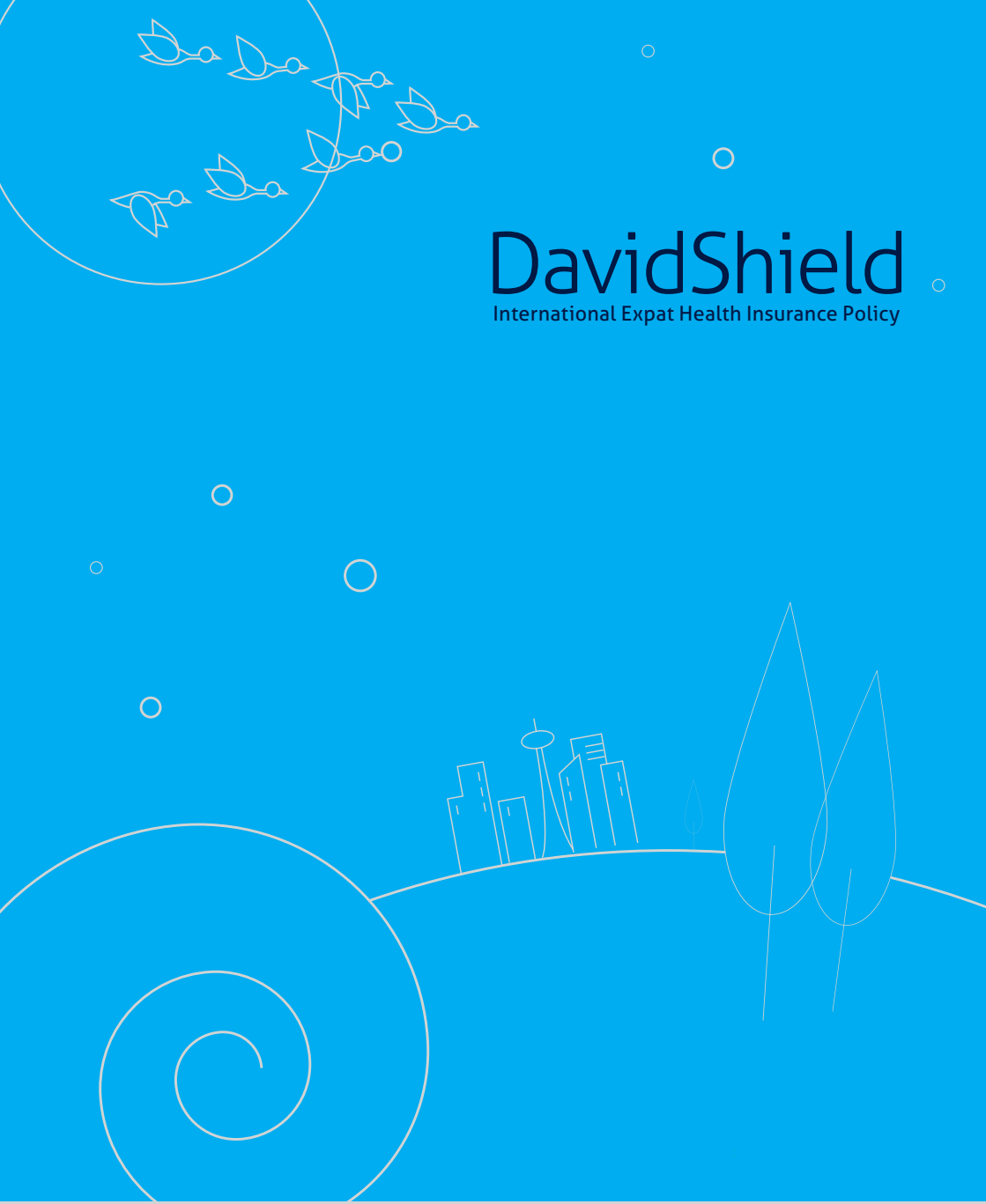
DavidShield

International Expat Health Insurance Policy



Administered by: DAVIDSHIELD International Medical Insurance

Hauteville Insurance Company Limited

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So long as the premium payment (specified in the Schedule) is being made, the Insurer will reimburse the Member, or pay the provider directly, in accordance with the plan chosen, for medical service expenses related to an Insured Event throughout the insurance period. Insured Event is defined below in the Sections of the Policy, including the Special Conditions Section, and Schedule. Reimbursement is dependent on the limit of the Insurer's liability as described in the terms of the Policy and its provisions.
Any reference to the Member in the male gender, will also apply to the female gender in the context of the Policy.

Section 1: Definitions

In the Policy, Schedule (as defined below), and in any attached appendix, the following terms will be interpreted as follows:

1.1 Insurer
The insurance company responsible for the Policy, as specified in the Schedule.

1.2 Member
A person and/or his/her spouse and/or their children (child up to the age of 21, up to the age of 26 if a full-time student and is dependent on the Member for not less than 50% for support and maintenance) whose names are designated in the Schedule, and the Member therein is staying in the designated Country of Destination, or intends to stay there, and who does not hold citizenship in that country.

1.3 Policyholder
A person/group of people/company or an association that enters into a policy agreement with the Insurer, and whose name is designated in the Schedule as the Policyholder.

1.4 Insurance Application
An Insurance Application determined by the Insurer, completed with all of the necessary details, including a health declaration and a medical confidentiality waiver, and signed by the Member.
A declaration given by the Member over the phone is considered as signed by the Member.

1.5 Policy
This insurance contract between the Policyholder and/or the Member, including the Application, Schedule, and Tables of Member Cost Sharing and Benefit Maximums, insurance commencement date, premium cost and payment date, etc.

1.6 Insurance Certificate / Schedule
The page with the insurance items attached to the policy including, among other things, the chosen plan, the Policy number, name of the Policyholder, the name of each Member, Country of Destination, Country of Origin, start-date of the insurance, premium cost, payment date, verification form, etc., all forming an inseparable part of the Policy.

1.7 Tables of Member Cost Sharing and Benefit Maximums
Summarized tables that itemize the extent of the Insurance Cover in accordance with the plan chosen, medical services, total Insurance Benefits payable, and Member's cost sharing, including the deductible, covered under the policy; which are inseparable parts of the policy.

1.8 Age of the Member
Age of the Member, calculated in complete years. Once a person has reached six months after his/her birthday, a full year to the Member's age will be added.

1.9 Insured Event
A medical and/or other service provided to the Member following a medical need as specified in the Sections of the Policy in accordance with the plan chosen.

1.10 Date of Occurrence of the Insured Event
The actual date the Member received a medical and/or other service.

1.11 Waiting Period
Any period, specified in days or months, that may be specified in the

Sections of the Policy, beginning on the policy commencement date, and during which the Member will not be covered for the specified medical services within the framework of the Insurance Cover in accordance with the Policy and the plan chosen.

1.12 Previous Medical Condition
A medical condition (including those resulting from an illness or accident) diagnosed before the date the member joined the Insurance. In this case "diagnosed": is a documented medical diagnoses or a documented medical procedure that was conducted up to five (5) years before the date the Member joined the Insurance.

1.13 Restriction on Account of a Previous Medical Condition
A general restriction in the insurance contract of an Insured Event that occurred during the period in which the restriction applied, and a substantial factor to its occurrence was a normal process of a Previous Medical Condition, and which releases the Insurer from liability, or reduces the liability of the Insurer, or the scope of coverage of said Insured Event.

1.14 Country of Origin
The country of which the Member is a citizen, and that differs from citizenship in the Country of Destination.

1.15 Country of Destination
The country in which the Member intends to stay, according to his/her declaration in the Application, for a period greater than 90 continuous days, or in which the Member is already staying, and based on that information, the Insurer has agreed to accept him/her to the Insurance.

1.16 Deductible
A monetary amount, as indicated in the Table of Member Cost Sharing, which forms part of or the total expenses for, an Insured Event. The sum effectively paid by the Member, cumulative over a calendar year, represents a threshold that once reached, initiates the liability of the Insurer according to the Policy.

1.17 Coinsurance
(applies only when the Country of Destination is the USA)
A monetary amount or installment the Member must pay for a medical service, as outlined in the Table of Member Cost Sharing, in a calendar year, in conjunction with the medical service track chosen by the Member/Policyholder. The amount will be deducted from the Insurance Benefits, above the Deductible, and until the specified limit in the Table of Member Cost Sharing.

1.18 Special Deductible
(applies only when the Country of Destination is the USA)
The amount as described in the Sections of the Policy that is paid by the Member in addition to, and not dependent on, not connected to, Coinsurance, Co-Payments, Deductibles, or the maximum amount of the Member's expenses.

1.19 Medical Expenses
Payments for medical services received by the Member, as a result of an Insured Event, for essential, suitable and appropriate medical services that are consistent with the specified price levels (Usual, Customary and Reasonable - UCR) of similar medical service providers for the same medical services.

1.20 Usual, Customary and Reasonable (UCR)
The standard or most common charge for a particular medical service when rendered.

1.21 Premium
The Premium and other relevant payments that the Policyholder and/or Member are obligated to pay the Insurer, according to the terms of the Policy.

1.22 Premium Table
The table that contains the variable premiums in accordance with the age of the Member. Premium charges incurred by the Member and/or Policyholder will be based on this table. The Insurer will revise the table at the end of each calendar year.

1.23 Surgical Procedure
An invasive/penetrative procedure that penetrates the tissue with the

aim of treating an illness and/or injury and/or repair of an impairment or defect in the Member. Within this context, the following will also be deemed as Surgical Procedures: operations carried out by laser for diagnosis or treatment; observation of internal organs through endoscopy, catheterization, or angiography; and dispersion of kidney stones or gallstones by ultrasounds.

1.24 Elective Surgery
A Surgical Procedure for which the need was expected and the admission of the Member to a hospital for the Surgical Procedure was not based on a referral from the emergency room as an urgent event, rather a referral from an outpatient specialist physician (including the outpatient clinic of a hospital).

1.25 Major Surgical Procedure
Brain surgery and/or spinal surgery and/or heart surgery and/or other similar procedure that necessitates hospitalization for a period of more than 96 hours. In this matter, a Caesarian operation that entails hospitalization for a period greater than 96 hours will not be deemed as a Major Surgical Procedure.

1.26 Transplant
Surgical excision or removal from the body of the Member of a lung, heart, kidney, pancreas, liver, and any combination thereof, and a transplant of a whole or partial organ that has been taken from the body of a donor, or the transplant of bone marrow from the body of a donor, into the body of the Member. Transplant will also include the transplant of an artificial heart once the procedure ceases to be defined as experimental in the United States. The transplant of an artificial heart before the transplant of a heart from the body of the donor will be considered as one Insured Event.

1.27 Implant
Any accessory, natural organ or part of a natural organ, artificial limb, or artificial or natural joint transplanted or assembled in the Member's body during a surgery covered by the framework of the insurance (such as a lens, hip joint, etc.), except for prosthetic dentistry, dental implant, dentures and an implant during Transplantation (as specified above in clause 1.26).

1.28 Diagnostic Medical Tests
A laboratory test (i.e. blood test, discharge examination, cell test, etc.), x-ray, EKG, imaging test (ultrasound, computerized tomography, MRI, scan, PET scan), and any other test that is required according to the accepted medical criteria for the diagnosis of the Member's illness or to determine a method of treating it.

1.29 Physician
Holder of a license to engage in medicine (MD) and/or a physiotherapist, chiropractor, psychologist, or psychiatrist, who has been authorized by the competent authorities in the country in which he/she is engaged in the practice of medicine. This does not include a DPM and/or therapist or a person who engages in medicine but does not answer one of the above descriptions.

1.30 Specialist Physician
A Physician who has been authorized by the competent authorities of the country in which he practices his/her profession in a certain field of medicine and holds a license number as a specialist.

1.31 Hospitalization
A stay within a medical or psychiatric framework for diagnostic purposes and/or to conduct an emergency and/or elective operation, including a stay in the hospital, examinations, and/or medications connected with the purpose of the hospitalization.

1.32 Hospital
A Medical Institution that is recognized by the competent authorities in the country in which it is located, as a public or private hospital.

1.33 Medical Institution
A clinic, laboratory, diagnostic center, pharmacy, etc.

1.34 Medical Services
A surgical procedure, Medical Examination, medical treatment, visit to a doctor, hospitalization, provision of medication, and similar service, as specified in the Sections of the Policy.

1.35 In-Network Provider
A Physician, Hospital, Medical Institution, etc. that has entered into an agreement with the Insurer and the name of whom will be indicated on a periodically publicized list created by the Insurer.

1.36 Out-of-Network Provider
A Physician, Hospital, Medical Institution, etc. that has not entered into an agreement with the Insurer.

1.37 List of In-Network Providers
A book, booklet, disc, Internet site, Smartphone application, and/or other media that contains the details of all In-Network Providers.

1.38 List of Medications
A List of Medications approved by the competent authorities in the Country of Destinations.

1.39 Customer Service Center
A call center or Internet site of the Insurer, details of which are specified on the Member's insurance ID card. The purpose of the Customer Service Center is to coordinate services between the Member and service provider, to verify the Member's eligibility for the Medical Service, coordination of preauthorization of the Insurer, etc.

1.40 Currency
The type of currency as defined in the Schedule and other appendices to the Policy.

1.41 Foreign Currency Indexation
An amount in US Dollars (USD) that is the equivalent of the foreign currency at the representative rate published by the Bank of England that is known at the date of receipt of service.

1.42 Insurance Year
A continuous 12-month period commencing on the start-date of the insurance as stated in the Schedule. Any date prescribed in the Policy is according to the Gregorian calendar.

1.43 Insurer's Authorization
Authorization granted in writing by a director on behalf of the Insurer and/or DavidShield, for the receipt of a medical service and finance thereof, however not an authorization to carry out any specific medical procedures.

1.44 Prescription Medication
A medication that can only be purchased with a prescription from a Physician.

1.45 Co-Pay (for a Physician/Prescription Medication/Emergency Room Visit/Emergency Center Visit)
(applies only when the Country of Destination is the USA)
A fixed monetary amount applied to each Member individually, as it appears in the Table of Member Cost Sharing, which is paid for any Medical Service and/or purchase of Prescription Medication.

Section 2: General Conditions

2.1 The Cover
The Insurer will pay the Service Provider and/or will reimburse the Member on the occurrence of an Insured Event for the Medical Service received by the Member as specified in the Sections of the Policy, subject to its conditions and exclusions and in accordance with the plan chosen.
Any treatment must be recognized by local medical authorities and provided by practitioners exercising within a field in which they are qualified (in line with legislative, regulatory and other requirements in respect of professional standards in the country concerned).

2.2 Validity of the Insurance
The Insurance will be effective from the date as defined by the Schedule, subject to the following cumulative conditions:

2.2.1 The Insurer's consent will be granted, on all conditions, exclusions and exceptions in the Insurance Application. In order to

dispel any doubt, if money has been paid to the Insurer in the form of a Premium before the Insurer's consent has been granted (as aforementioned), such payment will not be deemed as the consent of the Insurer to implement the Insurance in accordance with the Policy.

2.2.2 The applicant for the Insurance has forwarded a signed standing order with the bank or credit card company for the payment of the Premium to the Insurer.

2.2.3 The insurer will send the Member the health declaration (as given by the Member and has been updated with the Insurer), insurance acceptance conditions (medical underwriting), a candidates statement, and data validation form (hereafter, the "Assessment"). The insurance applicant will return all of the above, and the Policy to the Insurer within 30 days of receiving the Assessment, signed and approved by the Policyholder or the Member.

2.2.4 From the date of the Medical Examination or the declaration of health as communicated over the telephone or from the signature of the applicant on the declaration of health, until the date on which the Insurer consents to issue the Policy in the name of the applicant, no change has occurred in the state of the applicant's health, physical condition, or profession/occupation, which if the Insurer had prior knowledge, it would have affected the consent of the Insurer and/or the conditions on which the Insurer consented to the Insurance Application.

2.2.5 The addition of a family member to the Policy, whose name is not listed in the Schedule, is contingent on a declaration of health signed by the Policyholder or Member (as may be the case) that relates to the additional family member, and with the consent of the Insurer.

2.3 Age and Period of Insurance

2.3.1 The minimum age for joining the Insurance is 15 days.

2.3.2 The maximum age for joining the Insurance is 64 years.

2.3.3 The period of insurance will be from the date on which the Member joins the Insurance and for his/her lifetime, unless otherwise indicated in the Policy and/or Schedule.

2.4 Payment of the Premium

2.4.1 The Policyholder and/or Member will pay for each of the Members under the Policy, for each month of the Period of Insurance; the Premium is due as indicated in the Schedule, as outlined in Section 2.5 "The Premium." The Premium will be paid for each new Member that may join the Policy, and will be determined at the time that he/she joins the policy.

2.4.2 The Premium will be paid monthly, in advance, on the date of the month as agreed upon with the Insurer.

2.4.3 In the event of payment of the Premium by standing order to the bank (checking service), or by bank transfer to the Insurer's account, the date on which the Insurer's account is credited, will be deemed to be the date on which the premium is paid.

2.4.4 An overdue Premium payment will be charged with interest customary throughout the Company at the time.

2.4.5 The Premium, Insurance Benefits, and the amount of the Insurer's liability as specified in the Policy, its Appendices and Schedule, will be specified according to the currency and/or currency indexation indicated in the Schedule (as state in Clauses 1.40 and 1.41).

2.5 The Premium

2.5.1 The Premium paid for the Policy will be determined by the age of the Member on the date he/she joins the Insurance and at the start of each additional year of Insurance according to the age of the Member at that date.

2.5.2 In addition to Clause 2.5.1 above, the Insurer may change the

Premium and/or Deductible, Coinsurance, and/or Co-Payments, annually, after December 31, subject to written notice given to all Members 30 days prior to the date of change. The above changes will be made for all Members in the same age group, of the same gender, and located in the same Country of Destination.

2.6 Prior Notice

2.6.1 Reimbursement of the Member in accordance with the Policy is contingent on prior notice given on behalf of the Member to the Customer Service Center as soon as possible before or after the occurrence of the Insured Event.

2.6.1.1 Pregnancy and childbirth: the Insurer must be notified within the first three months of the pregnancy.

2.6.1.2 Hospitalization: the Insurer must be notified a minimum of 72 hours before non-emergency Hospitalization, and a maximum of 48 hours after emergency Hospitalization.

2.6.1.3 Any operation and/or surgical procedure.

2.6.1.4 Any medical treatment in a hospital.

2.6.1.5 Nursing services.

2.6.1.6 MRI, PET Scans or similar imaging tests.

2.6.1.7 Hospitalization in a hospice.

2.6.1.8 Transplants.

2.6.1.9 Family unification.

2.6.2 The Insurer may reduce the Insurance Benefits by up to 50% for excess expenses effectively incurred by the Insurer as a result of the failure to give Prior Notice by the Member when it was required.

2.6.3 In order to receive prior authorization from the Insurer, the Member will notify the Customer Service Center of the need to receive the Medical Service, as early as possible, and in any case no less than 72 hours before the specific date on which the Medical Services will be received, as specified in the Sections of the Policy.

2.6.4 The previous Clause (2.6.3) will not apply to an emergency service provided that the Member gives notice within a mandatory 48 hours of the date the emergency service was received.

2.6.5 In order to dispel any doubt, any direction given by the Customer Service Center, should not be regarded as an undertaking for cover of the Medical Service and/or a recommendation for the provision of a Medical Service as aforementioned. Prior Notice given for an Insured Event does not guarantee payment of the expenses involved in the Medical Service and its cover is subject to the conditions of the Policy, its provisions, and exclusions.

2.7 The Member's Card

2.7.1 Every Member, over the age of 18, who is eligible for Medical Service within the framework of the Policy, will receive a Card that may contain the name of the Member, and his/her personal details.

2.7.2 The Member will be asked to produce the Card in addition to photo identification that enables him to be identified by any Service Provider.

2.7.3 Compliance with this provision is a pre-condition to receipt of Medical Service and the Insurer's liability to pay Insurance Benefits pursuant to the Policy. In order to dispel any doubt, it is made clear that while the Card confirms the eligibility of its holder for Medical Services, it does not necessarily confirm that the Member is covered by a Policy that is in force.

2.8 Receipt of Medical Services

Receipt of Medical Services as specified in the Sections of the Policy will be affected as specified below:

2.8.1 The Insurer will reimburse the Member for the costs of Medical Services actually received by the Member and/or for Medical Expenses submitted for payment by the Service Provider, subject to Policy terms, provisions and exclusions, in accordance with the plan chosen.

2.8.2 On the occurrence of an Insured Event in the context of which the Member is in need of a Medical Service and subject to the provisions of the Policy, there are two options available to the Member for receipt of Medical Services, as specified below:

2.8.2.1 Receipt of a Medical Service through an In-Network Provider.

2.8.2.1.1 The Member may choose a Service Provider whose name is indicated in the List of In-Network Providers. The Member will pay the Deductible/Coinsurance/Co-Payments (when applicable) as indicated on the Table of Member Cost Sharing for In-Network Services. The Insurer will pay the Insurance Benefits only in excess of the amount effectively paid by the Member in the form of the Deductible/Coinsurance/Co-Payments.

2.8.2.1.2 Payments by the Insurer to the In-Network Provider will be made according to the arrangement between the Service Provider and Insurer.

2.8.2.1.3 The total Coinsurance paid by the Member for him/herself and/or his/her family members that are included in the Policy according to his/her family status, is subject to a Coinsurance maximum per calendar year, as indicated in the Table of Member Cost Sharing. It is made clear that payment of the Insurance Benefits by the Insurer is up to the UCR maximum.

2.8.2.2 Receipt of a Medical Service through an Out-of-Network Provider.

2.8.2.2.1 The Member may, at his/her discretion, apply for receipt of a Medical Service from an Out-of-Network Provider, other than for Medical Services outlined in the Sections of the Policy that obligate the Member to obtain them through an In-Network Provider.

2.8.2.2.2 With this option, the applicable Deductible/Coinsurance/Co-Payments are indicated on the Table of Member Cost Sharing for Out-of-Network Services. The Insurer will pay the Insurance Benefits only in excess of the amount effectively paid by the Member on account of the Deductible/Coinsurance/Co-Payments.

2.8.2.2.3 (Applies only when the Country of Destination is the USA). With this option, the Member will bear the payments of the Coinsurance as specified in the Table of Member Cost Sharing. The total Coinsurance paid by the Member for him/herself and for his/her family members that are included in the Policy according to his/her family status, is subject to a Coinsurance maximum per calendar year as indicated in the Table of Member Cost Sharing. It is made clear that the payment of the Insurance Benefits by the Insurer is up to the UCR maximum.

2.8.2.3 In order to dispel any doubt, it is made clear that compliance with the provisions of Clause 2.8.2.2 and all its paragraphs is effective other than in the following instances:

2.8.2.3.1 In instances where there is no In-Network Provider defined as a clinic (a single Physician or a group of Physicians; Section 7: Special Conditions, Sub-Section 1 in the Policy) within traveling distance of 25 kilometers from the place at which the Member is located.

2.8.2.3.2 In instances where there is no In-Network Provider that is not a clinic (hospital, laboratory, medical center, x-ray, or imaging institutes, etc.; Section 7: Special Conditions, Sub-

Sections 2-5 of the Policy) within traveling distance of 75 kilometers from the place at which the Member is located. In the above instances, compliance with the provisions of Paragraph 2.8.2.1 and all its paragraphs is effective.

2.8.3 The Member will provide the Customer Service Center with the information that relates to his/her claim, including the diagnosis of the attending Physician and the medical documents that are required by the Insurer to clarify the claim. The Member will deliver the above information to the Insurer at the stage of obtaining the Insurer's prior consent, or after receipt of Medical Services, according to the type of service as specified in the Sections of the Policy.

2.8.4 Payment of the Insurance Benefits is contingent on completion of all the details on the Prior Authorization Form and Claim Form as stated above to the satisfaction of the Insurer, and forwarding any additional details at the request of the Insurer and subject to the Policy.

2.8.5 The Insurer will pay the Insurance Benefits as stated when in possession of all the information and documents required to clarify the claim. All this being above the Deductible, less the Coinsurance, Co-Payments, and the Special Deductibles, and subject to the terms of the Policy terms, conditions and exclusions.

2.8.6 If necessary, and subject to the delivery of Prior Notice, and advance coordination with the Customer Service Center, the Insurer will pay the costs of the medical treatment directly to the Service Provider that was selected by the Member, in excess of the amount that the Member is obligated to bear, in accordance with that stated in the Table of Member Cost Sharing.

2.8.7 In order to dispel any doubt, it is made clear that the amounts paid by the Member as the Deductible and Coinsurance in any calendar year, will only relate to that calendar year.

2.9 Medical Examination
Within the framework of clarifying the Member's claim and the Insurer's liability in respect thereof, the Member will, if necessary, be

available for a medical examination by a physician acting on behalf of the Insurer.

2.10 Delivery of Documents and/or Waiver of Medical Confidentiality
Within the framework of clarifying the Member's claim and the Insurer's liability in respect thereof, the Member will deliver information and/or a medical document that may be required by the Insurer, and will give signed permission to the Service Provider and to any other body and/or institution to deliver all information that concerns his/her medical condition, to the Insurer.

2.11 Coordination of Medical Treatment
Within the framework of clarifying the Member's claim and the Insurer's liability in respect thereof, the Insurer may obtain an update on the nature of the Medical Treatment required, its extent and duration, directly from the Member's personal Physician and/or the attending Physician. Compliance with the provisions of paragraphs 2.8.3, 2.8.4, 2.9 and 2.10 constitute a prior condition to the liability of the Insurer for payment of the Insurance Benefits in accordance with the Policy.

2.12 In the event of payments made by the Insurer that are not covered by the Policy, and on a detailed request for the refund of these payments having been given in writing to the Member, the Member will be responsible to pay the amount due within 10 days of the date on which the request was sent on behalf of the Insurer as stated. In the event of non-payment, the Insurer will offset the excess payments from any amount that the Insurer is liable to pay pursuant to the Policy.

2.13 Right of Subrogation

2.13.1 If the Member has a right to reimbursement from a third party for any reason whatsoever because of an Insured Event, this right will be assigned to the Insurer who has made the Insurance Benefits pursuant to the Policy and in the amount of the benefits paid.

2.13.2 The Insurer may not exercise the right assigned according to this paragraph in a manner that will prejudice the right of the Member to collect any reimbursement from the third party that

exceeds the benefits that the Member received from the Insurer.

2.13.3 If the Member received reimbursement and/or compensation from a third party that is due to the Insurer according to this paragraph, he will transfer it to the Insurer. If he/she has made a settlement, waiver or other action that prejudices the right that he/she has transferred to the Insurer, he/she is obligated to compensate the Insurer in the matter.

2.13.4 The provisions of this paragraph will not apply if the Insured Event is the result of an unintentional act and/or omission by a person from whom a reasonable Member would not claim reimbursement or compensation because of a family relationship.

2.14 Miscellaneous

2.14.1 The Insurer may update the list of In-Network Providers periodically.

2.14.2 If the Member is eligible for cover for expenses paid in accordance with the Policy, whether in full or in part, within the framework of another policy with the Insurer and/or from another insurance company, the Insurer will pay its prorated share to the extent of cover, and the amount to which the Member is entitled from each insurer.

2.15 Jurisdiction

The laws of UK shall apply to the Policy, and to any dispute that is derived from it, and jurisdiction is vested with the leading international arbitration institute in one of the OECD member countries.
In case any of the above creates a "forum non convenience" to the Member, the Insurer may agree to another international arbitration institute of the same standards.

2.16 Statute of Limitations

The period of limitation for a claim for Insurance Benefits pursuant to the Policy is 24 months from the date of the Insured Event.

2.17 Taxes and Levies

The Policyholder or Member, as in the case, is obligated to pay all the governmental taxes, and any other taxes that apply to the Policy, or that are imposed on the Premium and Insurance Benefits, and all the other payments that the Company is obligated to pay according to the Policy, whether these taxes exist at the date on which the Policy comes into effect, or whether they are imposed at a later date. The Insurer is not responsible for any tax collection, and the Premium collected by the Insurer does not include any tax.

2.18 Status of the Policyholder

The Policyholder declares that he/she is the agent of each separate Member for purposes of the Policy and that any notice that is sent to him/her by the Insurer in regard thereto will be deemed to have been delivered by him/her to each Member.

2.19 Cancellation of the Policy and Changes to its Conditions

2.19.1 Upon giving 45 days prior notice, the Insurer may alter the conditions of the Policy if a law is enacted in the future which prevents the Insurer from reimbursing the Member, whether directly or indirectly, completely or partially, in accordance with, or as stated in the Policy.

2.19.2 If the Premium, or any part thereof, was not paid on the due date, and not paid within 30 days after days after the due date, the Insurer may notify the Policyholder and/or Member, in writing, that the Policy will be cancelled as of the original due date. Making the payment within the 30 days grace period will guarantee continuity of benefits and of waiting periods.
The aforementioned will not detract from the Insurer's right to cancel the Policy according to the provisions of the Policy and/or the provisions of any law.

2.19.3 The Insurer may offset the Member's debt from payments of the Insurance Benefits to which the Member is entitled.

2.19.4 The Member may cancel the Policy upon giving 30 days notice prior to the date of cancellation to the Insurer. In such case, the Insurer will not be obligated to fulfill the Insurance Benefits or any liability under the policy from the date of its cancellation.

2.20 Notices

2.20.1 Any notice from the Insurer to the Policyholder and/or Member and/or a beneficiary and/or to any licensee authorized to receive notices and documents. Including service of process, as may be the case, will be delivered to the last address of which the Insurer was informed in writing, and/or electronically to the last email address of which the Insurer was informed, and/or to a password protected "self-service" website/Smart Phone application. The Member and/or Policyholder undertakes to notify the Insurer through the Customer Service Center of any change in address/email address, and no claim that he/she makes that any notice did not reach him/her will be considered if it has been sent to the last address and/or email address and/or "self-service" website or Smart Phone application of which the Insurer was notified.

2.20.2 In order to dispel any doubt, any notice from the Insurer to the Policyholder and/or to the Member and/or to a beneficiary including written documents of any sort whatsoever, including service of process that was delivered to a licensee authorized to receive notices and documents that was appointed by the Member, will be deemed, for all intents and purposes, to have been delivered to the Policyholder and/or Member and/or a beneficiary.

2.20.3 Any alteration to the Policy, if required, will take effect only after it is included by the Insurer in the Policy and/or in an Appendix to revise the Policy, which is issued by the Insurer.

Section 3: Waiting Periods

The Insurer will not be obligated to make any payment for Insured Events from which monetary obligations are derived, that were created during the Waiting Periods specified below, when applicable, in accordance with the plan chosen. The Waiting Period for a new Member that may join the Policy, after its inception, will apply from the date on which he/she joined the Policy.

3.1 Pregnancy and Childbirth

(applies for the "Preferred" and "Elite" plans) The Insurance Cover for monitoring pregnancy, pregnancy risk, childbirth, childbirth complications, abortion, diseases emanating from the Member's pregnancy, treatment of a fetus, treatment of a newborn child during the first 31 days of his/her life, will take effect only after a waiting period of 12 continuous months from the date of inception of the Insurance. (See also Section 7, and Sub-Section 9 and 10 below and the Tables of Member Cost Sharing and Benefit Maximums, as they concern pregnancy and childbirth).

3.2 Mental Health

Psychiatric/psychological treatment - Insurance Cover for all that is concerned directly or indirectly with mental disturbances, diagnosis and psychological and/or psychiatric treatment, including hospitalization and treatment by medication, will take effect only after a waiting period of 12 continuous months from the date of inception of the Insurance, providing that there is no previous medical history of the above as defined in Section 1, paragraph 1.12). (See also Section 7, Sub-Section 4 below, and the Tables of Member Cost Sharing and Benefit Maximums as they concern treatment of Mental Health).

3.3 Previous Medical Condition

Subject to the fact that the Insurance Application has been completed by the Member as to his/her state of health before joining the Insurance, it is made clear that a Medical Service for a Previous Medical Condition, as defined in Section 1, paragraph 1.12, will be covered only after a waiting period of 12 continuous months from the date of inception of the Insurance.

Section 4: Disclosure of Previous Medical Conditions

4.1 Obligation to Disclose

4.1.1 The Policy is issued on the basis of the Insurance Application, the notices and declarations delivered in writing and/or over the telephone to the Insurer by the Policyholder and/or Member, that form an inseparable and material part of the Policy. The accuracy

and integrity of the above information, answers, notices, and declarations are fundamental to the validity of the Policy.

4.1.2 If the Policyholder and/or Member provide inaccurate or incomplete answers to fundamental questions, or if facts that may have influenced the Insurer's decision to accept the Member to the Insurance, or to accept him/her by the conditions specified in the Policy, were not brought to the attention of the Insurer, the following provisions will apply:

4.1.2.1 If the Insurer is informed before the occurrence of an Insured Event, the Insurer may cancel the Policy by giving written notice to the Policyholder and/or Member, who will be entitled to a refund of the Premium paid for the period after the cancellation, after deducting the Insurer's expenses, unless the Member acted with the intention to deceive.

4.1.3 If an Insured Event has occurred before the Insurance is cancelled by virtue of this paragraph, the Insurer is obligated only to reduce Insurance Benefits proportional to the relationship of the Premium customarily paid according to the true condition and the agreed Premium. Despite that stated above, the Insurer will be released from any obligation in all of the following instances:

A. The answer was given with the intent to deceive.
B. The Insurer is of the opinion that such Insurance would not have been issued even for a higher Premium, had the Insurer known of the Member's true condition. In such case, the Policyholder is entitled to a refund of the Premium paid for the period after the occurrence of an Insured Event, after deducting the Insurer's expenses.

4.2 Previous Medical Condition

4.2.1 The Insured Event: Provision of any of the Medical Services that are covered under the Policy in relation to medical conditions that are consistent with the definition of a Previous Medical Condition (Section 1, paragraph 1.12).

4.2.2 If the Member was asked at the time of his/her acceptance to the Insurance, on making the Declaration of Health, as to a certain health condition that is included in the definition of a previous state of health as defined above, the Member will disclose in the Declaration of Health, whatever he/she was asked. If the Member is asked about a Previous Medical Condition and did not disclose the facts about his/her condition to the Insurer, the legal provisions as to the rule of disclosure will apply to the Insurance.

4.2.3 If the Member notifies the Insurer of a specific medical condition, the Insurer may limit its liability and/or the extent of cover because of a specific medical condition. This restriction will take effect for the period recorded in the Schedule alongside that specific health condition.

4.2.4 If the Member has given prior notice of a specific medical condition and the Insurer did not explicitly exclude the specific medical condition in the Schedule, the Insurance will take effect without any restriction of limitation of any sort in regard to the Previous Medical Condition.

Section 5: Exclusions and Restrictions to the Policy

Your policy covers you according to the plan chosen, as specified in the relevant Table of Benefit Maximums.
The Insurer will not pay and will not be liable for the proficiency of the diagnosis, the treatment and advice, and all that is connected directly or indirectly with Insured Events and/or the Medical Conditions specified below:

5.1 General Exclusions

5.1.1 The Insurer is not liable for any damage that the Member and/or a third party may suffer as a result of the Member's selection of and/or referral by the Insurer to a Physician, family physician, Specialist, surgeon, anesthetist, hospital, or any other In-Network or Out-of-Network Provider and/or as a result of an act or omission of the former, or advice, treatment, surgical procedure, medication

or other action taken by them, including not performing a surgical procedure and/or not providing medical treatment on the date specified for any reason whatsoever. It is made clear that the Service Providers are not deemed to be agents or employees of the Insurer.

5.1.2 The Insurer will not be liable and will not pay insurance benefits in accordance with the Policy for an Insured Event that is connected directly or indirectly and/or that derives from:

5.1.2.1 War, invasion, acts of terrorism, and any act of a foreign enemy, hostile acts or warlike acts (whether war has been declared or not), civil war, and acts of terror perpetrated by persons who take an active part on behalf of or in connection with any organization whatsoever. For purposes of this category, terrorism means the use of force for political and/or religious ends, including the use of violence, the purpose of which is to intimidate the public and/or any part thereof, rebellion, military or popular uprising, mutiny, insurrection, revolution, military rule or rule that was seized illegally, a military regime or state of siege or incidents, any factors that lead to the declaration or existence of a military regime or stage of siege, and/or boycott, subject to the following conditions:

A. The insured, while taking a risk enters a place and/or area where a known war or uprising is taking place.
B. The insured takes an active part in a war or an uprising.
C. The insured deliberately ignores the risk, while being fully aware of putting himself in danger.

5.1.2.2 The accidents specified below, if the Member is obligated, by law of the designated country (and/or the law of the country in which the accident occurred), to purchase insurance cover for said events, and/or if the Member is entitled to compensation and/or medical treatment for such accidents from any governmental and/or other body in the country in which the accident occurred:

5.1.2.2.1 A road accident

5.1.2.2.2 A work accident, whatever the cause, the accident occurring of or in connection with his work.

5.1.2.2.3 An accident during the course of the Member's military service.

5.1.3 Treatment for alcoholism and/or addiction to drugs and/or misuse of matter other than drugs.

5.1.4 Attempted suicide and/or an intentionally self-inflicted injury, whether the Member was sound-of-mind or not.

5.1.5 Any exposure whatsoever to ionizing radiation, radioactive pollution, nuclear process, military nuclear matter, or any nuclear waste whatsoever or any chemical substance whatsoever.

5.1.6 An accident and/or injury and/or wound that was caused as a result of a sporting or artistic or competitive activity for which the Member received any compensation whatsoever.

5.1.7 Without detracting from the general nature of that which is stated in Paragraphs 5.1.2.1 and 5.1.2.2, an accident and/or injury and/or wound as a result of parachuting, gliding, diving, sky-diving, use of surf gliders or surf boards, races of various sorts, riding and use of all-terrain motorcycles (without a license and/or on an unpaved road), riding and use of all-terrain vehicles, use and driving a self-built vehicle (such as a "buggy"), mountain and rock climbing, rappelling, rope traversal, rafting, bungee jumping, skiing outside of a permitted and marked ski site and route, and any extreme sport in which a Member risks him/herself in any significant manner.

5.1.8 An accident at sea, in a vehicle or in the air, for which the before or after the period of insurance is liable for the expenses for the Medical Service.

5.1.9 Debts caused as a result of, or that occur during, a violation of the law on the part of the Member.

5.1.10 Any physical and/or mental injury that is caused by an unreasonable risk taken by the Member.

5.1.11 Any deliberate termination of pregnancy, except in the case of a medically necessary termination in compliance with local law.

5.2 Special Exclusions

The Insurer will not pay Insurance benefits for an Insured Event that is connected either directly or indirectly with and/or that derives from:

5.2.1 Treatment that is not recognized by medical science and/or medical treatment and/or examinations based on medical technology that is not authorized by the competent authorities, or that are undergoing a trial investigation or examination, but that have not come into regular use at the date which the Insured Event occurred.

5.2.2 Treatment required for an Insured Event that occurred before or after the period of insurance.

5.2.3 Treatment for an injury or illness for which payment was not requested within 24 months of the date of occurrence.

5.2.4 Treatment that was not arranged by a Physician.

5.2.5 Treatment carried out by a person who is not a member of the staff of a Hospital and/or Clinic.

5.2.6 Therapy, treatment, service or medical supply that is not medically necessary.

5.2.7 Treatment of the Member for which no charge was made.

5.2.8 Advice over the telephone or failing to keep a planned appointment.

5.2.9 Diagnosis and treatment of addiction to dangerous drugs, alcohol, smoking and addictive substances.

5.2.10 Treatments based on alternative or holistic medicine, other than chiropractic/physiotherapy prescribed by a physician, and carried out by a licensee in the medical field.

5.2.11 Medical service carried out or given by a close relative of the Member other than with the prior written consent of the Insurer.

5.2.12 Vision tests, diagnosis of myopia, eye and vision training, a laser operation to correct myopia or any other medical treatment the purpose of which is the correction of myopia, adjustment of spectacles or contact lenses, refraction of the eyes, treatment of vision, or for any examination or adjustment that is connected with these aids; an eye operation such as radial insurrection of the cornea if the main purpose is to correct myopia, longsightedness or astigmatism.

5.2.13 A hearing test, hearing aids, hearing implants, other medical accessories intended to improve hearing.

5.2.14 A medical service and/or nursing service provided by a person who usually resides in the home of the Member, other than with the prior written consent of the Insurer.

5.2.15 Medical treatment and medical accessories as specified below: orthopedic shoes, orthopedic aids prescribed by a physician that are meant to be attached to, or placed inside shoes (such as insoles or heel lifts), treatments for the feet and weak feet, deformities of the feet and flat feet (pes planus), instability or lack of balance, and treatment of varicose veins (swollen veins on the legs/hands). In order to dispel any doubt, it is hereby made clear that there will be no cover for any service and/or diagnosis and/or advice and/or treatment given by anyone other than a Physician (for example, a DPM).

5.2.16 Treatment and therapy for hair loss, including wigs, hair implants and/or medications that guarantee hair growth, whether prescribed by a physician or not, other than as a result of a medical treatment that causes hair loss (for example, chemotherapy) for which cover is provided by the Insurer within the framework of the Policy.

5.2.17 Diagnosis and treatment of sleep disturbances, including medical treatment for the prevention of sleep disturbances,

medical equipment for the treatment of sleep disturbances, and examinations at sleep laboratories, whether required for a diagnosis of illness or for the diagnosis of sleep disturbances.

5.2.18 Exercise programs (including but not limited to gym memberships, weight loss programs, etc.) whether prescribed or recommended by a Physician or not.

5.2.19 Travel accommodations expenses, other than expenses for transportation by a local ambulance that ends in hospitalization, emergency evacuation, and benefits provided within the framework of transplants.

5.2.20 Surgical procedures or treatment undertaken for purposes of research, experiment and/or investigation.

5.2.21 Weight adjustment or treatment of obesity, or a surgical procedure for the treatment of obesity including binding the teeth, and/or any other procedure to reduce the stomach and/or intestine bypasses.

5.2.22 Adjustment of the body shape for the improvement of a person's psychological, mental or emotional wellbeing, for example, a sex-change operation.

5.2.23 Treatment or surgery for cosmetic or esthetic purposes, such as a nose operation, an operation for breast enlargement/reduction, scar removal, etc.

5.2.24 Any medication or treatment that encourages or prevents pregnancy including use of pills to prevent pregnancy, artificial fertilization, fertilization treatment and/or impotency and/or sterilization and/or a procedure to reverse sterilization, and/or any medication or procedure whether it increases or improves impotency or impaired sexual functioning.

5.2.25 Dental and gum treatments, including illnesses that originate in gum and dental disorders. Dental implants.

5.2.26 Temporomandibular treatment (TMJ).

5.2.27 A circumcision other than for medical reasons.

5.2.28 Monitoring or treating newborn infants after the first 31 days from their birth have elapsed.

5.2.29 Expenses for keeping a donor alive for a transplant procedure whether the transplant procedure is covered or not and any expenses incurred in relation to the acquisition of an organ.

5.2.30 Any treatment, diagnosis and advice that is in connection with a viral illness of the sexual organs and sexually transmitted diseases.

5.2.31 HIV detection tests and/or AIDS detection and/or the detection of AIDS related illnesses.

5.2.32 Treatment of the Member for the exacerbation of a medical condition that from the start was covered under the Policy in respect of which the Member was required to act according to the instructions of his physician, but the Member did not obey the Physician's instructions, for example taking essential medication, follow-up examinations, and preventative treatment.

5.2.33 Payment required for sending tests and/or specimens to a laboratory or from a laboratory to the attending Physician or in a Hospital.

5.2.34 Vaccinations and treatments given other than because of a medical need and for purposes of immigration and that were not requested by a Specialist Physician in writing.

5.2.35 Receipt of medical services at the home of the Member or outside a medical institution (other than an emergency or nursing service) without prior written consent of the Insurer.
Section 6: Limits of Liability of the Insurer.

Section 6: Insurer's Limits of Liability

6.1 The limits of the Insurer's liability according to the Policy to each of the Members is to the maximum sum prescribed in the Table of Benefit Maximums that is attached to this Policy and in accordance with the plan chosen.

6.2 The limits of the Insurer's liability for the total sum of the Medical Services covered according to the Policy, for each one of the Members, throughout the period of insurance, is up to the maximum sum prescribed in the Table of Benefit Maximums and in accordance with the plan chosen.

6.3 The limits of the Insurer's liability for each of the Medical Services covered by the Policy is in accordance with the medical expenses as stated above in Paragraph 1.19, but no more than the limit of the Insurer's liability for the total of each of the Medical Services.
The Tables of Benefit Maximums and Member Cost Sharing that are attached form an inseparable part of the Policy, and should be read over by the Member.

Section 7: Special Conditions, Receipt of Services

Without detraction from the general nature of that stated in Sections 1-6, and in addition thereto, the Insurer will reimburse the Member for Medical Expenses for Medical Services and/or will pay the Provider directly to the maximum of the Limits of the Insurer's Liability for Insured Events as follows:

7.1 Visit to a Family Physician, Pediatrician, and/or Specialist
The Insured Event: A visit by the Member to a family Physician and or pediatrician and/or a Specialist or any Physician as defined in Paragraph 1.29 of the Policy, for the purposes of a diagnosis and/or advice and/or treatment regarding the Member's state of health.

7.2 Diagnostic Medical Tests
The Insured Event: A visit by the Member and/or sending of a specimen to a laboratory or a visit by the Member to an x-ray or imaging institution, for purposes of diagnosis or treatment that derives from the Member's state of health.

7.3 Medical Hospitalization
The Insured Event: Hospitalization of the Member in a Hospital, including in an intensive care unit, for diagnostic purposes and/or for medical treatment and/or for a surgical procedure that derives from the Member's state of health, including the surgeon's fee, anesthetist's fee, operating room expenses, and/or for childbirth including postnatal treatment. It is made clear that the tariff for hospitalization will be for the costs of a semi-private room (two to three beds in a room), including normal room services, food provided by the Hospital, and a nurse and auxiliary nurse, but does not include telephone charges, a television, and other ancillary services that are not involved in the medical treatment.

7.4 Mental Disorders and Psychiatric Hospitalization
The Insured Event: Medical treatment and medication for the Member's state of health that derives from mental disorders that were diagnosed in the Member by a Specialist.
It is hereby made clear that the Insurer's limit of liability and its duration in respect to the above service differs from the other medical services as they appear in the Table of Benefit Maximums that is attached to the Policy. (Please see Sections 3 and 6 above).

7.5 Day Hospitalization
The Insured Event: The daytime hospitalization of the Member without an overnight stay at an outpatients' clinic of a Hospital and/or a medical institution, for diagnostic purposes and/or for medical treatment and/or for a surgical procedure that derived from the Member's state of health, that does not require hospitalization in a Hospital and/or intensive care unit.

7.6 Emergency Room Visit (without Hospitalization)
The Insured Event: Receipt of a diagnostic service and treatment that derives from the Member's state of health in an Emergency Room of a Hospital solely as a result of an emergency where treatment could

not be delayed until after a visit to a Physician or Specialist could be made.

7.7 Emergency Clinics
The Insured Event: Receipt of a diagnostic service and treatment that derives from the Member's state of health at an emergency clinic other than an Emergency Room of a Hospital (that is open to the public after normal hours of admission).

7.8 Transportation by Ambulance
The Insured Event: Transportation of the Member by ambulance to an emergency room and/or between a Hospital in which the Member is hospitalized, and another Hospital as a result of medical circumstances that derive from the Member's state of health that do not allow the Member to reach the Emergency Room by any means of transport of than an ambulance. In order to dispel any doubt, it is made clear that the obligation of the Insurer as aforesaid is only in the event of hospitalization of and/or operation on the Member following the time of his/her arrival by ambulance to the Emergency Room.

7.9 Purchase of Medication
The Insured Event: The actual purchase of a prescription medication that is approved by the competent authorities in the Country of Destination for use by the Member, in order to treat the Member's state of health as diagnosed by a Specialist and as approved for the use by the aforesaid.
Financing the use of medication will apply to the Insurer after the Member has reached the annual deductible as specified in the Table of Member Cost Sharing and subject to the copayments for the Member for each 30-day supply at the rates specified in the Table of Member Cost Sharing that is attached to the Policy.
Chronic prescription medications will be supplied for a period of up to 90 continuous days for each prescription by means of an In-Network Provider only, and the copay/coinsurance will be charged for every 30-day supply.
The Member may purchase a medication that is not included in the List of Medications provided that it is purchased through an In-Network Provider. In this case the Member will bear the copay/coinsurance at the rate prescribed in the Table of Member Cost Sharing that is attached to the Policy.

If the Member has asked to purchase a medication that has a brand name, when a generic medication is available, the Member will bear, in addition to his copay/coinsurance, the difference in cost between the two medications.
In order to dispel any doubt, it is made clear that the Insurer will not be responsible for payments for any experimental medications and/or medications that are not approved by the competent authorities.
The provisions of the General Exclusions Section and the Special Exclusions Section in the Policy will apply respectively also to the purchase of a medication within the framework of this Section, and to a special deductible as specified in the Table of Member Cost Sharing.
In order to dispel any doubt, it is made clear that the Insurer will not be responsible for payments for the replacement of medications that were lost, stolen, damaged, or that are out of date and/or for medications that may be purchased without a medical prescription even if a prescription was given for them.

7.10 (Not applicable for the Essential plan)
Pregnancy and Childbirth (without Complications)
The Insured Event: A normal state of pregnancy of the Member including monitoring the pregnancy on the recommendation of a gynecological Specialist, childbirth, and the treatment of the mother and child during the Hospitalization after the birth, including treatment of the newborn child from the moment of his/her birth for the first 31 days of his/her life, and routine post-natal medical monitoring of the mother.
In this matter, "a normal state of pregnancy" is the course of the pregnancy until childbirth for which no medical intervention is required beyond the routine monitoring checks according to the accepted criteria, including a health child born of a vaginal delivery (including forceps or vacuum delivery). The maximum limit of the Insurer's liability and special deductibles are as specified in the Tables of Member Cost Sharing and Benefit Maximums that are attached to the Policy. (Please review Sections 3 and 6 above).

7.11 (Not applicable for the Essential plan)
Complications of Pregnancy and Childbirth and Treatment of the Newborn Child
The Insured Event: Any abnormal state of pregnancy; an abortion (other than for personal reasons and/or socio-economic reasons); an abnormal delivery; treatment of the newborn child for the first 31

days of his life, all within the framework of the cover provided to the Member mother. In this matter, the following medical situations will be deemed to be complications of pregnancy: preeclampsia, toxemia, kidney infection, gestational diabetes, anemia, bladder infection, location and/or severance of the placenta, a tear in the womb, an infection of the placenta, endometriosis, late delivery (42 weeks and more) RH sensitivity in the blood of the fetus, premature labor pains, premature rupture of membranes (more than 12 hours before the delivery), the neck of the womb has ceased to extend, labor pains for over 20 hours, stillbirth, ectopic pregnancy, extreme vomiting, or associated or similar pathologies.
In this matter, the following conditions will be considered as complications of childbirth and/or the fetus and/or the newborn child: a cesarean operation, an anomalous presentation of the fetus, induction of labor for medical reasons, abnormality of the amniotic fluid, a slow or fast heartbeat, prolapse of the umbilical cord, embolism of the amniotic fluid in the lungs, a birth weight below 2 kilograms, a premature birth (a premature baby – one that was born before the 37th week of pregnancy), a delivery while the mother is under a general anesthetic, congenital anomalies or similar or associated pathologies. The maximum limit of the Insurer's liability and Special Deductibles are as specified in the Tables of Member Cost Sharing and Benefit Maximums that are attached to the Policy.

7.12 (Not applicable for the Essential plan)
Routine Care of Baby and Child
The Insured Event: General physical examinations, functional assessment, development checks, and receipt of recommendations regarding the need for diagnostic examinations and vaccinations for the bay and child, on the condition that at the time of the test specified above, the patient examined was Member under the Policy.

7.13 (Not applicable for the Essential plan)
Vaccinations
The Insured Event: Inoculation of the baby and child from the date of his/her birth until his/her 17th birthday, to the extent customary in the Country of Destination and subject to the instructions of a Physician. Inoculation of an adult aged 17 and older will be covered within the framework of the Policy at the request of a Specialist and in any case within the framework of periodic check-ups and exclusions

to the Policy (Sub Section 15 below and Paragraph 5.2.35 above).

7.14 Transplants
The Insured Event: A transplant carried out as meant in Paragraph 1.26 above, including the medical expenses involved therein as specified in this Section. The Insurer will pay the Service Provider for transplant expenses to the upper Limit of the Insurer's Liability as specified in the Table of Benefit Maximums. The assessment of a medical Specialist before the Transplant, the Transplant procedure, a repeat Transplant if it occurs during the course of Hospitalization for the first Transplant and further treatment after the Transplant.
The cost of harvesting the organ in a Hospital other than an effective purchase or acquisition of an organ or tissue, up to the amount specified in the Table of Benefit Maximums that is attached to the Policy. All the aforesaid will be carried out exclusively through In-Network Providers as authorized by the Insurance Company and subject to the prior written authorization of the Insurer. The Medical Expenses that are created in respect of a living donor of an organ or tissue within the framework of the Transplant procedure, travel and hotel expenses, through a Service Provider are up to the amount specified in the Table of Benefit Maximums that is attached to the Policy in accordance with the plan chosen.

7.15 (Not applicable for the Essential plan)
Periodic Medical Examinations (Wellness)
The Insured Event: A periodic medical examination of the Member on condition that at least 12 months have elapsed since his last periodic medical examination. The Insurer will be responsible for reasonable medical expenses to the Benefit Maximum according to this Section for periodic medical examinations in accordance with the gender of the Insurance and his selection, as specified below:

- Medical history
- Height and weight measurements
- Medical advice and a physiological examination including a prostate examination
- Blood tests, general values including cholesterol level
- Stool tests for concealed blood
- Periodic general gynecological examinations including a

manual breast examination
- Pap smears
- Bone density checks
- Mammography
- Vaccinations if requested in writing by a specialist

7.16 Evacuation in a Medical Emergency

The Insured Event: Emergency transportation by air and/or sea, as a result of the Member's state of health, to a Hospital or to an airfield closest to the Hospital to which the Member is referred or transferred to the Country of Origin at the discretion of the Insurer including any emergency land evacuation that is necessary before the air or sea transport and thereafter. In order to dispel any doubt, it is made clear that the Insurer's obligation pursuant to this Section is only if all the cumulative conditions specified below have been met:

A. The Member is in need of essential medical treatment to save his/her life.

B. The essential medical treatment cannot be administered to the Member in the place he/she is located.

C. Transportation other than emergency evacuation is likely to end in the death of the Member.

D. That stated in the above paragraphs is requested by a specialist and authorized at the discretion of the Insurer.

In order to dispel any doubt, it is made clear that effecting the emergency evacuation is possible only on the track for receiving Medical Service through an In-Network Provider and in no case by means of an Out-of-Network Provider.

7.17 (Not applicable for the Essential plan)

Additional Medical Expenses

Without detracting from that stated in Sections 1-16 above and in addition thereto, the Insurer will cover the Medical Services below through Service Providers:

Artificial limbs, artificial eyes, voice boxes and breast prosthetics (basic functional accessories but not a replacement or repair); acquisition of non-perishable medical equipment that is required, including the following items: basic standard hospital beds and/or basic standard wheel-chair, up to the purchase price and all to the maximum specified in the Table of Benefit Maximums that is attached to the Policy, in accordance with the plan chosen.

Physiotherapy and chiropractic therapy to a maximum of 12 treatments in a calendar year.

Radiation treatment and chemotherapy.

Hemodialysis and hospital charges for processing and giving blood or blood components but not the cost of purchasing them.

Oxygen and other gases. Semi-anesthesia administered to the Member by a physician.

Service for nursing care at the Member's home, immediately after he/she was hospitalized in a hospital by a qualified nurse and according to the medical need as determined by a specialist in the relevant field of medicine, medical treatment service in a medical nursing and/or rehabilitation institution immediately after hospitalization in a hospital, according to the medical need as determined by a specialist in the relevant field of medicine and all to the maximum specified in the Table of Benefit Maximums that is attached to this Policy in accordance with the plan chosen.

Emergency dental treatment and or dental surgery required for dental reconstruction or replacement of stable natural teeth that were lost or damaged in an accident that was covered under this Policy.

Section 8: Family Unification

The Insured Event: Reimbursement of the Member up to the Benefit Maximum for the purchase of a tourist class flight ticket for the Member's first degree relatives (spouse/children/parents/siblings) to fly them to the Country of Destination in the event of a Major Surgery (as defined in Paragraph 1.25 in the Definitions Section) to be undergone by the member in the Country of Origin, 15 days before the date of the major surgery until 30 days after the Major Surgery.

The Member will deliver medical authorization to the Insurer for a medical Specialist as to the Major Surgery that the Member will undergo. Provision of the Service through a Service Provider who has entered into an agreement with the Insurer. In order to dispel any doubt, it is made clear that the provisions of this Section will not apply to the Insured Events are a Previous Medical Condition or that are consistent with the definition of a Previous Medical Condition.

Reimbursement is in accordance with that specified in the Table of Benefit Maximums. It is hereby made clear that the Benefit is for the

cost of flight tickets only and up to the amount that appears in the Table of Benefit Maximums and does not include payment of airport taxes, security taxes, visas, cancellation fines or extensions and other levies beyond the basic cost of the flight ticket.