer would pay the Insured if he/she had contacted the Insurer in advance with a request to obtain said approval.

8.1.3. Access to tests at imaging institutes, diagnostic institutes, gastroenterological institutes, laboratories and elective hospitalization services shall be dependent upon the prior written consent of the Insurer.

The Insured must submit a written request to the Insurer for approval of the services listed in this subsection, together with the confirmation of the attending physician that the Insured requires this medical service.

The requested approval or a notice of refusal to provide it shall be provided within 7 days of the date of determination by the attending physician regarding the need for the test or hospitalization, according to the matter at hand and/or from the date on which the Insurer received the request of the Insured, and in any case, shall not be postponed to a date that could endanger the Insured or reasonably impair the treatment to which he/she is entitled under this Policy.

If the Insured does not contact the Insurer for the purpose of obtaining its approval of expenses as said above, the Insurer shall have the right to reduce the amount of insurance benefits to which the Insured is entitled to the amount that the Insurer would have paid if the Insured had contacted the Insurer in advance with a request to obtain the said approval.

8.1.4. With the exception of the cases listed in Section 7.3 above, the Insurer shall not bear the expenses of medical services of the Insured in an emergency room, except if the Insured received the prior approval of the attending physician.

Table of Limits of Liability for the Policy

Main Areas of Coverage	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 physician, diagnostic tests, imaging services, medications	Full coverage
Emergency room - subject to the criteria determined in the Ordinance	Full coverage
Special one-time compensation for an employee who holds a license in the nursing care sector who is found unfit to perform his job for medical reasons, subject to the terms specified	₪80,000
Medical flight - accompaniment of medical staff and equipment required by the medical condition of the Insured insofar as he/she has lost the capacity to work	Full coverage
Additional coverages	
Emergency dental treatment	Full coverage
Transportation of a corpse	Full coverage
Emergency flight for a close relative and expenses of stay in Israel of up to 10 days	₪6,000 ₪160 per day in a hotel
Air ticket back to country of origin in the case of loss of capacity to work	₪8,000

The Insurer is bound solely by the full terms and exclusions of the Policy.

Full Disclosure

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Summary of the Insurance Terms - SAFE STAY + Extended Health Insurance Policy for the Foreign Worker

05/2021 Edition

Summary of Insurance Terms	
Name of Insurance Plan	SAFE STAY +
Type of Insurance	Health insurance for foreign workers
Insurance period	The period specified on the Insurance Details Sheet and not exceeding 12 months from the beginning date of the insurance as specified in Section 1.11 of the Policy
Description of insurance	Health insurance for a person staying in Israel as a foreign worker, including health services according to the National Health Insurance Law, the basket of medications and basket of services at work. The services will be provided by a contracted service provider of the Company unless specified otherwise. There is also coverage for emergency dental care, compensation for disability for a worker in the nursing care industry.
The policy does not cover the Insured for the following events (exclusions in the Policy)	In insurance events regarding a preexisting medical condition and the other events specified in Section 5 of the Policy. You may ask the Company for detailed information regarding this matter.
Co-pay	According to the customary payment as defined in Section 1.24 of the Policy.

Summary Description of Coverage in the Policy		
Name of coverage	Description of coverage	Maximum amount of a claim
Healthcare services	Section 3 of the Policy – A basket of treatments according to the second amendment of the National Health Law, including medical expenses during hospitalization and not during hospitalization – from the service provider.	According to that defined in the National Health Insurance Law.
One-time compensation for a worker in the nursing care industry	Section 3 of the Policy – One-time compensation for a worker who is licensed in the nursing care industry who is found unable to carry out his work for medical reasons and who is above the length of employment and according to the terms of the Policy.	Section 3 of the Policy – One-time compensation in the amount of ₪80,000.
Medical flight and other coverages	Section 4 of the Policy – Provision of full coverage for expenses related to flight of the Insured from Israel back to the country of origin of the Insured, in a medical event as specified in the terms of the Policy. Also, coverage of additional expenses, such as emergency flight of a close relative and expenses of a stay in Israel in the case of a special medical condition of the Insured as defined in the terms of the Policy.	Section 4 of the Policy – Expense of the stay of a close relative, up to the amount of ₪6,000 Cost of a stay of up to 10 days in a hotel, up to a maximum amount of ₪160 day
Notes	"In the case of indemnity, the Insurance Company will pay the actual expenses, and this up to the ceiling specified in the Policy. Note that if you have identical coverage in another policy, you will not be entitled to a double refund beyond the level of the actual expenses and subject to the terms of the Policy."	

The complete and binding terms are the terms specified in the Policy.

Contact details

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