Passportcard Relocation ND Insurance Policy

Davidshield Insurance Company Ltd | 2024

DAVIDSHIELD INSURANCE COMPANY LTD.

This is an Israeli insurance policy issued by an Israeli insurer located in the State of Israel, under the supervision of the Capital Market, Insurance and Savings Authority Supervisor in the Israel Ministry of Finance.
The laws of the State of Israel shall govern this policy and any dispute arising out of it. The place of jurisdiction shall be a competent court in the State of Israel according to law.

PASSPORTCARD RELOCATION INSURANCE POLICY

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PROPER DISCLOSURE OF THE PASSPORTCARD RELOCATION INSURANCE POLICY

SUBJECT	HEADING	TERMS AND CONDITIONS
General	Insurance Plan Name	PassportCard Relocation Worldwide
	Policy Owner	As stated on the Certificate of Coverage
	Coverages	As detailed in the Table of Benefits
	Duration of Policy	As stated on the Certificate of Coverage
	Terms and Conditions for Automatic Renewal	None
	Qualifying Period	None
	Waiting Period	12 months for pregnancy and childbirth 12 months for mental health
	Cost-sharing	As detailed in the Table of Cost- sharing and Copay Appendix attached to the Certificate of Coverage
Terms and Conditions Changes	Changes to the Policy's Terms and Conditions During the Insurance Period	With the prior approval of the Insurance Supervisor, the change will take effect 60 days after the date of the insurer's written notice to the insured person
Premiums	Premium Amount	As stated on the Certificate of Coverage
	Premium Structure	Variable premium according to insured person's age during the insurance period
	Changes to Premium During the Insurance Period	• Upon transition to a new age group • With Insurance Supervisor's prior approval The change will take effect 60 days after the date of the insurer's written notice to the insured person
Terms of Cancellation	Cancellation by the Insured Person	At any time

SUBJECT	HEADING	TERMS AND CONDITIONS
Terms of Cancellation	Cancellation by the Insurer	• If the insurance premiums are not paid on time, the policy will be cancelled according to the provisions of the Insurance Contract Law • At the end of the insurance period • At the time the maximum coverage according to the policy is exhausted • If a future law is enacted that will prevent the insurer, directly or indirectly, wholly, or partly, from indemnifying an insured person according to or as stated in the policy, the insurer will be allowed to change the policy's conditions, by giving sixty (60) days advance written notice and after the Insurance Supervisor's approval • The insurer will be allowed to cancel this policy if during the insurance period the insured person stays in the country of origin for a period exceeding 90 consecutive days unless the insured person received prior written approval on behalf of the insurer for a longer stay • In case of a breach of the Policy's Chapter relating to the obligation to disclose and subject to the law
Restrictions and Exclusions	Exclusion for Pre-existing Medical Conditions	As detailed in Chapter 3 of this policy
	Restrictions and Exclusions - General	As detailed in Chapter 5

INSURANCE COVERAGE COMPONENTS AND BENEFIT MAXIMUM

The insurer's maximum benefit for all insured events for the entire insurance period is $5,000,000, except in cases where it is indicated otherwise in the table below:

Health Insurance Coverage	Insurer's Benefit Maximum	Waiting Period	Pre-Notification / Comments
Family Physician, Pediatrician or Specialist Visit The insured person's visit to a family physician and/or a pediatrician and/or a specialist or any physician, for diagnosis and/or consultation and/or treatment arising from the insured person's medical condition.	Policy Maximum Benefit	-	No
Medical Diagnostic Tests The insured person's visit and/or sending of a sample to the laboratory and/or the insured person's visit to Radiology or Imaging Institutes, for the purpose of diagnosis or treatment arising from the insured person's medical condition			No
Hospitalization/Day Hospitalization* The insured person's hospitalization in a hospital, including in the Intensive Care Unit, for the purpose of diagnosis and/or medical treatment and/or undergoing surgery arising from the insured person's medical condition, including surgeon fees, anesthesiologist's fees, and operating room expenses. Day Hospitalization: as mentioned above without an overnight stay in the hospital. Chemotherapy services, dialysis, hemodialysis, blood processing, units of blood, etc., are included as part of hospitalization or day hospitalization coverage. It is clarified that the hospitalization rates will be for the cost of a semi-private room (two to three beds in a room) including regular room services, food provided by the hospital, a nurse and ancillary nursing, but not including telephone, television and other ancillary services that do not involve medical treatment. *Hospitalization due to pregnancy or mental health is not included in this coverage and is detailed below.			Yes

Health Insurance Coverag	Insurer's Benefit Maximum	Waiting Period	Pre-Notification / Comments
Medical Follow-Up Care for Baby and Child (Family Health Care Centers) Medical follow-up and physiological development, including the provision of vaccinations as required in the insured person's country of destination or origin, up to the age of 16.	Policy Maximum Benefit	-	No
Medications Actual purchase of prescription medicines to treat the insured person's medical condition. Chronic prescription medications will be supplied for a period of up to 90 consecutive days, for each prescription, only through an In-Network Provider . If the insured person insists on purchasing a brand-name drug for which a generic drug is available, the insured person shall bear, in addition to his/her Cost-sharing, the difference between the cost of the two medications			No
Emergency Dental Treatment Emergency dental care and/or dental surgery necessary to restore or replace stable, natural teeth lost or damaged in an accident that was covered under the policy.			Yes
Dental First Aid Providing immediate and one-time primary care to relieve toothache, including medications.	Up to $200 per calendar year	-	No
Diagnosis and Treatment of ADHD in Children and Youth up to the Age of 16 Diagnosing by various customary tests and medications or other medical treatment, according to the diagnostic results.	$2,000 for the entire policy term	12 consecutive months from the insurance commencement date	No

<table>
<tr><th colspan="2">Health Insurance Coverage</th><th>Insurer's Benefit Maximum</th><th>Waiting Period</th><th>Pre-Notification / Comments</th></tr>
<tr><td colspan="2">Adult Periodic Physical Examinations
Performing a periodic medical examination for the insured person provided that at least 12 months have elapsed since his/her last periodic medical examination. Medical consultation and physiological examination, including a digital rectal examination for examining the prostrate; Blood test - general values including cholesterol level; Fecal occult blood test; Periodic general gynecological examination, including manual breast examination; Pap Smear test; Mammography examination.</td><td>$500 per calendar year</td><td>-</td><td>No</td></tr>
<tr><td rowspan="5">Special Screening Tests</td><td>Colonoscopy
Examination of lower gastrointestinal tract (bowel) for early diagnosis of colon cancer or bowel tumors</td><td rowspan="5">Policy's Maximum Benefit</td><td rowspan="5">12 consecutive months from the insurance commencement date</td><td>From the age of 50, once every 5 years, and on condition that no test was performed during the last five years</td></tr>
<tr><td>Intraocular Pressure Test
This test is intended for the early diagnosis of glaucoma.</td><td rowspan="2">Coverage will be given for this test once every two calendar years for insured persons over the age of 40.</td></tr>
<tr><td>PSA Test
This test is designed to detect signs that may indicate the development of prostate cancer</td></tr>
<tr><td>Bone Mineral Density
A test that diagnoses the density of bone components and helps in the early diagnosis of osteoporosis.</td><td>Coverage will be given for this test once every two calendar years for insured persons over the age of 50.</td></tr>
<tr><td>Special Imaging Tests
Virtual Catheterization CT scan that allows early detection of coronary artery disease</td><td>Coverage will be given for this test once every three calendar years for insured persons over the age of 40.</td></tr>
</table>

Health Insurance Coverage	Insurer's Benefit Maximum	Waiting Period	Pre-Notification / Comments
Routine Prenatal Care In accordance with the table of services detailed at the end of the policy	Policy Maximum Benefit	12 consecutive months from the insurance commencement date	No
Childbirth Expenses Routine vaginal delivery, without any medical intervention beyond assisting a woman to give birth by vaginal delivery	Up to $15,000 per birth Up to $ 30,000 cumulative for entire insurance period		No
Multiple Pregnancy or Pregnancy Complications, Childbirth Complications, Treatment of Premature Babies Multiple pregnancy; Abnormal pregnancy conditions; abortion (other than for personal and/or socio-economic reasons); any birth defect; newborn care during the first 31 days of life, as part of the coverage provided to the insured mother, for which additional medical intervention beyond the normal course of childbirth, including diseases and/or defects formed in the insured woman and/or in the fetus and/or in the newborn, as a result of an abnormal course of pregnancy or childbirth; Post-pregnancy medical follow-up of the mother, diagnosis and treatment of the mother's post-pregnancy medical problems; diagnosis, treatment and/or follow-up for medical problems of a newborn during the first 31 days of life, all within the scope of the coverage given to the insured mother. The following medical conditions are examples of complications that may occur during pregnancy: pre-eclampsia, Toxemia, kidney infection, gestational diabetes, anemia, infection of the bladder, position and/or abruption of placenta, uterine rupture, infection of the placenta, endometriosis, late birth (week 42 and above), Rh sensitization to the fetal blood, early labor, rupture of membrane more than 12 hours before birth, cervical dilation stops, labor over 20 hours, intrauterine death, ectopic pregnancy, excessive vomiting, and related or similar pathologies.	Up to $100,000 (cumulative for entire insurance period		No

Health Insurance Coverage	Insurer's Benefit Maximum	Waiting Period	Pre-Notification / Comments
The following situations are examples of childbirth and/or fetus or newborn complications: cesarean section, abnormal fetus presentation, induction of labor for medical reasons, abnormal amniotic fluid, slow or fast heart rate, prolapse of the umbilical cord, amniotic fluid embolism in the lungs, birth weight less than 2 kg, premature birth (a baby born before the 37th week of pregnancy), birth under general anesthesia of the mother, birth congenital disorders or similar or related pathologies.	Up to $100,000 (cumulative for entire insurance period)	12 consecutive months from the insurance commencement date	No
Organ Transplant The insurer shall pay the service provider expenses for the transplant, a specialist physician's assessment before the transplant, the transplant procedure, a repeat transplant, if it occurs during the hospitalization of the first transplant and follow-up treatments after the transplant. Before providing indemnification or compensation to finance the performance of a transplant, the provisions of the Law (Organ Transplant law, 2008-5768) will be examined by the insurer, including whether all the following were met: 1) Organ harvesting and transplant were carried out in according to the applicable law in that country; 2) The provisions of the law concerning the prohibition of organ trafficking are being followed. **Transplants shall be performed only by In-Network Providers.**	$500,000 (cumulative for entire insurance period)		Yes, at least 72 hours before hospitalization

Health Insurance Coverage	Insurer's Benefit Maximum	Waiting Period	Pre-Notification / Comments
Medical expenses incurred by a living donor of an organ or tissue and/or the donor's travel and hotel accommodations	$5,000 per insured event	-	Yes
Air/Sea Medical Emergency Evacuation Emergency air and/or sea transport, due to the insured person's medical condition, to a hospital or nearest airport to the hospital, to which the insured person is evacuated or transferred, or to the country of origin at the insurer's discretion, including the necessary ground transportation before and after the air or maritime transportation. For the avoidance of doubt, it is hereby clarified that the insurer's liability according to this Chapter will only arise if all the following cumulative conditions are met: a. The necessary medical care needed for the Insured is lifesaving ; b. The necessary medical treatment cannot be given to the insured person at his/her location. c. Transportation other than by emergency evacuation may end in the death of the insured person. d. The provisions of the above sections are required by a specialist physician and approved by the insurer. For the avoidance of doubt, it is clarified that performing an emergency evacuation is only possible in the course of receiving medical service solely through In-Network Providers and not through an Out-of-Network Provider.	$25,000 per insured event		Yes, the services will be provided only by In-Network Providers. all services will be ordered and coordinated by the insurer
Physiotherapy / Hydrotherapy / Chiropractic / Occupational Therapy / Disorders and Speech Therapy	$75 per visit Up to 24 visits per calendar year per each insured event		No

Health Insurance Coverage	Insurer's Benefit Maximum	Waiting Period	Pre-Notification / Comments
Mental Health and Psychiatric Hospitalization Medical treatment and medications for the insured person's state of health, resulting from his mental conditions, diagnosed by a specialist physician	$20,000 for entire period of insurance	12 months	No
Patient Transport by Ground Ambulance Transfer of an insured person by ambulance to an emergency room and/or between the hospital in which the insured person is hospitalized to another hospital, due to medical reasons arising from the insured person's medical condition	$2,500 per each insured event	-	No
Non-Perishable Medical Equipment and Medical Devices Rental of ancillary equipment such as a wheelchair, crutches, hospital bed. Purchase of artificial limbs, voice, or breast prosthesis	$5,000 for entire period of insurance	-	No
Nursing Services Post-hospitalization Nursing services provided in the insured person's home or in a rehabilitation institution continuously after hospitalization of the insured person in a hospital	$50,000 for entire period of insurance	-	Up to 60 consecutive days per insured event
Rehabilitation Institution - Prolonging Life (Hospice)		-	
Family Reunion Indemnifying the insured person, up to the insurer's limit of liability, for the purchase of airline tickets in economy class, for the insured person's immediate family members (spouse/insured person's children /parents/brothers/sisters) for their flight to the country of destination, in the event of a major surgery being performed on the insured person in the country of destination, all 15 days before the major surgery and up to 30 days after it. The insured person will provide the insurer with a medical certificate, on behalf of a specialist physician, regarding the performance of major surgery on the insured person in the country of destination. The service is provided through the insurer's In-Network Providers. It is hereby clarified that the benefit is for the cost of the flight tickets only, up to the amount shown in the Insurer's Table of Benefits, and does not include payment for airport taxes, security taxes, visas, fines for cancellations or extensions, and additional charges exceeding the basic cost of the flight ticket.	Up to $1,000 for entire period of insurance	-	No

Health Insurance Coverage	Insurer's Benefit Maximum	Waiting Period	Pre-Notification / Comments
Repatriation of Mortal Remains In the case of the insured person's death due to an event covered by this policy, the insured person's legal dependents will be reimbursed for the expenses of the flight for repatriation of the insured person's mortal remains to the country of origin.	Up to $25,000	-	Yes
Parental Accomodation In the case of hospitalization of an insured person who is a minor up to the age of 16, coverage will be provided for the parent's stay and accommodation expenses in the hospital room with the minor insured person.	Up to $100 per night		Up to a limit of 10 nights per insured event

All coverages in the **insurance** plan are types of indemnity and are considered as additional **insurance**, except for Chapter 7 (Returning Israeli Citizens to Israel) which is an indemnity and is considered an **alternative insurance**. All coverages that are considered as an indemnification can be offset against insurance benefits from another **insurance** if they are received in relation to the same matter.

There are several types of coverage in health insurance:

• **Alternative insurance -** Private Insurance constituting an alternative to the services provided by the public medical service package and/or the HMO'S additional health services. The insurance premiums in this policy shall be paid regardless of the rights stemming from the basic levels (from the first dollar).

• **Supplemental health insurance –** Private Insurance according to which the insurance benefits are above and beyond the basic medical services package and/or the HMO'S additional health services, meaning, the insurance benefit payments are the difference between the actual expenses and the expenses stemming from the basic medical services package and/or the HMO'S additional health services.

• **Additional insurance –** Private insurance including services that are not included in the basic medical services package and/or the HMO'S additional health service. Additional Insurance premiums are paid from the first dollar.

GENERAL HEALTH INSURANCE TERMS AND CONDITIONS

In return for payment of the insurance premiums as stated below, the insurer will indemnify the insured person for expenses for medical services and/or pay directly to the service providers for an insured event, and all as defined and detailed in the Policy's provisions and chapters on the Certificate of Coverage, during the insurance period, within the insurer's limit of liability according to the policy's terms and conditions. Provisions relating to an insured person in the masculine language will also apply to an insured woman under this policy.

CHAPTER 1 – DEFINITIONS

The following terms and conditions in this policy, on the Certificate of Coverage, as defined below and in any appendix attached to it, will be interpreted as follows:

1.1. **"The Insurer" -** DavidShield Insurance Company, Ltd.

1.2. **"The Insured Person" -** The person whose name appears on the Certificate of Coverage.

1.3. **"Policy Owner" -** A person, a group of people, or a corporation that entered into an insurance contract with the insurer, and whose name is stated on the Certificate of Coverage as the policy owner.

1.4. **"Insurance Application" -** A completed application form whose wording will be determined by the insurer, including a health declaration and a waiver of medical confidentiality, signed by the insured person, or an application recorded during a conversation.

1.5 **"The Policy" -** The insurance contract between the insurer and the insured person, including the offer, Certificate of Coverage, Table of Benefits and Table of Cost sharing and Copay Appendix, insurance start date, premium amount, date of payment, etc.

1.6 **"Certificate of Coverage" -** A document attached to the policy that includes among other things: the policy number, policy owner's name, the name of each individual insured person, country of destination, country of origin, insurance commencement date, premium amount at date of commencement, type of currency according to which the calculation will be made, and date of payment. The Certificate of Coverage constitutes an integral part of the policy.

1.7 **"Table of Cost-sharing and Copay Appendix" -** A tabular summary detailing the sums of Cost-sharing and fees. This appendix constitutes an integral part of the policy.

1.8 **"Insured Person's Age" -** Will be calculated in whole years as the difference between the insured person's date of birth and the date on which his age must be determined. Six (6) months or more will add a full year onto the age of the insured person. The insured person's age, used to determine his rights entitlements within the plan, during the final year of the insurance period, will be determined according to the insured person's date of birth.

1.9 **"The Insured Event" -** Medical and/or other service provided to the insured person, due to medical necessity, as specified in each chapter of this policy,

1.10 **"The Insured Event's Date of Occurrence" -** The date of the actual receipt of the medical and/or other service by the insured person.

1.11 **"Waiting Period"-** A period, specified in days or months, as specified in the policy's chapters, which begins on the insurance commencement date, during which no medical service will be granted to the insured person as part of the insurance coverage according to the policy.

1.12 **"Pre-existing Medical Condition" -** A set of medical circumstances that were diagnosed in the insured person before the date of joining the insurance, including due to illness or accident. In this matter, "diagnosed in the insured person", by way of a documented medical diagnosis, or in the process of a documented medical diagnosis, that was carried out during the six months prior to the date of joining the insurance.

1.13 **"Exclusion of Pre-existing Medical Condition " -** A general exclusion in the insurance contract below, which releases the insurer from its liability, or which reduces the insurer's liability or the scope of coverage, due to an insured event whose actual cause was the normal course of a prior medical condition, and which occurred to the insured person during the period in which the exclusion applies.

1.14 "**Country of Origin" -** State of Israel and/or country where the main insured person has citizenship other than the country of destination.

1.15 **"Country of Destination" -** The country in which the insured person intends to stay according to his statement in the insurance application.

1.16 **"Co-insurance" -** A monetary amount or percentage of a monetary amount that the insured person must pay for the medical service, as specified in the Table of Cost-sharing and Copay Appendix, which will be deducted from the insurance benefits up to the maximum limit stated in the Table of Cost-sharing and Copay Appendix and the insurer's Table of Benefits.

1.17 **"Medical Expenses" -** Payments for medical services due to an insured event, submitted to the insurer, for necessary, adequate, and appropriate medical services that are in line with the parallel medical service providers' fixed price levels, regarding the same medical services. (UCR - Usual Customary & Reasonable).

1.18. **"Insurance Premiums" -** Premium and other payments that the policy owner and/or the insured person must pay to the insurer, according to the policy's conditions.

1.19. **"Surgery" -** An invasive-intrusive procedure that penetrates tissues, aimed at treating a disease and/or injury and/or repair a defect or deformity in the insured person's body. The following invasive-intrusive procedures shall be considered as surgery: operation carried out using a laser beam for diagnosis or treatment, endoscopic visualization of internal organs, catheterization, angiography, and lithotripsy for kidney stones and gallstones.

1.20. **“Elective Surgery” –** The need for surgery is planned, and for which the insured person’s admission to the hospital for the purpose of performing the surgery was not a referral from an emergency room as an urgent case, but rather the insured person was referred for surgery by a specialist physician from a clinic (including the hospital’s outpatient clinic).

1.21. **“Major Surgery” -** Brain and/or spine and/or heart surgery or other similar surgery requiring hospitalization for a period exceeding 96 hours. For this matter, a caesarean section accompanied by a hospitalization of more than 96 hours should not be considered a major operation.

1.22. **“Transplantation” -** Surgical resection or removal from the insured person’s body of a lung, heart, kidney, pancreas, liver, and any combination thereof, and the transplantation of a whole organ or part of an organ taken from the body of another person in their place, or the transplantation of bone marrow from another donor into the insured person’s body. Transplantation will also include an artificial heart transplant, at which point the procedure ceased to be defined as experimental in Israel. In the event that an artificial heart is transplanted prior to a heart transplant from another person’s body, this will be considered as one insured event.

1.23 **“Implant” -** Any device, natural organ or part of a natural organ, or artificial organ, artificial or natural joint that are implanted or assembled in the insured person’s body during surgery covered under the insurance such as: lens, hip joint, etc. except for dental prosthesis, dental implant, and implant during the implant procedure (as detailed in this section).

1.24 **“Diagnostic Medical Tests” -** Laboratory tests (such as blood, secretions, and cell tests, etc.), X-ray, EKG, imaging tests - ultrasound, computerized tomography, magnetic resonance tests (MRI), mapping, PET, and any other test required according to accepted medical standards for diagnosing the insured person’s illness or for determining its treatment methods

1.25. **“Physician” -** Licensed to practice medicine (MD) and/or a physiotherapist, chiropractor, psychologist or psychiatrist, certified by the competent authorities in Israel or abroad, respective to the country in which he practices the medical profession, but not a DPM and/or therapist, or a person engaged in the medical profession and does not meet one of the above qualifications.

1.26. **“Specialist Physician” -** A physician in Israel or abroad who has been certified by the authorities in the country in which he practices as a specialist in a certain medical field and has a specialist license number.

1.27. **“Hospitalization” -** A stay in a medical and/or psychiatric setting, for the purpose of diagnosis and/or for the purpose of performing an emergency and/or elective surgery, which includes a stay in the hospital, tests and medications related to the purpose of the hospitalization.

1.28. **“Hospital” -** A medical institution in Israel or abroad recognized by the competent authorities, in the country where it is located, as a public or private hospital.

1.29. **“Medical Institution” -** A medical institution in Israel and/or abroad, including a clinic, laboratory, diagnostic center, pharmacy, etc.

1.30. **“Medical Services” -** Surgery, medical tests, medical treatment, a visit to a physician, hospitalization, supplying of medicines, etc., and all as detailed in each of the policy’s chapters.

1.31. **“In-Network Provider“ -** A physician, hospital, medical institution, pharmacy, etc. contracted by the insurer and whose name will be indicated in the list held by the insurer, which will be regularly updated and published by the insurer from time to time.

1.32. **“Out-of-Network Provider“ -** A physician, hospital, medical institution, etc. that did not enter into a contract with the insurer.

1.33. **“List of Service Providers” -** A website on the Internet and/or other digital media that includes the names of all service providers.

1.34. **“ Medications included in the Healthcare Package” -** A list of medicines which will be defined from time to time by the insurer and will not contain less than the list of medicines approved by the National Health Insurance Law 1994- 5754.

1.35. **”Service Center” -** A telephone center or website, on behalf of the insurer, the details of which are listed on the insured person’s card. The center’s purpose is to coordinate service between the insured person and the service providers, verify the insured person’s eligibility for medical services, and arrange for the issuance of an insurer’s approval, etc.

1.36. **“Abroad” -** Any country outside the State of Israel or outside of the Country of Origin.

1.37. **“Currency” -** The type of currency specified on the Certificate of Coverage and in the policy’s other appendices.

1.38. **“Currency Linkage” –** A sum in dollar equal to the currency’s exchange rate as published by the Bank of Israel and known on the day of payment.

1.39. **“Insurance Year” -** A period of 12 consecutive months that begins on the insurance commencement date as stated on the Certificate of Coverage. Each date in the policy is determined according to the Gregorian calendar.

1.40. **“Insurer’s Approval” -** An approval given in writing by a manager on behalf of the insurer, including via Davidshield Life Insurance Agency (2000) Ltd., for the purpose of receiving medical service and its financing, but not an approval to perform any medical procedures due to the insured person’s medical condition.

1.41. **“Prescription Medicine” -** A medicine that cannot be purchased, except with a medical certificate from a physician and with a prescription from the physician for a medicine that cannot be purchased without a prescription.

1.42. "Copay" - A fixed sum of money paid for each medical service, for each visit and for each individual insured person separately, as it appears in the Table of Cost-sharing and Copay Appendix.

1.43. "Accident" - Bodily injury to the insured person caused by a sudden and unforeseen event, which was caused to the insured person during the insurance period by external violent means visible to the eye and is the only, direct and immediate cause of the insured event.

CHAPTER 2 – GENERAL TERMS AND CONDITIONS

2.1 **The Coverage -** The insurer will pay the service provider and/or indemnify or compensate the insured person, on the occurrence of an insured event, for medical services received by the insured person, detailed in each of the chapters of this policy, all subject to the policy's terms and conditions and exclusions.

2.2 **Policy's Validity -** This insurance policy will be valid from the date specified on the Certificate of Coverage and subject to the cumulative terms and conditions detailed below. For the avoidance of doubt, if funds were paid to the insurer at the expense of the insurance premiums before the insurer's consent was given as stated under this policy, this payment will not be considered as the insurer's consent to issuing the insurance under the policy.

- a. The insurance applicant provided the insurer with a valid means of payment that can be collected from in respect of and for the insurance premiums due to the insurer, as stated on the Certificate of Coverage.
- b. The addition of a family member to the policy, whose name is not detailed on the Certificate of Coverage, is subject to the insurer's consent and the signing of a health declaration by the policy owner or the insured person (as the case may be) associated with the additional family member.

2.3 **The Insurance Period -** The insurance period as specified on the Certificate of Coverage in relation to each individual insured person.

2.4 **Payment of Insurance Premiums**

- a. The policy owner and/or the insured person will pay monthly for each of the insured persons in the policy, during the insurance period, the insurance premiums due to the insurer, as stated on the Certificate of Coverage and according to the provisions of clause 2.5 below. The insurance premiums will be paid for each new insured person who joins the policy, and the premiums will be determined at the time of his joining the policy.
- b. The insurance premiums will be paid in advance for each month.
- c. In the case of payment of insurance premiums by a bank transfer to the the insurer's account, the date of crediting the insurer's bank shall be considered as the date of payment of the insurance premiums.
- d. Late payment of insurance premiums will be charged interest in accordance with the provisions regarding interest on arrears in the Adjudication of Interest and Linkage Law, 5721-1961.
- e. The insurance premiums, the insurance benefits, and the sums of the insurer's benefit maximums specified in the policy, its appendices, and the Certificate of Coverage will be specified according to the currency and/or linked to the currency indicated on the Certificate of Coverage.

2.5 Insurance Premiums

2.5.1 The insurance premiums paid for this policy will be determined according to the insured person's age at the time of enrolling in the insurance as well as at the beginning of each additional insurance year according to the insured person's age at that time, respectively.

2.5.2 In addition to clause 2.5.1 above, the insurer may change the insurance premiums and/or the Cost-sharing and fees, subject to the approval of the Insurance Supervisor in the State of Israel of a request for such changes and subject to giving written notice to all the insured persons 60 days prior to the date of the change. The above changes will be made in respect to all insured persons in the same age group and gender in the country of destination.

2.6 Prior Notice

2.6.1 Indemnification of the insured person under this policy is subject to prior notice provided by the insured person to the service center, as early as possible, before or after the date of occurrence of the insured event. In the absence of prior notice, the insurer may reduce the insurance benefits as specified in section 2.6.2.

- 2.6.1.1 Pregnancy and Childbirth - the insurer will be notified during the first three months of pregnancy.
- 2.6.1.2 Hospitalization - the insurer will be notified a minimum of 72 hours before the actual hospitalization and a maximum of 48 hours after hospitalization resulting from an emergency.
- 2.6.1.3 Any surgery and/or surgical procedures.
- 2.6.1.4 Nursing and hospice services.
- 2.6.1.5 Magnetic resonance imaging (MRI) or positron emission tomography (Pet Scan) or any imaging test similar in its components.
- 2.6.1.6 Admission to Inpatient Care at Hospice.
- 2.6.1.7 Home hospitalization.
- 2.6.1.8 Transplants.
- 2.6.1.9 Family Reunion.

2.6.2 The insurer shall be entitled to a reduction of the insurance benefits up to a rate of 50% due to excess expenses actually incurred by the insurer, due to a failure by the insured person to provide prior notice in cases where prior notice was required, and up to the amount that the insurer would have paid if prior notice would have been given to him.

2.6.3 In order to obtain the insurer's prior approval, the insured person shall notify the service center of the need to receive the medical service, as early as possible. and in any case not less than 72 hours before the scheduled date for receiving the medical service, as detailed in each of the policy chapters, respectively.

2.6.4 The provisions of this section shall not apply to the performance of an urgent medical service for which the insured person is obligated to notify the insurer within 48 hours of its occurrence.

2.6.5 For the avoidance of doubt, the guidance provided by the service center in Israel and/or the USA and/or anywhere else in the world should not be considered as a commitment to cover the medical service and/or a recommendation for the provision of such medical service. Provision of prior notice regarding the insured event does not guarantee the payment of the expenses associated with the medical service, and its coverage is subject to the policy's conditions, terms, and exclusions.

2.7 Receiving Medical Services

The receipt of the medical services as detailed in each of the policy chapters shall be made as follows:

2.7.1 The insurer will indemnify the insured person for expenses for medical services actually provided to the insured person for receiving a medical service and/or for medical expenses submitted for payment by the service provider, all subject to the policy's conditions, terms, and exclusions.

2.7.2 On the occurrence of an event, for which the insured person is required to receive a medical service, the insured person has the choice of two methods for receiving medical services subject to the provisions of the policy and as detailed below:

2.7.2.1 Receiving medical service through an In-Network Provider:

2.7.2.1.1 In order to receive medical service, the insured person shall contact a service provider, whose included in the list of In-Network Providers. If the insured person chooses this method of receiving a service, he will bear the payment of the Cost-sharing as detailed in the Table of Cost-sharing and Copay Appendix for a calendar year. The insurer will pay the insurance benefits only exceeding the amount of the deductibles actually paid by the insured person .

2.7.2.1.2 The insurer's payments to the In-Network Provider will be according to the arrangements made between the In-Network Provider and the insurer.

2.7.2.1.3 The insured person person's total Cost-sharing for himself and/or his family members included in the policy, according to his family status, are subject to the maximum limit of Cost-sharing and the insured person's expenses for each calendar year, as specified in the Table of Cost- sharing and Copay Appendix.

2.7.2.2 Receiving a medical service through an Out-of-Network Provider

2.7.2.2.1 In order to receive a medical service, the insured person,

may, at his discretion, contact Out-of-Network service providers, except in those chapters of this policy for which there is an obligation to receive service through an In-Network Provider.

2.7.2.2.2, The insurance benefits payment maximum, according to this method of receiving a service, will apply as detailed in the Table of Cost-sharing and Copay Appendix for a calendar year. The insurer will pay the insurance benefits only exceeding the amount of the deductibles actually paid by the insured person and Cost-sharing .

2.7.2.2.3 The insured person will bear, according to this method of receiving a service, the payments of Cost-sharing and fees as detailed in the Table of Cost- sharing and Copay Appendix for a calendar year. The insured person's total Cost-sharing for himself and/or his family members included in the policy, adapted to his family situation, are subject to the insured person's maximum limit of Cost-sharing and maximum expenses for each calendar year, as specified in the Table of Cost-sharing and Copay Appendix. **It is hereby clarified that the payment of insurance benefits by the insurer is up to the UCR maximum limit.**

2.7.2.3 For the avoidance of doubt, it is clarified that the provisions of clause 2.8.2.2 and all its sections shall be in full force and effect, except in the following cases:

2.7.2.3.1 If there is no In-Network Provider defined as a clinic in the contract, (a single physician or a group of physicians - chapter 7 - Special Terms and Conditions, subclause 1 in this policy) within a travel distance of 25 km from insured person's location.

2.7.2.3.2 In cases where the is no In-Network Provider that is not defined as a clinic (hospital, laboratory, medical centers, radiology and imaging institutes, etc. - chapter 7 - Special Terms and Conditions - subclauses 2, 3, 4, 5 of this policy) within a travel distance of 75 km from the insured person's location. In the above cases, the provisions of clause 2.8.2.1 and all its sections shall be in full force and effect.

2.7.3 The insured person will provide the service center with the information relating to his claim, including the diagnosis of the attending physician and the medical documents necessary for the insurer to investigate the claim. The insured person will deliver the above information to the insurer, at the stage of receiving prior approval or after receiving the medical service, in accordance with the type of service as detailed in each of the policy chapters.

2.7.4 The insurer will pay the insurance benefits as stated when he has

received all the information and documents required by him to investigate the claim and all above the deductibles, minus the Coinsurance and Special Coinsurance and subject to the terms and conditions and the exclusions of the policy.

2.7.5 If necessary and subject to prior notice and coordination with the service center, the insurer will pay the medical treatment expenses directly to the service provider, chosen by the insured person, according to the Table of Benefits and exceeding the amount which the insured person has to bear, in accordance with the Table of Cost-sharing and Copay Appendix for a calendar year.

2.7.6 For the avoidance of doubt, it is clarified that the amounts paid by the insured person and accrued for the purpose of the insurance benefits maximum and cost -sharing in a calendar year will be ascribed solely to that calendar year.

2.8 **Medical Examination –** As part of the investigation relating to the insured person's claim and the insurer's liability in this regard, if the insurer demands, the insured person will present himself for a medical examination by a physician on behalf of the insurer, provided that the examination is reasonable under the circumstances and at the insurer's expense. It is clarified that the insured person may at any time request to exhaust his rights granted to him by virtue of the policy in court.

2.9 **Production of Documents and/or Waiver of Medical Confidentiality -** The insured person, with regard to his claim and the insurer's obligation in this context, shall deliver information and/or a medical document demanded by the insurer, and authorize by his signature, the service provider and/or the service supplier and any other entity and/or institution, to provide the insurer with any information regarding the insured person's medical condition.

2.10 **Obtaining Information -** As part of the investigation relating to the insured person's claim and the insurer's liability in this regard, the insurer may be updated directly by the insured person's personal physician and/or therapist regarding the nature of the medical treatment required, its scope, and timing.

2.11 In the event that payments made by the insurer are not covered under the policy by the insurer, and a written reasoned request is submitted to the insured person for the return of these payments, the insured person will be obligated to pay them within 10 days from the delivery date of the aforementioned request on behalf of the insurer. In the event of non-payment as stated, the insurer will deduct the excess payments from any amount he is obligated to pay according to the policy.

2.12 **The Right of Subrogation**

2.12.1 If the insured person also had a right of indemnification against any third party in the case of an insured event, for whatever reason, this right will be transferred to the insurer, when paying the insurance benefits according to the policy, and in the amount of the benefits paid by the insurer.

2.12.2 The insurer is forbidden to use the right transferred to it pursuant to this section, in a way that would infringe the insured person's right to collect from the third party an indemnity, in excess of the benefits received by him from the insurer.

2.12.3 If the insured person received indemnification and/or compensation from the third-party that was due to the insurer according to this section, the insured person must transfer it to the insurer. If the insured person made a compromise, waiver or other action that violates the right transferred to the insurer, the insured person must compensate the insurer accordingly.

2.12.4 The provisions of this section shall not apply if the insured event is the result of an unintentional act and/or omission, by a person from whom the reasonable insured person would not claim indemnity or compensation due to family ties.

2.13 Preservation and Continuity of Rights

2.13.1 The insured person shall be entitled to a continuity of insurance rights according to which, upon his return to Israel for a period exceeding 90 days, he shall be entitled to continuous alternative insurance coverage on behalf of the insurer to the extent of the insurance coverage included in the insurer's health policy existing at that time, but not exceeding the insurance coverage included in the basic policy, or in a policy that includes a more limited insurance coverage, according to the insured person choice.

2.13.2 The continuity of the insured person's rights will be preserved in such a way that the insured person will not be required to undergo a new procedure for acceptance to the insurance, including completing a health declaration, a waiting period, and a qualification period. The continuity of rights will be preserved as stated, provided that the insured person has notified the insurer of his desire for alternative insurance coverage, not later than 30 days from the policy's cancellation date. The insurance premiums for the new insurance coverage will be paid in accordance with the conditions of acceptance and underwriting, determined by the insurer regarding that insured person at the time of acceptance for insurance under the policy.

2.14 Miscellaneous

2.14.1 The insurer will be entitled to change the list of In-Network Providers from time to time.

2.14.2 The insurer will not be allowed to change the terms of the policy, including the special conditions and the maximum benefits, except with the prior approval of the Insurance Supervisor in the State of Israel. The changes will take effect 60 days from the date on which the insurer notified the change in writing to all the insured persons under the policy.

2.15 **Jurisdiction -** The laws of the State of Israel will apply to this policy and all disputes arising from it, and the place of jurisdiction will be in the competent court in the State of Israel only, according to law.

2.16 **Statute of Limitations -** The statute of limitations for a claim for insurance benefits according to the policy is 5 years from the date of the occurrence of the insured event and in the case of a minor, 5 years from the date he turned 18.

2.17 **Taxes and Levies -** The policy owner or the insured person, as the case may be, must pay all government and other taxes applicable to this policy or imposed on insurance premiums, insurance benefits and all other payments that the Company must pay according to the policy, whether these taxes exist on the date the policy entered into in force and whether they will be imposed at a later date, either in the State of Israel or in the country of destination.

2.18 **Status of the Policy Owner - T**he policy owner declares that he is the proxy of each individual insured person for the purpose of this policy and that any notice sent by the insurer to him regarding policymatters will be considered as having been delivered by him to each insured person.

2.19 **Canceling the Policy and Changing its Terms**

2.19.1 The insurer will be allowed to change the terms of the policy if a law is enacted in the future shall prevent the insurer, directly or indirectly, wholly or partly, from indemnifying an insured person according to or as stated in the policy, and this is with 45 days prior notice and subject to the prior written approval of the Insurance Supervisor in the State of Israel.

2.19.2 The insurer shall be entitled to cancel this policy if during the insurance period the insured person stays in the country of origin for a period exceeding 90 days, unless he has received prior written permission on behalf of the insurer, for a longer stay and, if the insured person becomes a citizen of the country of destination. The insured person shall inform the insurer of his change of citizenship immediately upon receiving the citizenship of the country of destination.

2.19.3 If the insurance premiums or part of them have not been paid on time, and have not been paid within 15 days after the insurer demanded from the insured person or the policy owner in writing to pay them, the insurer may notify the policy owner and/or the insured person in writing that the policy will be canceled after an additional 21 days, if the amount in arrears is not paid off beforehand.

2.19.4 The above does not detract from the insurer's right to cancel the policy according to the provisions of the policy and/or according to the provisions of any law.

2.19.5 The insurer may offset the insured person's debts out of the payments of the insurance benefits to which the insured person is entitled in accordance with the provisions of any law.

2.19.6 The insurer may cancel this policy by virtue of the Insurance Contract Law and for breach of the obligation to disclose (Chapter 4 below).

2.19.7 The insured person shall be entitled to cancel the policy by a notice delivered to the insurer 3 days before the cancellation date. In such a case, the insurer will not be liable for insurance benefits or any liability under the policy from the date of its cancellation.

2.20 Notices

2.20.1 The insurer's notice to the policy owner and/or the insured person and/or the beneficiary, and/or to the person authorized to receive notices and documents, including legal documents, as the case may be, will be given according to their last address or the e-mail provided in writing to the insurer. The insured person and/or the policy owner undertake to inform the insurer through the service center of any change in his details and the insured person shall not claim that a notice did not reach him if it was sent according to the most recent address provided by the insured person to the insurer.

2.20.2 For the avoidance of doubt, any notice from the insurer to the policy owner and/or the insured person, and/or to the beneficiary, including written documents of any kind, including legal documents, which was delivered to an authorized person appointed by the insured person or the policy owner to receive notices and documents, shall be considered as having been delivered to the insured person and/or the policy owner respectively.

2.20.3 Any change in the policy, if requested, will enter into force only after it has been included by the insurer in the policy and/or in an update of the policy's appendix issued by the insurer.

CHAPTER 3 – WAITING PERIODS

3. Waiting Periods

3.1 The insurer shall not be liable for payment for insured events for which liabilities arising out of them were created during the waiting periods detailed below. The waiting periods regarding a new insured person who will be added to the policy, after its commencement, will begin on the date of his addition to this policy.

3.2 The insurance coverage for pregnancy monitoring and childbirth, mental health, ADHD and Special Screening Tests will only come into effect after a waiting period of 12 consecutive months from the insurance start date.

3.3 **Pre-existing medical condition -** Subject to the filling out of an insurance application by the insured person regarding his health condition, prior to joining the insurance, it is clarified that medical services for a previous condition, as defined in clause 1.12 above, will be covered only after a waiting period as detailed below:

3.3.1 For insured person who is under the age of 65 at the insurance commencement date, there will be a waiting period of 12 consecutive months from the insurance commencement date.

3.3.2 Insured person who is 65 years old or above at the insurance start date, there will be a waiting period of 6 consecutive months from the insurance commencement date. (Also see chapter 4 below and the Table of Benefits regarding a pre-existing medical condition).

CHAPTER 4 – OBLIGATION TO DISCLOSE AND PRE-EXISTING MEDICAL CONDITIONS

4.1 Obligation to Disclose

4.1.1 This policy was issued on the basis of the insurance application, notices and statements delivered in writing and/or by telephone to the insurer by the policy owner and/or the insured person and they constitute an integral and essential part of the policy. Truthful and complete information, answers, notices, and statements are essential to the policy's validity.

4.1.2 If untruthful and incomplete answers were given by the insured person and/or the policy owner to questions on material matters to which they were asked to answer, or facts that were not brought to the insurer's attention which would have influenced the insurer to accept the insured person to the insurance policy or to accept him under the terms and conditions specified in the policy, the following instructions will apply;

4.1.2.1 If the insurer became aware of this before the occurrence of the insured event, the insurer may cancel the policy by written notice to the policy owner and/or the insured person who will be entitled to a refund of the insurance premiums that were paid after the cancellation, minus the insurer's expenses, unless the insured acted with fraudulent intent.

4.1.3 If the insured event occurred before the policy was cancelled by virtue of this clause, the insurer is only liable for reduced insurance benefits at a proportional rate, which is the ratio between the insurance premiums that would have been customary paid by the insurer in the factual situation and the agreed insurance premiums. The insurer is completely exempt in any of the following cases:

a. The answer was given with fraudulent intent.

b. A reasonable insurer would not have entered the same contract, even with higher insurance premiums, if he knew the truth of the factual situation; In this case, the policy owner is entitled to a refund of the insurance premiums paid by him for the period after the occurrence of the insured event, minus the company's expenses.

4.1.4 The insurer is not entitled to the remedies specified in clause 4.1.3 in each of the following cases, unless the untruthful and incomplete answer was provided with fraudulent intent:

a. The Insurer knew or should have known the factual situation at the time of signing the contract or the insurer caused the answer to be untruthful and incomplete;

b. The fact to which an untruthful and incomplete answer was given ceased to exist before the insured event occurred, or did not affect the event, the insurer's liability, or its scope.

4.1.5 In addition to aforementioned in clause 4.1.3 above and in the cases specified in clause a and b above, the insurer may claim from the insured person the return of all insurance benefits paid by the insurer for insured events from the insurance's commencement date until the policy's cancellation date.

4.2 Pre-existing Medical Conditions

4.2.1 Insured event: rendition of any of the medical services covered under the policy in connection with medical conditions, which meet the definition of a pre-existing medical condition (definitions chapter 1.12).

4.2.2 Exclusion for a pre-existing medical condition regarding an insured person whose age on the insurance start date is:
a. Under 65 – will be valid for a period not exceeding one year from the insurance start date.
b. 65 years and above - will be valid for a period not exceeding half a year from the insurance start date.

4.2.3 If the insured person is asked at the time of his acceptance to the insurance policy, while making a health declaration, about a certain health condition included in the definition of a pre-existing medical condition as defined above, the insured person will disclose in the health declaration the matter he was asked about. If the insured person was questioned about a pre-existing medical condition and did not disclose his condition to the insurer, the rules of disclosure according to the provisions of the law will apply to the insurance.

4.2.4 If the insured person informs the insurer of a certain medical condition, the insurer will be entitled to exclude its liability and/or the scope of coverage due to a certain medical condition, and this exclusion will be valid for a period that will be recorded on the Certificate of Coverage next to that particular medical condition.

4.2.5 If the insured person informed about a certain medical condition and the insurer did not expressly stipulate the particular medical condition on the Certificate of Coverage, the insurance will be valid unconditionally or unlimitedly regarding a pre-existing medical condition.

CHAPTER 5 – POLICY EXCLUSIONS AND RESTRICTIONS

The insurer will not pay and will not bear financial liability for diagnosis, treatment, consultation, and anything directly or indirectly related to the insured events and/or the medical conditions listed below:

5.1 General Exclusions:

5.1.1 The insurer bears no liability for any damage caused to the insured person and/or to a third party due to the insured person's choice and/or referral by the insurer to a physician, family physician, professional physician, surgeon, anesthesiologist, hospital or any In-Network Provider or Out-of-Network Provider and/or due to an act or omission of the aforementioned, consultation, treatment, surgery, medicine or other act performed by them including failure to perform surgery and/or medical treatment on a fixed date for any reason whatsoever. It is clarified that the service providers are not considered as the insurer's proxies or employees.

5.1.2 The insurer will not be responsible and will not pay insurance benefits according to the policy for event directly and/or indirectly related and/or arising from:

5.1.2.1 War, invasion, acts of sabotage and any act of a foreign enemy, acts of hostilities or acts of war (whether declared or not) civil war, as well as acts of terrorism, rebellion, military or popular uprising, mutiny, insurrection, coup, military rule or a government that was seized illegally, a military regime or a state of siege or disturbances, any factors that lead to the declaration or establishment of a military regime or a state of siege, boycott, if one of the following terms and conditions is met:

a. The insured person, while taking a risk, enters a place and/or an area where fighting or insurrection is known to occur.

b. The insured person actively participates in fighting or insurrection.

c. The insured person ignored the risk on purpose, despite the clear knowledge that he was endangering himself.

5.1.3 Any exposure to ionizing radiation, radioactive contamination, nuclear processes, war nuclear material or any nuclear waste or to any chemical substance if one of the following terms and conditions is met:

a. The insured, while taking a risk, enters a place and/or an area where fighting or exposure to the above is known to occur.

b. The insured is an active participant in this type of combat or chooses to expose himself to the aforementioned situations.

c. The insured ignored the risk on purpose, despite the clear knowledge that he was endangering himself.

5.1.4 The accidents listed below, if the insured will be obligated to purchase insurance coverage for the cases listed below according to the law of the country of destination and/or the country where the accident occurred and/or if he was obligated to receive coverage or purchase it according to the law of the country of destination and/or if the insured person, will be entitled to compensation and/or medical treatment for these accidents from a government entity and/or other entity in the country where the accident occurred:
5.1.4.1.1 Road accident.
5.1.4.1.2 Work accident.
5.1.4.1.3 Hostilities.
5.1.4.1.4 An accident occurred during the insured person's military service, including reserve duty, which resulted directly from an activity of a military nature.
5.1.5 Treatment of alcoholism and/or drug addiction and/or abuse of non-narcotic substances.
5.1.6 Attempted suicide and/or intentional self-harm, whether the insured was sane or not.
5.1.7 Artificial abortion and its results performed for mental and/or social and/or economic and/or family planning reasons.
5.1.8 An accident and/or injury and/or damage caused by a sporting or artistic or competitive activity for which the insured person was given consideration.
5.1.9 Without prejudice to the generality of the foregoing provisions of sections 5.1.2.1 and 5.1.2.2, an accident and/or injury and/or damage as a result of parachuting, paragliding, diving, gliding, windsurfing or wave surfing, races of all kinds, riding and using off-road motorcycles (without a license and/or on non- paved road), riding and using all-terrain vehicles (ATV's), using and driving self-build vehicles (such as a "Buggy"), climbing mountains and cliffs, rappelling/ abseiling, zipline, rafting, bungee, skiing, snowboarding that was performed outside authorized and marked sites and tracks .
5.1.10 Sea, car, or air accident for which the expenses of the medical service are at the expense of the person causing the accident and/or another insurer.
5.1.11 Treatments that are not recognized by medical science and/or medical treatments and/or tests based on medical technologies not approved by the competent authorities in the country of destination, or in the experimental, research and testing stage which were not in regular use on the date of the insured event's occurrence.
5.1.12 Treatment required for an insured event that occurred before or after the insurance period.
5.1.13 Healing, treatment, services, or medical supplies that are not medically necessary and are not according to an acceptable treatment protocol in the country in which the service is provided in accordance with the diagnosis or the required medical procedure.
5.1.14 Alternative, holistic, non-conventional medical treatments in the country in which the service is provided.

5.1.15 Medical service performed or provided by an insured person's relative, except with prior written approval from the insurer.
5.1.16 Vision tests, myopia diagnosis, eye and vision training, laser surgery to correct myopia or any other medical treatment aimed at correcting myopia, fitting glasses or contact lenses. Eye refraction, vision care, or for any test or adjustment related to these aids. Eye surgery, such as radial corneal excision, where the primary goal is to correct myopia, hyperopia, or astigmatism.
5.1.17 Hearing tests, hearing aids, cochlear implants, and other medical accessories intended to improve hearing.
5.1.18 Psychological or other treatment for marital/family counseling.
5.1.19 Medical and/or nursing service provided by a person who usually lives in the insured person's home. This exclusion is valid as long as the insurer has not given prior written approval.
5.1.20 The medical treatments and medical devices listed below: orthopedic shoes, orthopedic aids prescribed by a physician that should be attached or inserted into shoes (such as insoles, heel elevation), treatment of weak, deformed, unstable or unbalanced legs and feet, and treatment of varicose veins (dilated veins in the legs/arms). For the avoidance of doubt, it is hereby clarified that there will be no coverage for any service and/or diagnosis and/or consultation and/or treatment provided by a therapist who is not a physician (such as DPM).
5.1.21 Treatment and healing of natural hair loss, including wigs, hair transplants and/or medicines that guarantee hair growth, whether prescribed by a physician or not, except due to medical treatment that causes hair loss (such as chemotherapy) for which the insured person is covered under this policy.
5.1.22 Diagnosis and treatment of sleep disorders, including medical treatment for the prevention of sleep disorders, medical devices for the treatment of sleep disorders and tests in sleep laboratories, whether required to diagnose diseases or sleep disorders.
5.1.23 Exercise programs, whether or not prescribed or recommended by a physician.
5.1.24 Charges for travel or accommodation, with the exception of transportation expenses by a local ambulance that ends in hospitalization, emergency evacuation and benefits provided in the framework of transplants.
5.1.25 Surgeries or treatments performed for purposes of research, experiment, and investigation.
5.1.26 Body weight adjustment or treatments for weight loss and/or surgery to treat obesity, and any form of gastric bypass surgery, sleeve, balloon and/or intestinal bypasses or any other procedure aimed at helping to lose weight.
5.1.27 Adjusting the shape of the body in order to improve a person's psychological, mental or emotional well-being, such as gender reassignment surgery.

5.1.28 Treatment or surgery for cosmetic or aesthetic reasons such as rhinoplasty, breast augmentation/reduction, or scar removal.

5.1.29 Any medication or treatment that encourages or prevents pregnancy, use of birth control pills, artificial insemination, fertility treatments and/or vasectomy or reversal of sterilization. Any medicine, treatment or procedure that increases, improves, or corrects impotence or poor sexual function.

5.1.30 Dental and gum treatments, including diseases originating from disorders of the gums and teeth.

5.1.31 Treatment of temporomandibular joint.

5.1.32 Circumcision surgery, except for medical reasons.

5.1.33 Supervision or treatment of newborns after the first 31 days from their birth.

5.1.34 Artificial or mechanical devices intended to temporarily or permanently replace human organs, unless coverage is explicitly specified in the policy.

5.1.35 The costs of keeping a donor alive for the transplant process, whether the transplant process is covered or not.

5.1.36 Any treatment, diagnosis and consultation related to viral diseases of the genitals and sexually transmitted diseases.

5.1.37 Tests to detect the HIV virus, and/or to detect the AIDS disease and/or to detect diseases related to AIDS.

5.1.38 Treatment of the insured due to a deterioration of a medical condition, which was initially covered under this policy, for which the insured person was required to act according to his physician's instructions, and did not obey his physician's instructions, such as not taking necessary medications, follow-up tests and preventive treatment.

5.1.39 Vaccinations and treatments that are given without medical necessity and for immigration purposes and were not required in writing by a specialist physician.

CHAPTER 6 – EXTENSION OF THE POLICY COVERAGE PERIOD

6.1 Preamble

This chapter guarantees, without the payment of any insurance premiums, and subject to deductibles in the amount specified in the Table of Cost-sharing and Copay Appendix for a calendar year and for the other cost-sharing that appear in the policy, a continuity of insurance coverage for the insured in the Passportcard Relocation policy (hereinafter: "the Basic Policy") whose stated insurance period has ended or the who became a citizen of the country of destination during the insurance period, subject to the conditions and instructions detailed below.

6.2 The Insured Event

Medical and/or other service provided to the insured person due to medical necessity as specified in each of the basic policy's chapters, commencing from the end of the insurance coverage's end date or from the date when the insured person became a citizen of the country of destination and subject to the fulfillment of the terms and conditions and instructions stated in clause 3 below.

6.3 Insurer's Liability

6.3.1 Subject to the additional deductibles specified in the Table of Cost-sharing and Copay Appendix for a calendar year and the other cost-sharing that appear in the policy, starting from the end of the insurance period, in policies that include a time-limited insurance period as detailed on the Certificate of Coverage and/or starting from the date the insured became a citizen of the destination country, the insurer will continue to bear responsibility for Insurance cases that actually form or occur during the insurance period for 12 consecutive months (hereinafter: "the Extension Period").

6.3.2 This chapter will be in effect during the Extension Period subject to the existence of the following cumulative terms and conditions:

6.3.2.1 The insured person purchased another medical insurance policy from another insurer (hereinafter: "the New Policy").

6.3.2.2 The insurance coverage in the New Policy will include coverage for hospitalizations, medications, and physician visits.

6.3.2.3 The New Policy determines a waiting period for receiving service for an insured event that occurred during the insurance period of the Basic Policy.

6.3.2.4 The insurance period specified in the Basic Policy has expired and the insurance has not been renewed by the insurer.

6.3.3 For the avoidance of doubt, it will be clarified that the insurer's liability during the Extension Period will be for medical services that are included in the New Policy for which a waiting period has been **determined, and not exceeding the coverages in the Basic Policy.**

6.4 General

6.4.1 In the event of a conflict between the provisions of this chapter and the provisions of the Basic Policy, the provisions of this chapter shall apply.

6.4.2 The other provisions of the Basic Policy remain unchanged.

CHAPTER 7 – RETURNING ISRAELI CITIZENS TO ISRAEL

Additional insurance to cover expenses for medical services in Israel defined in the National Health Package during the waiting period.

7.1 **Preamble -** This chapter guarantees that the person insured by Passportcard Relocation Policy - (hereinafter: "the Basic Policy"), shall receive insurance coverage for medical and/or other services included in the Health Law, provided to the insured person due to medical necessity, after his return to the State of Israel for purposes other than a visit, and this for the duration of the waiting period stipulated by law, according to which he is not entitled to receive the medical services from the HMO of which he is a member. All the above is subject to the terms and conditions, and instructions listed below:

7.2 **Definitions**

7.2.1 "The Health Law" - National Health Insurance Law, 1994 -5754, and the regulations published and/or to be published pursuant to it.

7.2.2 "The National Insurance Law" - National Insurance Law (Consolidated version) 1995- 5755 and the regulations published and/or to be published pursuant to it.

7.2.3 "Entitlement to Service" - the insured person's entitlement to receive the full range of medical services included in the Health Law in accordance with the type of coverage included in the Basic Policy.

7.2.4 "Waiting period" - a period specified, or which will be specified in the Health Law and/or the National Insurance Law, during which, in accordance with the provisions of the said laws, the insured person will not be entitled to service upon his return to Israel, after the insured person's stay abroad. For the avoidance of doubt, it is clarified that the waiting period according to the provisions of this appendix, will not exceed 6 consecutive months from the Determining Date.

7.2.5 "The Policy" – "The Basic Policy" - Passportcard Relocation's Insurance Plan

7.2.6 "Service Provider" – the insurer's contracted service provider, as will be published by the insurer.

7.2.7 "The Determining Date" – the return date of the policy owner and/or insured person for a stay exceeding 90 days in Israel.

7.3 **Insured Event**

Medical and/or other service included in the Entitlement to Service that will be provided to the insured person, due to medical necessity, during the Waiting Period subject to the fulfillment of the terms and conditions, and instructions stated in section 7.5 below.

7.4 **Liability of the Insurer**

7.4.1 The insured person will be entitled to receive the medical service included in the Entitlement to Service by the service provider during the waiting period, commencing from the Determining Date, and subject to the fulfillment of the instructions and terms and conditions detailed in section 7.5 below,

7.4.2 The insurer will pay the service provider, on the occurrence of an insured event, the insured person's expenses for medical services included in the Entitlement to Service.

7.4.3 For the avoidance of doubt, the insurer's liability will apply only for the service included in the National Health Package as defined in the Health Law, and not exceeding the type of coverage included in the Basic Policy.

7.5 Insurance Conditions

7.5.1 The policy owner and/or the insured person shall notify the insurer of his desire to activate the insurance coverage contained in this Chapter within 30 days of the Determining Date.

7.5.2 The grant of eligibility as defined in this insurance, replaces the insurance coverage included in the chapters of the special terms and conditions in the Basic Insurance.

7.5.3 The provisions of the general terms and conditions in the Basic Insurance will apply in full also regarding Entitlement to service.

7.5.4 The policy owner and/or the insured person shall notify the National Insurance Institute of his return to Israel other than for the purpose of a visit and shall settle his payments to the National Insurance Institute within 30 days of the Determining Date. For the avoidance of doubt, it is clarified that the existence of this additional insurance does not exempt the policy owner and/or the insured person from paying social security fees and/or health tax relevant to them.

7.5.5 The policy owner and/or the insured will be entitled to this additional insurance coverage only if they were insured in the Basic Policy for 12 consecutive months prior to the determining date.

7.6 Cancellation of the additional insurance - the insurance period of this additional insurance will expire in one of the cases below, the earliest between them:

7.6.1 The return of the policy owner and/or the insured person to Israel before a consecutive insurance period of 12 months within the framework of the Basic Policy has ended before the Determining Date.

7.6.2 If the insured person cancels the additional insurance as stated in section 7.1 above, the insurance premiums for the additional insurance will be returned to the insured person, minus the insurer's expenses.

7.6.3 The end of the Waiting Period (as defined in section 7.2.4).

7.6.4 When the Basic Policy is canceled for any reason.

7.7 General

7.7.1 In any case where this additional insurance was added to the Basic Policy, at any time after the Basic Policy's commencement date, this additional insurance will come into effect on the day it is added to the Basic Policy and subject to the general terms and conditions of the Basic Policy.

7.7.2 The insurance commencement date, for this additional insurance, will be considered the date on which the insured person is accepted for this additional insurance by the insurer, as specified on the Certificate of Coverage.

7.7.3 In the event of a conflict between the provisions of this appendix and the provisions of the Basic Policy, the provisions of this appendix shall apply.
7.7.4 All references made in masculine language pertaining to the insured person shall equally apply to any insured individual, regardless of gender, under this policy.

ROUTINE TESTS BEFORE / DURING PREGNANCY

STAGE OF PREGNANCY	TYPE OF TESTS	ADDITIONAL DETAILS/ COMMENTS
Pre-Pregnancy or Early Pregnancy	A test to rule out AIDS at the pre-pregnancy or early stage of pregnancy	One test for each insured event
Pre-pregnancy up to week 16	Tay-Sachs test	
Pre-Pregnancy	Rubella (German measles)	As stated on the Certificate of Coverage
Pre-Pregnancy or Early Pregnancy	Cystic fibrosis; Fragile X; Canavan; Fanconi; Dysautonomia; Gaucher's Disease; Alpha 1 deficiency; ML4; Niman Peak; Ataxia Telangiectasia; Bloom; FMF.	
Once a month, until week 38	Pregnancy follow-up including blood pressure test, weight, blood protein, Edema check.	
Weeks 6-8	Blood count, blood type and RH test, fasting sugar test, generalurine test and/or culture, VDRL test (Syphilis screening test).	
Weeks 6-12	Ultrasound to check the gestational age, the number of embryos, and their position.	
Weeks 10-12	CVS test, amniocentesis (subject to the recommendation of a treating physician)	
Weeks 10-14	Ultrasound examination for nuchal translucency. A blood test can be combined to detect Down Syndrome.	
Weeks 14-16	Early Anatomy Scam	
Weeks 16-18	Ttiple Test / (Alpha fetoprotein AFP)	Fetal protein biochemical screening to detect defects in the neural canal of the fetus and to estimate the risk of Down Syndrome

STAGE OF PREGNANCY	TYPE OF TESTS	ADDITIONAL DETAILS/ COMMENTS
Weeks 16-20	Amniocentesis	For women over 35 or high-risk pregnancy
Weeks 18-22	Anatomy scan for detecting defects	Ultrasound Scan
Weeks 20-23	Extended anatomy scan	Ultrasound Scan
Weeks 24-28	GCT and blood count For those persons having Negative RH-antibodies to RH	Without antibodies, coverage will also be provided for a vaccine injection at week 28 (if placental or amniocentesis was performed, coverage for the vaccine will be provided after these tests)
Weeks 30-36	Assessment of fetal weight, growthRate, and position of the fetus	Ultrasound Scan
Weeks 36-40	Blood pressure, weight, protein in the urine, and Edema test	once every two weeks
After Week 40	According to the discretion and recommendation of the treating medical team.	

PASSPORTCARD RELOCATION – TABLE OF COST-SHARING AND COPAY APPENDIX

<table>
<tr><th colspan="2">Service Included in the Policy</th><th>Physician Visit Copay</th><th>Co-Insurance In-Network Provider</th><th>Physician Visit / Co-Insurance Out-of-Network Provider</th><th>Comments</th></tr>
<tr><td colspan="2"></td><td></td><td>Maximum cumulative out-of-pocket cost-for a calendar year per insured person $4,500</td><td>Maximum cumulative out-of-pocket cost for a calendar year per insured person $10,000</td><td></td></tr>
<tr><td colspan="2">Physician Visit - Baby/Child Developmental Follow-up by Physician</td><td>$35</td><td></td><td>50%</td><td>Per Visit</td></tr>
<tr><td colspan="2">Periodic Tests</td><td>$35</td><td></td><td>50%</td><td></td></tr>
<tr><td colspan="2">Dental First Aid</td><td>$35</td><td></td><td>50%</td><td>Per Visit</td></tr>
<tr><td colspan="2">Physiotherapy / Chiropractic / Occupational Therapy/ Disorders and Speech Therapy</td><td>$35</td><td></td><td>50%</td><td></td></tr>
<tr><td colspan="2">Diagnostic Medical Tests</td><td></td><td>20%</td><td>50%</td><td></td></tr>
<tr><td colspan="2">Hospitalization / Day Hospitalization</td><td></td><td>20%</td><td>50%</td><td></td></tr>
<tr><td colspan="2">Prescription Medicines</td><td></td><td>20%</td><td>50%</td><td>Up to 30 day supply</td></tr>
<tr><td colspan="2">Emergency Room / Emergency Clinics</td><td></td><td>20%</td><td>50%</td><td></td></tr>
<tr><td colspan="2">Emergency Dental Treatments</td><td></td><td>20%</td><td>50%</td><td></td></tr>
<tr><td rowspan="3">Diagnosis and Treatment of ADHD</td><td>Psychologist/ Psychiatrist Visit</td><td>35%</td><td></td><td>50%</td><td>Per Visit</td></tr>
<tr><td>Attention and concentration tests such as TOVA</td><td></td><td>20%</td><td>50%</td><td></td></tr>
<tr><td>Imaging Tests</td><td></td><td>20%</td><td>50%</td><td></td></tr>
<tr><td colspan="2">Special Preventive Tests</td><td></td><td>20%</td><td>50%</td><td></td></tr>
</table>

Service Included in the Policy	Physician Visit Copay	Co-Insurance In-Network Provider	Physician Visit / Co-Insurance Out-of-Network Provider	Comments
		Maximum cumulative out-of-pocket cost-for a calendar year per insured person $4,500	**Maximum cumulative out-of-pocket cost for a calendar year per insured person $10,000**	
Routine Pregnancy Monitoring	$35		50%	For a visit to a gynaecologist only. Imaging or other tests in accordance with diagnostic medical tests
Childbirth Expenses		20%	50%	
Pregnancy or Childbirth Complications		20%	50%	
Organ Transplants		20%	The service is provided only through In-Network Providers	
Emergency Medical Evacuation		20%	50%	
Mental Health Psychologist / Psychiatrist	$35		50%	Per Visit
Psychiatric Hospitalization		20%	50%	
Ground Ambulance		20%	50%	
Non-perishable Medical Equipment / Medical Aids		20%	50%	
Ancillary Services after Hospitalization		20%	50%	
Hospice		20%	50%	

Service Included in the Policy	Physician Visit Copay	Co-Insurance In-Network Provider	Physician Visit / Co-Insurance Out-of-Network Provider	Comments
		Maximum cumulative out-of-pocket cost-for a calendar year per insured person $4,500	**Maximum cumulative out-of-pocket cost for a calendar year per insured person $10,000**	
Family Reunion		Without Cost-sharing	The service is only provided through In-Network Providers	
Repatriation of Mortal Remains		Without Cost-sharing	The service is only provided through In-Network Providers	
Parental Accommodation		Without Cost-sharing	Without Cost- sharing	