Best Medical Insurance for Foreign Workers in Israel

April 2025 Edition

Hachshara Insurance Company Ltd

Best medical insurance for foreign workers in Israel

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Medical Insurance for Foreign Workers in Israel

Whereas the Policyholder, whose name is specified in the Insurance Schedule, has applied to Hachshara Insurance Company Ltd. for the issuance of an insurance policy, the details of which are set forth in the Insurance Schedule, and has undertaken to pay the insurance premiums as agreed and stated in the Schedule of this Policy; therefore, this Policy certifies that, subject to the coverages, extensions, terms, conditions, limitations, and provisions detailed herein and/or that may be added or attached hereto with the mutual consent of the parties, the Insurer agrees to indemnify the Insured upon the occurrence of an insured event during the insurance period stated herein, in accordance with the limits of liability, coverages, and exclusions as specified in the chapters of this Policy. It is emphasized that the Insurance Schedule attached to this Policy, as well as the Health Declaration appended thereto, constitute the basis of the insurance and form an integral part of this Policy.

For the avoidance of doubt, this Policy has been specifically adapted to comply with the provisions of the Foreign Workers Order (Health Services Package for the Worker), 5761-2001 (hereinafter: the "Order"), and the Foreign Workers Order (Health Services Package for the Worker) (Amendment), 5776-2016. It is hereby clarified, for the removal of doubt, that in any case of discrepancy between the provisions of the Order and this Policy, the provisio of the Order shall prevail.

Chapter 1: Definitions

Introduction

1. **Definitions:**

1.1. **The Insurer:** Hachshara Insurance Company Ltd.

1.2. **The Policyholder:** The individual, group of individuals, or legal entity that enters into this insurance contract with the Insurer and whose name appears in the Schedule and/or in the insurance proposal as the Policyholder, who wishes to insure the foreign worker whose name is specified in the Insurance Details Page of this Policy.

1.3. **The Insured:** A person residing in the State of Israel as a foreign worker, employed by the Policyholder, and whose name is stated in the Insurance Details Page.

1.4. **Foreign Worker:** A person working in Israel who is neither an Israeli citizen nor a resident thereof.

1.5. **Insurance Proposal:** A proposal form in the format determined by the Insurer, fully completed, including a declaration of the date of entry into Israel and a waiver of medical confidentiality, signed by the Insured and the Policyholder where their signatures are required.

1.6. **The Policy:** This insurance contract, including the proposal, the Insurance Details Page, and any appendix or addendum attached there to.

1.7. **Insurance Details Page (Schedule):** A page attached to and forming an integral part of the Policy, which includes, inter alia, the policy number, personal details of the Policyholder, details of the Insured, the effective date and duration of the insurance period for the Insured, the insurance premium, and the conditions required to align the insurance policy with the terms of the insurance contract with the Insured. In the event of a discrepancy between the terms of the Policy and the terms set forth in the Insurance Details Page, the latter shall prevail.

1.8. **Health Declaration:** The Insurer's health declaration form and waiver of medical confidentiality, signed by the Insured.

1.9. **Insurance Event**: An event during which the Insured requires medical treatment in Israel during the insurance period as covered by this Policy, and such medical treatment is rendered during the insurance period and/or no later than 90 days following its expiration, all subject to the terms, limitations, and exclusions set forth in this Policy.

1.10. **Overseas / Outside of Israel:** Any location beyond the territorial boundaries of Israel, including any means of transportation in the course of travel to or from Israel.

1.11. **Israel:** The territory of the State of Israel, excluding any means of transportation in the course of travel to or from Israel, and including areas under the control of the Israel Defense Forces, but excluding territories administered by the Palestinian Authority.

1.12. **Insurance Period:** The period specified in the Insurance Details Page attached to this Policy, not exceeding 12 months from the commencement date of the insurance.

1.13. **Single Employment Period:** The entire duration of the Insured's employment, even if not continuous, during which an employer-employee relationship existed between a specific employer and a specific foreign worker.

1.14. **Medical Institution:** A hospital or clinic, including medical centers, laboratories, diagnostic centers, and pharmacies.

1.15 **General Public Hospital:** An institution in Israel recognized by the competent authorities as a general public hospital, serving solely as a hospital, excluding institutions that also serve as sanatoriums and/or rehabilitation centers.

1.16. **Physician:** A holder of a valid medical license authorized by law to practice medicine in Israel.

1.17. **Attending Physician:** A general (non-specialist) physician, as well as a physician specializing in family medicine and/or internal medicine and/or gynecology.

1.18. **Health/Medical Services:** All medical services to which the foreign worker is entitled pursuant to the terms of this Policy.

1.19. **Primary Medical Services**: An Insured who requires a general (non-specialist) physician, or a specialist in family medicine,internal medicine, or gynecology, may consult any physician affiliated with the Insurer under agreement for the provision of services pursuant to this Policy, without requiring the Insurer's prior approval.

1.20. **Medical Emergency:** Circumstances in which a person is in immediate danger to their life, or where there is an imminent risk of severe and irreversible disability if urgent medical treatment is not provided.

1.21. **Pre-existing Medical Condition:** A congenital defect or illness, including hereditary diseases and/or any health condition and/or medical phenomenon and/or illness, whether treated or untreated, and/or their consequences, whether directly or indirectly caused or aggravated due to a health condition existing prior to the commencement of the insurance. This applies during the first three years from the commencement date of the insurance, subject to the Insured's declaration and/or a physician's approval, and subject to the provisions of Section 5.1.4 below. Service Providers: General public hospitals, and additionally, physicians and/or medical institutions affiliated with the Insurer under agreement, from whom, and only **from whom, the Insured shall be entitled to receive the healthcare services detailed in this Policy, all subject to the terms of the Policy.**

1.22. **Insurance Contract Law:** The Insurance Contract Law, 5741-1981.

1.23. **Insurance Premium:** The amounts payable by the Policyholder to the Insurer in consideration for the insurance coverage provided under this Policy, in accordance with its terms, including deduction of any applicable co-payment as specified in the Insurance Details Page or on the Insured's Card.

1.24. **Customary Payment**: A payment, including a guarantee or deposit, required from the Insured, adjusted for inflation as specified in the Insurance Details Page, in exchange for the actual provision of medical services. The amount shall be determined based on the Second or Third Schedule of the National Health Insurance Law as in effect at the commencement of the insurance period, or in a notice issued by the State regarding applicable conditions and payments, or in an offer made by a recognized Health Maintenance Organization (HMO) pursuant to Section 8(a1) of the National Health Insurance Law, as approved under Section 8(a2) of the same law. Where different provisions stipulate different payments for the same medical service, the highest amount shall apply.

1.25. **Insured's Card:** The Insurer shall issue to the Policyholder, on behalf of each covered worker, an Insured's Card (of any type, including digital, at the Insurer's discretion) containing identifying details of the Insured and the Policyholder, as well as the Insurer's service center phone number. This card, together with a passport or official document bearing the Insured's photograph, shall serve as a means of identifying the Insured and verifying eligibility at the time of receivingservices.

1.26. **National Health Insurance Law:** The National Health Insurance Law, 5754-1994.

1.27. **Foreign Workers Law:** Foreign Workers Law (Prohibition of Unlawful Employment and Assurance of Fair Conditions), 5751- 1991.

1.28. **Health Services Basket:** As defined in the National Health Insurance Law.

1.29. **Foreign Workers Order:** The Foreign Workers Order (Prohibition of Unlawful Employment and Ensuring Fair Conditions) (Health Services Basket for Employees) 5761-2001.

1.30. **Health Services at Work Regulations:** The Parallel Tax Regulations (Health Services at Work), 5733-1973.

1.31. **Service Center:** A telephone service center operated by the Insurer that provides assistance to Insured persons in all matters related to this Policy, including the service providers with whom the Insurer has agreements and from whom the Insured may receive services

Chapter 2: General Conditions

2. **General Conditions:**

2.1. **Duty of Disclosure:** If, prior to the conclusion of the insurance contract, the Insurer presented the Insured with a written question - either in the insurance proposal form or by other written means - regarding a matter that may reasonably affect the willingness of a reasonable insurer to enter into the contract or to do so under specific terms (hereinafter: "Material Matter"), the Insured shall provide a complete and honest written answer. A sweeping question that conflates multiple matters without distinguishing between them does not require such an answer, unless the question was reasonable at the time the contract was concluded.

2.1.1. Willful concealment by the Insured of a matter known to be material shall be deemed equivalent to providing an incomplete or dishonest answer.

2.1.2. If an answer to a material question was not complete and honest, the Insurer may, within thirty (30) days from the day the matter became known to it - and provided that no insured event has occurred - cancel the Policy by written notice to the Insured.

2.1.3. If the Insurer cancels the Policy under this section, the Policyholder is entitled to a refund of the insurance premiums paid for the period following the cancellation, less the Insurer's expenses, unless the Insured acted with fraudulent intent.

2.1.4. If an insured event occurred before the Policy was canceled under this section, the Insurer shall only be liable to pay reduced insurance benefits in proportion to the ratio between the premium that would have been charged based on the actual circumstances and the agreed premium. The Insurer shall be fully released from liability in any of the following cases:

2.1.4.1. The answer was given with fraudulent intent.

2.1.4.2. A reasonable insurer would not have entered into the same contract, even for a higher premium, had it known the true circumstances. In such case, the Insured shall be entitled to a refund of premiums paid for the period following the occurrence of the insured event, less the Insurer's expenses.

2.1.5. The Insurer shall not be entitled to the remedies stated above unless the incomplete or dishonest answer was given with fraudulent intent, and provided none of the following apply:

2.1.5.1. The Insurer knew or should have known the true circumstances at the time of contract formation, or it caused the answer to be incomplete or dishonest.

2.1.5.2. The fact about which the incomplete or dishonest answer was given ceased to exist before the occurrence of the insured event, or did not affect the event, the Insurer's liability, or its scope.

2.1.6. In the case of insurance benefits that are of a compensatory nature, the Insurer shall not be entitled to the above remedies after three (3) years have passed from the date the contract was concluded, unless the Insured acted with fraudulent intent.

2.2. **Insurance Period:**

2.2.1. The commencement of this Policy shall be subject to the actual payment of the initial premium. This condition shall not apply where a means of payment has been received from the Insured that allows for collection of the insurance premium. If premiums are paid to the Company prior to the Insurer's approval of coverage, such payment shall not constitute acceptance by the Insurer. In such a case, the Insurer shall, within 90 days of initial receipt of the premium, issue a decision regarding acceptance or rejection of the applicant, and shall provide, as applicable, an insurance policy including the Insurance Details Page, or a rejection notice stating that the applicant is not approved and has no valid coverage, or a request for additional information or a counter-offer. If no such rejection notice, request for information, or counter-offer is issued by the Insurer within 90 days of initial receipt of the premium, the applicant shall be deemed to have been accepted under the terms stated in the insurance proposal. If an insured event occurs during the period between the initial receipt of the premium and the Insurer's decision, and in accordance with the Insurer's existing medical underwriting guidelines the applicant would have been accepted (had the insured event not occurred), the applicant shall be entitled to coverage under this Policy for the insured event, subject to all other terms and provisions of the Policy.

2.2.2. The insurance coverage for each Insured shall terminate upon the earliest of the following: the Insured's death, the expiration of the insurance period, or the termination of the employer-employee relationship - subject to the provisions of Section 2.8 below.

2.3. **Maximum Age:**

2.3.1. The maximum age for joining the Policy is 65. It is clarified that the above shall not derogate from the rights of an Insured whose acceptance was approved by the Insurer, even if he was enrolled at an age exceeding the stated maximum age.

2.3.2. The Insured shall provide proof of date of birth through documentation acceptable to the Insurer. The Insured's date of birth constitutes a material matter subject to the duty of disclosure, as set forth in Section 2 above. In the event of an incomplete or dishonest answer, or concealment of facts in this regard, the provisions of Section 2 shall apply.

2.4. **Health Declaration:**

2.4.1. The Policyholder shall provide the Insurer with a Health Declaration and a Waiver of Medical Confidentiality, signed by the Insured, authorizing the Insured's physicians and/or any medical body or institution, whether in Israel or overseas, and/or the National Insurance Institute, and/or the Ministry of Defense, and/or any other government office, and/or any insurance company, and/or recognized Health Maintenance Organization (HMO), to provide the Insurer with any reasonable medical information regarding the Insured that is in their possession.

2.4.2. The Policyholder shall ensure that the Insured signs a Health Declaration and Waiver of Medical Confidentiality form, as provided by the Insurer, in a language understood by the Insured, and shall submit the signed form to the Insurer together with a declaration by the Policyholder confirming that the Insured signed the form after its content was explained to him in a language he understands and/or that the Insured signed the form after reading and understanding its content in a language familiar to him.

2.5. **Claims:**

2.5.1. Notification of any insured event shall be provided to the Insurer within a reasonable time, as promptly and as early as possible. The notification shall include all details concerning the insured event, to be submitted to the Insurer for the purpose of gathering the necessary facts. The Insured may submit documentation, inter alia, via email, text message (SMS), or a personal online account.

2.5.2. The Policyholder and/or the Insured shall attach to the claim notification form all relevant medical documents related to the insured event, including diagnoses, case history (anamnesis), and, if payments were made by the Policyholder and/or the Insured, receipts evidencing such payments.

2.5.3. The Policyholder and the Insured shall cooperate with the Insurer before and after submission of the claim and shall do everything necessary to allow the Insurer to assess its liability under the Policy and the scope thereof.

2.6. **Medical Examination:**

The Company shall have the right, at any time, to reasonably examine the medical condition of the Insured in any manner it deems appropriate. The Insured undertakes to comply with medical examinations required by the Company, at the Company's expense, provided that such examination is reasonable under the circumstances. It is clarified that this shall not derogate from the Insured's right to assert any legal claims under the Policy before a court of law.

2.7. **Extension of the Insurance Period:**

2.7.1. The Insurer undertakes to extend the insurance period for the Insured, continuously, upon the expiration of the original period, upon request by the Policyholder or the Insured, provided that premiums are paid for the entire period from the end of the original insurance term until the extension, and as long as the Insured continues to work in Israel as a foreign worker for an employer.

2.7.2. The Insured or the Policyholder may renew the insurance coverage for the Insured continuously from the end of the policy term, without new underwriting, within 90 days.

2.7.3. An Insured who is not eligible for extension without new underwriting under Section 2.7.2 shall be subject to the provisions of Sections 2.7.4 and 2.7.5 below. All types of extensions shall be subject to the provisions of Sections 2.7.4-2.7.5.

2.7.4. In any case not covered under Sections 2.7.1 or 2.7.2, the Policyholder may apply to the Insurer for an extension of the insurance period. Such extension shall be subject to the Insurer's standard underwriting procedures and prior written approval. It is hereby clarified that, upon the expiration of the insurance period as defined in the Policy, coverage shall not be extended automatically unless agreed upon under this section, and within the time frame set out in Section 2.7.4.2, even if the Policyholder or the Insured made an offer to extend the Policy in some manner or at some time.

2.7.4.1. The Policyholder may submit a request to extend the insurance period (hereinafter: the "Extension Request"). The Extension Request shall be submitted to the Insurer by post at least 30 days prior to the expiration of the insurance period.

2.7.4.2. If the Insurer agrees to extend the insurance period, it shall notify the Policyholder in writing of such agreement within 20 days from receipt of the Extension Request. Upon such agreement, the Insured's coverage shall continue without interruption, including the "initial date" for purposes of pre-existing conditions.

2.7.5. The insurance premium for the extended period shall be calculated according to the number of extension days, based on the Insurer's prevailing premium rate at the start of the extension.

2.7.6. The Insurer shall be entitled to adjust the insurance premium at the beginning of each extension of this Policy.

2.8. **Policy Cancellation:**

2.8.1. If the Insured and/or the Policyholder fails to pay premiums properly and on time, the Insurer may cancel the Policy in accordance with the Insurance Contract Law, 5741-1981 (hereinafter: the "Insurance Contract Law").

2.8.2. If the Policyholder cancels the Policy before the end of the insurance period due to the termination of the Insured's employment with the Policyholder, the Insurer shall refund the portion of premiums corresponding to the period after cancellation, linked to the Consumer Price Index, subject to the Policyholder's obligations under the Insurance Contract Law.

2.8.3. For the purposes of Section 2.8.2, the pro rata premium refund shall be calculated for the period following the return of the Insured's Card to the Insurer.

2.8.4. If the Insured concealed a material fact from the Insurer, as specified in Section 2.1 and in accordance with the Insurance Contract Law.

2.8.5. If the Insured intentionally acted in a way that prevented or hindered the Insurer from verifying its liability, the Insurer shall only be liable to the extent it would have been had such act not occurred.

2.8.6. The Policyholder and/or the Insured may cancel the Policy at any time by providing written notice to the Insurer.

2.9 . **Disclaimer of Liability for Acts or Omissions of Service Providers:** The Insurer shall bear no liability whatsoever for the quality of medical or other services provided to the Insured under this insurance. The Insurer shall not be liable for any damage caused to the Insured or to any third party, whether directly or indirectly, due to the Insured's selection of, or referral by the Insurer to, any medical or other service provider, or due to professional negligence by such providers.

2.10. **Limitation Period:** The limitation period for filing a claim for insurance benefits under this Policy shall be five (5) years from the date of the insured event.

2.11. **Insurance Contract Law:** The provisions of the Insurance Contract Law, 5741-1981, shall apply to this Policy.

2.12. **Changes to Health Services:**

2.12.1. The Insured shall be entitled to receive the services included in the Health Services Basket, the Pharmaceutical Basket, and the Occupational Health Services Basket, as defined below, as amended from time to time.

2.12.2. Should there be any changes to the Health Services Basket and/or the Pharmaceutical Basket and/or the Occupational Health Services Basket and/or to the Health Insurance Law and/or to any order and/or regulation after the commencement of the insurance period (hereinafter: the "Updated Health Basket"), the Insurer shall notify the Policyholder and/or the Insureds of such changes. The Insurer shall also be entitled to amend the Policy and the insurance premium, including requiring payment of an additional premium resulting from the aforementioned changes.

2.13. **Notices:** The Policyholder must notify the Insurer of any change in their address. Any notice sent by the Insurer to the last address known to it shall be deemed to have been properly delivered.

2.14. **Payment of Premiums, Taxes, and Levies:**

2.14.1. Premiums shall be paid to the Insurer in advance by the Policyholder and/or the Insured who undertook to do so, prior to the commencement of the insurance period and for its entire duration, unless the Insurer has agreed otherwise in advance and in writing.

2.14.2. If premiums are paid by standing bank order or by credit card provided by the Policyholder and/or the Insured at the start of the insurance period, only the actual crediting of the Insurer's account at the bank or credit card company shall be deemed as payment of the premium.

2.14.3. Premiums shall be paid in New Israeli Shekels (NIS) and shall be linked to the Consumer Price Index as follows: the premiums payable by the Policyholder shall be increased or decreased in accordance with the change in the Index between the base index and the index published on the actual date of payment.

2.15. **Indexation:**

Premiums and Insurance Amounts: Premiums and insurance amounts stated in NIS shall be linked to the Consumer Price Index published by the Central Bureau of Statistics and shall be adjusted monthly. The base index shall be the Index published for October 2024.

2.16. **Jurisdiction:**

The sole and exclusive jurisdiction in any matter relating to or arising from this Policy shall lie with the competent courts of Israel, in accordance with Israeli law. No other court shall have jurisdiction. The law applicable to any claim arising out of or related to this Policy shall be the law of the State of Israel.

Chapter 3: Health Services

3. **Health services shall be provided to the Insured subject to the provisions of this Policy. The Insured shall be entitled to receive such services in exchange for a payment not exceeding the Customary Payment, and in the absence of such payment - free of charge, all as detailed below:**

3.1. **Treatment Basket:**

3.1.1. All services listed in the Second Schedule to the National Health Insurance Law as in effect at the commencement of the insurance period, as amended from time to time.

3.1.2. Hospitalization services in a psychiatric hospital or in a psychiatric ward of a general hospital, in a medical emergency, for a period not exceeding 60 days per single employment period.

3.1.3. The following specific services:

3.1.3.1. Amniocentesis for women aged 35 and over at the start of pregnancy.

3.1.3.2. Vaccinations against tetanus, rabies, and diphtheria.

3.1.3.3. Tuberculin (Mantoux) testing and chest X-rays.

3.1.3.4. Wheelchairs and walkers.

3.2. Pharmaceutical Basket: All services listed in the National Health Insurance (Medications in the Health Services Basket) Order, 5755-1995, as amended from time to time; medications purchased in accordance with a physician's instructions and based on a valid prescription, excluding medications specifically excluded under this Policy, and provided they are purchased at a pharmacy affiliated with the Insurer under agreement, as defined above.

3.3. Occupational Health Services Basket: All services listed in Regulations 2 and 5 of the Parallel Tax (Occupational Health Services) Regulations, as applicable and amended at the commencement of the insurance period.repatriation

2.8. **Policy Cancellation:**

2.8.1. If the Insured and/or the Policyholder fails to pay premiums properly and on time, the Insurer may cancel the Policy in accordance with the Insurance Contract Law, 5741-1981 (hereinafter: the "Insurance Contract Law").

2.8.2. If the Policyholder cancels the Policy before the end of the insurance period due to the termination of the Insured's employment with the Policyholder, the Insurer shall refund the portion of premiums corresponding to the period after cancellation, linked to the Consumer Price Index, subject to the Policyholder's obligations under the Insurance Contract Law.

2.8.3. For the purposes of Section 2.8.2, the pro rata premium refund shall be calculated for the period following the return of the Insured's Card to the Insurer.

2.8.4. If the Insured concealed a material fact from the Insurer, as specified in Section 2.1 and in accordance with the Insurance Contract Law.

2.8.5. If the Insured intentionally acted in a way that prevented or hindered the Insurer from verifying its liability, the Insurer shall only be liable to the extent it would have been had such act not occurred.

2.8.6. The Policyholder and/or the Insured may cancel the Policy at any time by providing written notice to the Insurer.

2.9 . **Disclaimer of Liability for Acts or Omissions of Service Providers:** The Insurer shall bear no liability whatsoever for the quality of medical or other services provided to the Insured under this insurance. The Insurer shall not be liable for any damage caused to the Insured or to any third party, whether directly or indirectly, due to the Insured's selection of, or referral by the Insurer to, any medical or other service provider, or due to professional negligence by such providers.

2.10. **Limitation Period:** The limitation period for filing a claim for insurance benefits under this Policy shall be five (5) years from the date of the insured event.

2.11. **Insurance Contract Law:** The provisions of the Insurance Contract Law, 5741-1981, shall apply to this Policy.

2.12. **Changes to Health Services:**

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2.12.2. Should there be any changes to the Health Services Basket and/or the Pharmaceutical Basket and/or the Occupational Health Services Basket and/or to the Health Insurance Law and/or to any order and/or regulation after the commencement of the insurance period (hereinafter: the "Updated Health Basket"), the Insurer shall notify the Policyholder and/or the Insureds of such changes. The Insurer shall also be entitled to amend the Policy and the insurance premium, including requiring payment of an additional premium resulting from the aforementioned changes.

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2.14.2. If premiums are paid by standing bank order or by credit card provided by the Policyholder and/or the Insured at the start of the insurance period, only the actual crediting of the Insurer's account at the bank or credit card company shall be deemed as payment of the premium.

2.14.3. Premiums shall be paid in New Israeli Shekels (NIS) and shall be linked to the Consumer Price Index as follows: the premiums payable by the Policyholder shall be increased or decreased in accordance with the change in the Index between the base index and the index published on the actual date of payment.

2.15. **Indexation:**

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2.16. **Jurisdiction:**

The sole and exclusive jurisdiction in any matter relating to or arising from this Policy shall lie with the competent courts of Israel, in accordance with Israeli law. No other court shall have jurisdiction. The law applicable to any claim arising out of or related to this Policy shall be the law of the State of Israel.

Chapter 3: Health Services

3. **Health services shall be provided to the Insured subject to the provisions of this Policy. The Insured shall be entitled to receive such services in exchange for a payment not exceeding the Customary Payment, and in the absence of such a payment - free of charge, all as detailed below:**

3.1. **Treatment Basket:**

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3.1.2. Hospitalization services in a psychiatric hospital or in a psychiatric ward of a general hospital, in a medical emergency, for a period not exceeding 60 days per single employment period.

3.1.3. The following specific services:

3.1.3.1. Amniocentesis for women aged 35 and over at the start of pregnancy.

3.1.3.2. Vaccinations against tetanus, rabies, and diphtheria.

3.1.3.3. Tuberculin (Mantoux) testing and chest X-rays.

3.1.3.4. Wheelchairs and walkers.

3.2. Pharmaceutical Basket: All services listed in the National Health Insurance (Medications in the Health Services Basket) Order, 5755-1995, as amended from time to time; medications purchased in accordance with a physician's instructions and based on a valid prescription, excluding medications specifically excluded under this Policy, and provided they are purchased at a pharmacy affiliated with the Insurer under agreement, as defined above.

3.3. Occupational Health Services Basket: All services listed in Regulations 2 and 5 of the Parallel Tax (Occupational Health Services) Regulations, as applicable and amended at the commencement of the insurance period.repatriation

3.3. Occupational Health Services Basket: All services listed in Regulations 2 and 5 of the Parallel Tax (Occupational Health Services) Regulations, as applicable and amended at the commencement of the insurance period.

3.4. Special One-Time Compensation for Long-Term Care Workers with Over 10 Years of Employment in Israel:
Following ten (10) years or more since the worker first received a permit to work in the long-term care sector, the Policy shall provide coverage for a one-time special compensation payment of 80,000 New Israeli Shekels, for a worker deemed medically unfit to continue working, as defined in Section 5.1.5 below, provided the worker has exercised their right to a return flight to their country of origin in accordance with Section 4.1.4 below. Eligibility for compensation shall apply to a worker who, at the time of the physician's determination under Section 5.1.5, holds a valid work permit for employment in the long-term care sector, or who held such a permit at any time during the twelve (12) months preceding said determination.

4. **Additional Obligations of the Insurer:**

4.1. Subject to the provisions of this Policy, the Insurer shall bear the following expenses, all in accordance with the conditions, limitations, and exclusions set forth herein:

4.1.1. Coverage for the full cost of the Insured's flight from Israel back to the Insured's country of origin, including medical escort or other special arrangements required due to the Insured's medical condition.

4.1.2. Repatriation of the Insured's body:

4.1.2.1. In the event of the Insured's death under circumstances entitling him to medical services under the terms of this Policy, the Insurer shall bear the full cost of repatriating the body from Israel to the Insured's country of origin.

4.1.2.2. Notwithstanding Sections 4.1.2.1 above and 5.1.7 below, in the event of the Insured's death resulting from a work-related injury, as defined in Section 5.1.7 below, the Insurer shall bear the full cost of repatriating the Insured's body from Israel to his country of origin.

4.1.2.3. **The Insurer's liability under Sections 4.1.2.1 and 4.1.2.2 is subject to prior approval from the Insurer and to the repatriation being arranged by the Insurer exclusively.** If the Insured or anyone on his behalf fails to contact the Insurer in advance for such approval, the Insurer may reduce the insurance benefits to the amount it would have paid had such approval been obtained prior to the repatriation

4.1.3. **Emergency Flight for a Close Family Member to Israel:**

4.1.3.1. For the purpose of this section, a **"Close Family Member"** means: spouse, son, daughter, brother, or sister.

4.1.3.2. If the Insured is hospitalized **under circumstances entitling him to medical services under this Policy**, for the purpose of undergoing an invasive surgical procedure requiring hospitalization exceeding 10 days, or if the attending physician determines that the Insured's life is in danger, the Insurer shall cover the cost of a flight ticket and travel to the Insured's place of hospitalization in Israel for one close family member, up to a maximum amount of NIS 6,500, and hotel accommodation costs for up to 10 days, up to a maximum of NIS 165 per day. **This obligation is subject to the flight and accommodation arrangements being made through the Insurer and approved by the Insurer in advance and in writing.** If the Insured fails to obtain such prior approval from the Insurer, the Insurer may reduce the insurance benefits to the amount it would have paid had such approval been obtained in advance.

4.1.4. Repatriation Costs in Case of Work Incapacity: If a specialist in occupational medicine determines that the Insured is unfit to perform the job for which he was employed by the Policyholder, and is unlikely to become fit to resume such work within 90 days from the date of examination - even with appropriate medical treatment (hereinafter: "Work Incapacity") - and such determination is made during the insurance period, the Insurer shall cover the cost of a flight ticket to the Insured's country of origin, up to a maximum amount of NIS 8,000. **The Insurer shall not bear the cost of such flight if the work incapacity arises from circumstances that do not entitle the Insured to medical services under this Policy, except in the circumstances described in Sections 4.1.1 above and 5.1.5 below.**

4.1.5 **Emergency and First Aid Dental Services:**

4.1.5.1 The Insured shall be entitled to receive only the emergency and first aid dental services listed below, and no others, through dental clinics across Israel as designated from time to time by the Insurer. Information on such clinics may be obtained through the Insurer's service center and/or the service provider's call center.

4.1.5.1.1 Extensive dental caries - temporary filling.

4.1.5.1.2 Open cavity - temporary filling.

4.1.5.1.3 Exposed tooth neck - desensitizing agent.

4.1.5.1.4 Acute inflammation - root canal opening or medicated dressing.

4.1.5.1.5 Dental abscess - drainage and/or occlusal adjustment.

4.1.5.1.6 Food impaction - periodontal treatment.

4.1.5.1.7 Pericoronitis - rinsing and/or medication.

4.1.5.1.8 Post-extraction pain - pain relief.

4.1.5.1.9 Pressure sores under an existing denture - relief of pressure points.

4.1.5.1.10 Any additional treatment arising from tooth pain - palliative or pain-relieving care.

4.1.5.1.11 Examination and X-ray of painful teeth.

4.1.5.1.12 Issuance of a suitable prescription for pain relief when the tooth cannot be treated at that time.

4.1.5.2 Notwithstanding the provisions of Section 4.1.5 above, the Insured shall be entitled to the emergency and first aid dental services listed in Section 4.1.5.1 even if such services are required due to a pre-existing condition.

5. **Exclusions to Chapter 3:**

5.1. Notwithstanding the provisions of Sections 3 and 4 above, the Insurer shall not bear any expenses and/or medical costs for the services listed below, and the Insured shall not be entitled to such expenses and/or services under this Policy:

5.1.1. Under the Treatment Basket:

5.1.1.1. Psychological services.

5.1.1.2. Treatments at the Dead Sea for psoriasis patients.

5.1.1.3. Genetic testing.

5.1.1.4. Long-term care hospitalization or other nursing services.

5.1.1.5. Services related to erectile dysfunction, sexual performance disorders, male or female infertility, as well as artificial insemination or in vitro fertilization treatments.

5.1.1.6. Services rendered outside of Israel.

5.1.1.7. The insured event occurred after the expiration of the insurance period and/or consecutive insurance periods, as set forth in Section 2.6 above.

5.1.2. **Under the Pharmaceutical Basket:**

5.1.2.1. Medications for the treatment of Alzheimer's disease.

5.1.2.2. Medications intended for the treatment of erectile dysfunction, sexual performance disorders, male or female infertility, or medications administered as part of artificial insemination or in vitro fertilization treatments.

5.1.3. **Pregnancy:** Health services related to pregnancy during the first 9 cumulative months in which an employer-employee relationship exists between the female worker and one or more employers in Israel, except in a medical emergency.

5.1.4. **Pre-existing Medical Condition:** The Insured shall not be entitled to health services as detailed in this Policy if the medical event constituting the insured event, for which the Insured requires health services, derives from a medical condition that existed prior to the commencement date of the insurance period under this Policy (hereinafter: a "Pre-existing Medical Condition") and/or prior to the first date on which any employer in Israel arranged medical insurance for the Insured (hereinafter: the "Initial Date"), and if any of the following applies:

5.1.4.1. The Insured confirmed that the medical problem requiring treatment derives from a pre-existing condition.

5.1.4.2. A physician confirmed, based on available findings, that the medical problem requiring treatment derives from a pre-existing condition.

5.1.4.3. The Insured remained outside of Israel, after the Initial Date, for a period or periods exceeding 90 consecutive days while employed by multiple employers, or for a period exceeding 120 consecutive days if the absence occurred between two employment periods with the same employer. In such cases, the new "Initial Date" for purposes of Section 5.1.4 shall be the first date after the return to Israel on which the worker is again covered by medical insurance.

5.1.4.4. Health services in a medical emergency due to a pre-existing condition: Notwithstanding Section 5.1.4 above, the Insurer shall bear the medical costs for emergency health services required by the Insured in connection with a pre-existing condition, for the purpose of stabilizing the Insured's medical condition to a state that allows for continued treatment outside of Israel. The Insurer shall also cover the costs of other medical services required as a result of the same condition, provided they are rendered within 30 days of the physician's determination as described above or the determination that the medical condition has stabilized.

5.1.5. **Work Incapacity:**

5.1.5.1. Medical services required by the Insured after a specialist in occupational medicine has determined that the Insured is unfit to perform the job for which he was employed by the Policyholder, and that he is not expected to regain the ability to perform such job within 90 days from the date of the examination, even if provided with the necessary medical treatment.

5.1.5.2. Notwithstanding Section 5.1.5.1 above, the Insured shall be entitled to medical services required in a medical emergency for the purpose of stabilizing his condition to allow for treatment outside of Israel, as well as to other necessary medical services arising from the same condition, if provided within 30 days following the physician's determination or the determination that the Insured's condition has been stabilized.

5.1.6. **Road Accidents and Hostile Acts:** Medical services required by the Insured due to:

5.1.6.1. A road accident, as defined in the Compensation of Victims of Traffic Accidents Law, 5735- 1975.

5.1.6.2. Hostile acts, as defined in the Compensation for Victims of Hostile Action Law, 5730-1970, if the Insured is considered a victim as defined in that law.

5.1.7. **Medical Services Due to Work Injury:**

5.1.7.1. The Insurer shall not bear the costs of medical services required by the Insured due to a work injury, as defined in the National Insurance Law (Consolidated Version), 5755-1995 (hereinafter: "Work Injury"), provided that the employer confirmed, using the designated form prescribed by the National Insurance Institute (hereinafter: "Injury Form"), that the injury is in fact a work injury.

5.1.7.2. If the employer submitted an Injury Form and the National Insurance Institute does not determine, within three months from the date of the injury, that it qualifies as a work injury, the Insurer shall bear the cost of medical services provided to the Insured as a result of that injury during those three months, even if provided by non-affiliated service providers, and beyond the three months only if such services are provided by the Insurer's affiliated providers.

5.1.7.3. Where the injury results from a work injury, the Policyholder is obligated to confirm the injury on the Injury Form as stated in Section 5.1.7.1 above and submit a copy to the Insurer within 7 days from the date of the injury. A Policyholder who fails to do so and it is later determined that the injury was indeed a work injury shall reimburse the Insurer for all expenses incurred, with linkage differentials and maximum statutory interest, within 7 days from the Insurer's written demand.

5.1.8. **Receiving services from a service provider not under agreement with the Insurer.**

6. **Guidelines for the Approval or Determination by a Specialist Physician - Pre-Existing Condition and Work Incapacity**

6.1. Confirmation by a physician that the medical condition for which the Insured requires medical services derives from a pre-existing condition, and a determination that the Insured has reached medical stabilization, shall be made by a specialist physician. A determination that the Insured is unfit for work, even if provided with medical treatment, shall be made by a specialist in occupational medicine.

6.2. The 30-day period mentioned in Sections 5.1.4 and 5.1.5 shall be calculated only from the date of the final confirmation or determination as set forth in Section 6.3 below. However, a determination that an Insured has reached medical stabilization shall not be considered final if the head of the hospital department in which the Insured is hospitalized, or the deputy department head in the absence of the head, determines that, as of the date on which the Insured's entitlement to health services under this Policy is expected to cease, the Insured has not yet reached medical stabilization. This determination shall remain in effect until otherwise determined by the department head or their deputy as above.

6.3. The rules for the approval or determination referred to in Section 6.2 shall be as follows:

6.3.1. The Insurer may require the Insured to undergo an examination by a specialist physician on behalf of the Insurer, at the Insurer's expense. The specialist's opinion shall be provided to the Insured together with a notice of the Insured's right to obtain a counter-opinion as stated in Section 6.3.2 below, as well as the contact details of bodies or organizations that have agreed to assist the Insured in exercising that right.

6.3.2. The Insured is entitled to obtain a counter-opinion from a specialist physician of their choice, which must be submitted to the Insurer within 21 days from the date the Insured received the opinion issued on behalf of the Insurer. The Insurer shall cover the cost of the counter-opinion up to the amount set by the Director General of the Ministry of Health and the Commissioner of Insurance and Capital Markets at the Ministry of Finance (hereinafter: the "Prescribed Fee").

6.3.3. If the two specialist physicians disagree, the parties shall jointly appoint an agreed-upon physician, whose opinion shall be final. The cost shall be borne by the Insurer. If the parties fail to agree on such physician, a deciding specialist shall be appointed by the Chairperson of the relevant medical association of the Israeli Medical Association (hereinafter: the "Association"), based on the field relevant to the Insured's condition, and for the determination of work incapacity - by the Chairperson of the Association for Occupational Medicine (hereinafter: the "Deciding Physician"). The Deciding Physician's opinion shall be final. If the Chairperson does not appoint a Deciding Physician within 15 days of the Insurer's request, the appointment shall be made by the Director General of the Ministry of Health or a person authorized by them. The Deciding Physician's fee shall be the Prescribed Fee and shall be paid by the Insurer.

Chapter 4: Medical Service Providers and Medical Services

7. **Service Providers:**

7.1. The medical services included in this Policy shall be provided exclusively by the designated service providers, subject to any changes of which the Insurer shall notify the Policyholder in writing. If a service provider ceases working with the Insurer, the Insured shall contact the Insurer's service center to receive a referral to an alternative provider.

7.2. The medical services under this Policy shall be provided to the Insured based on medical discretion, at a reasonable quality level, within a reasonable time, and at a reasonable distance from the Insured's place of residence.

7.3. Notwithstanding Section 7.1 above, the Insured shall be entitled to receive, at the Insurer's expense, the following medical services under the following circumstances:

7.3.1. **Emergency room services at any general hospital in Israel (not limited to hospitals under agreement) in the following cases:**

7.3.1.1. Any new bone fracture

7.3.1.2. Acute dislocation of the shoulder or elbow

7.3.1.3. Injury requiring suturing or alternative wound closure

7.3.1.4. Aspiration of a foreign body into the airway

7.3.1.5. Penetration of a foreign body into the eye

7.3.1.6. Treatment for cancer

7.3.1.7. Treatment for hemophilia

7.3.1.8. Treatment for cystic fibrosis

7.3.1.9. Ambulance evacuation to the emergency room from a public place due to a sudden event

7.3.1.10. The emergency visit resulted in non-elective hospitalization

7.3.1.11. Medical emergency

7.3.2. Hospitalization services provided immediately after an emergency room visit, if the visit occurred under one of the circumstances listed in Section 7.3.1 above.

8. **Access to Medical Services:**

8.1. **Access to various medical services shall be subject to prior approval from the Insurer and/or approval from the attending physician and/or shall be unrestricted, as detailed below:**

8.1.1. **Access to primary medical services included in this Policy shall be unrestricted, and the Insured shall not be required to obtain prior approval from the Insurer to receive such services.**

8.1.2. **Access to non-primary medical services, except in cases listed in Section 7.3 above, shall be subject to prior approval from the attending physician in primary care. If the Insured fails to contact the Insurer in advance for such approval, the Insurer may reduce the amount of insurance benefits payable to the Insured to the amount it would have paid had prior approval been obtained.**

8.1.3. **Access to imaging tests, diagnostic centers, gastroenterology institutes, laboratories, and elective hospitalization services shall require prior written approval from the Insurer.The Insured shall submit a written request for approval of the services listed in this subsection, along with confirmation from the attending physician that the Insured requires such services. The approval or notice of denial shall be provided within 7 days from the date the physician determined the necessity of the test or hospitalization, or from the date the Insurer received the request - whichever is later - and in any case shall not be delayed in a manner that could endanger the Insured or compromise the reasonableness of care to which the Insured is entitled under this Policy. If the Insured fails to obtain the Insurer's prior approval for the above-mentioned expenses, the Insurer may reduce the amount of insurance benefits payable to the Insured to the amount it would have paid had prior approval been obtained.**

8.1.4. **Except for the cases listed in Section 7.3 above, the Insurer shall not bear the cost of emergency room services unless prior approval was obtained from the attending physician.**

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Schedule of Policy Liability Limits

Coverage Summary	Liability Limit
Medical expenses during hospitalization	Full coverage
Medical expenses during hospitalization in psychiatric hospitals	Up to 60 days of hospitalization
Outpatient medical expenses - including general practitioner, specialist, diagnostic tests, imaging services, medications	Full coverage
Emergency room - subject to the criteria established in the Order	Full coverage
Special one-time compensation for a caregiver permit holder found medically unfit to work, subject to the detailed conditions	NIS 80,000
Additional Coverages	**Liability Limit**
Emergency dental treatment	Full coverage
Repatriation of remains	Full coverage
Emergency flight for a close family member and accommodation in Israel for up to 10 days	NIS 6,500 for flight / NIS 165 per hotel night
Return flight to country of origin in case of work incapacity	NIS 8,000

The full terms and exclusions of the policy shall be binding on the insurer

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Summary of Policy Details

Website: www.hcsra.co.il	Address: 6 HaMelacha St., Holon	Email Address: ovdimizarim@hcsra.co.il	Fax: 03-5163064

Policy Name	**Best Medical Insurance for Foreign Workers in Israel**
Type of Insurance	**Health insurance for foreign workers in Israel**
Insurance Period	**The period specified in the Insurance Details Page and not exceeding 12 months from the start date of the insurance, as detailed in Section 1.12 of the Policy**
Policy Description	**Health insurance intended for foreign workers, under which the foreign worker is entitled to receive health services under the National Health Insurance Law, the Pharmaceutical Basket, and the Occupational Health Services Basket.** **Services shall be provided by a service provider under .agreement with the Company, unless stated otherwise** **The covered services include, among others: purchase of medications, general/primary care, specialist care, diagnostic tests, pregnancy-related health services, ambulance expenses, emergency room services, hospitalization in a general hospital, psychiatric .hospitalization, etc** **In addition to the above services under the health basket, the policy includes additional coverages such as flight expenses in case of work incapacity, and repatriation of the .insured's body for burial in the country of origin**
Insurance Premium	**According to the Customary Payment, as defined in Section 1.24 of the Policy.**

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Summary of Policy Coverage Description

Coverage Name	Coverage Description	Maximum Claimable Amount
Coverage for health services under the National Health Insurance Law	All services included in the Treatment Basket as detailed in the Second Schedule to the National Health Insurance Law - hospitalization / outpatient medical expenses, Pharmaceutical Basket, Occupational Health Services Basket - from authorized service providers only, as specified in Section 3 of the Policy.	As defined in the National Health Insurance Law.
One-time compensation for long-term care workers	Section 3 of the Policy - one-time compensation for a licensed caregiver who is found medically unfit to perform his or her work, with sufficient tenure and subject to the conditions set forth in the Policy.	Section 3 of the Policy - one-time compensation in the amount of NIS 80,000.
Medical evacuation and additional coverages	Section 4 of the Policy - full coverage for expenses related to the insured's flight from Israel back to their country of origin, in a medical case as detailed in the Policy terms. Also includes coverage for additional expenses such as an emergency flight for a close family member and hotel accommodation in Israel due to a special medical condition of the insured, as defined in the Policy.	Section 4 of the Policy - accommodation expenses for a close family member up to NIS 6,500; hotel stay up to NIS 165 per day.
Note	**"In the case of indemnification, the insurance company will reimburse actual expenses up to the cap specified in the policy. Please note: if you have identical coverage under another policy, you will not be entitled to double reimbursement beyond the actual amount of expenses incurred, and subject to the policy terms."**	

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