Passportcard Relocation Global Plan Policy

David Shield Insurance Company Ltd | 2024

PassportCard

DAVID SHIELD INSURANCE COMPANY Ltd.

This Israeli insurance policy was issued by an Israeli insurance company located in the State of Israel and supervised by the Capital Markets, Insurance and Savings Authority – Israeli Ministry of Finance (hereinafter: "Insurance Commissioner").
This insurance policy, and any dispute arising under it, are subject to Israeli law and shall be adjudicated by a competent Israeli court of law only.

Passportcard Relocation Global Policy

Index

Full disclosure of the policy including table of benefits and benefit maximums and limitations.

Please Note:
This document is a free translation of the original Hebrew Policy and is for your convenience only. The binding document is the original Hebrew document approved by the Israeli Commissioner of Insurance. This translation cannot serve as the basis for any actions.

Table of Benefits and Proper Disclosure

Subject	Clause	Terms
General	Plan name	Passportcard Relocation Global Plan
	Policy Holder	As prescribed in the insurance certificate
	Benefits	As prescribed in the table of benefits
	Coverage period	As prescribed in the insurance certificate
	Terms for automatic renewal	None
	Qualification period	None
	Waiting Period	12 months for pregnancy and childbirth 12 months for mental coverage
	Deductibles, co-payments, and co-insurance (hereinafter: "Deductibles")	Based on the type of selected benefits, as prescribed in the table of Deductibles enclosed with the insurance certificate
Amendments of Terms	Amendments of terms during the period of coverage	Subject to the Insurance Commissioner's approval. Any amendment(s) will enter into force 60 days after the insurer has notified the insured member.
Premium	Premium	As prescribed in the insurance certificate
	Premium structure	Changes to the premium are subject to the insured member's age during the insurance period
	Changes to the premium during the insurance period	· During the transition to a new age group · Subject to the Insurance Commissioner's approval The changes shall enter into force 60 days after the insurer has notified the insured member.
Terms of Termination	Termination by the insured member	At any time, subject to three (3) days' notice period.

Terms of Termination	Termination by the insurer	· For unpaid premium, the insurance policy shall terminate as prescribed in the Insurance Contract Law of 1981. · At the end of the insurance period · When the benefits of the insurance policy have been exhausted · The insurer shall be entitled to amend the terms of the insurance policy if future legislation shall prevent it, directly or indirectly, partially or fully, to pay benefits as prescribed in the insurance policy, subject to (1) 60 days' notice to the insured member, and (2) approval of the Insurance Commissioner. · The insurer shall be entitled to terminate this insurance policy if the insured member has resided, for more that 90 consecutive days, in his home country, unless he has received a written approval from the insurer. · If the insured member has breached his obligations under the "Full Disclosure" chapter, and subject to applicable laws.
Exclusions	Exclusion due to pre-existing conditions	Applies and as prescribed in chapter 3 of the insurance policy
	Exclusions and limitations – general	As prescribed in chapter 5.
	Special exclusions (chapter 5) – full exclusion's wording as it appears in the insurance policy	Clause 5.2.10 – treatment for eye vision problems, strabismus, astigmatism, shortsightedness and the adjustment of vision aids.
		Clause 5.2.11 – diagnosis and treatment of hearing loss and adjustment of hearing aids.
		Clause 5.2.13 – orthopedic accessory. Diagnosis and treatment of varicose veins, deformed legs, fatigue, and flat feet (known as pes planus). Treatment via DPM. Clause 5.2.23 – dental treatments. Clause 5.2.24 - temporomandibular joints (TMJ) treatment. Clause 5.2.27 – prosthesis Clause 5.2.29 – viral sexually transmitted diseases

Transplants	Provisions regarding transplant coverage	Prior to compensating an insured member for transplant procedure, the applicable laws shall be examined (the law for organ transplants of 2008), and the following terms shall be established: 1. The organ harvest and transplant are done in compliance with the laws of the jurisdiction in which they take place. 2. The requirements in the law against organ trade are met.

SCOPE OF LIABILITY

The insurer's scope of liability* for all insured events for the period of the insurance policy is USD 5,000,000 unless otherwise is stipulated herein:

Type of Benefit	Insurer's max amount of liability	Waiting Period	Advanced notice to the insurer/comments
Office visit to a family doctor, pediatrician, or a specialist (Chapter 7 sub-chapter 1)	USD 5,000,000	-	Not required
Diagnostical medical test (Chapter 7 sub-chapter 2)		-	Not required
Inpatient (for less and more than 24 hours) (Chapter 7 sub-chapter 3, 5)		-	Required
Medical check-up for babies and children (Chapter 7 sub-chapter 12)		-	Not required
Children's vaccines (Chapter 7 sub-chapter 13)		-	Not required
Medicines (Chapter 7 sub-chapter 9)		-	Not required
Emergency room / Urgent care clinics (Chapter 7 sub-chapter 6, 7)		-	Not required
Chemotherapy and radiation therapy (Chapter 7 sub-chapter 17(c))		-	Not required
Hemodialysis and blood test (Chapter 7 sub-chapter 17(d))		-	Not required
Anesthetics (Chapter 7 sub-chapter 17(f))		-	Not required
Oxygen and other types of air supply (Chapter 7 sub-chapter 17(e))		-	Not required
Periodic physical check-ups for adults (Chapter 7 sub-chapter 15)	USD 500 per calendar year	-	Not required

Pregnancy, childbirth, pregnancy complications, childbirth complications and treatment for pre-term newborns. (Chapter 7 subchapter 10 and 11)	USD 30,000 (cumulative for the entire insurance period)	12 months	Not required
Transplants (Chapter 7 sub-chapter 14)	USD 500,000 (cumulative for the entire insurance period)	-	Yes, at least 72 hours before hospitalization
Organ live donor's medical costs and travel expenses (trips and accommodations) incurred due to the organ donation	USD 5,000 for each insurable event	-	Required
Airborne emergency medical evacuation (Chapter 7 sub-chapter 16)	USD 25,000 For each insurable event	-	Required, the services shall be provided by a vendor with which the insurance company has an agreement, and the insurance company shall order and coordinate all services.
Physical therapy / Chiropractic therapy / Occupational therapy / Speech therapy. (Chapter 7 sub-chapter 17(b))	USD 50 per visit, up to 24 visits per year for each medical event	-	Not required
Mental health (Chapter 7 sub-chapter 4)	USD 10,000 per calendar year USD 20,000 for the entire insurance period	12 months	Not required
Ambulance services (Chapter 7 sub-chapter 8)	USD 2,500 per event	-	No
Durable medical equipment (Chapter 7 sub-chapter 17(a)	USD 5,000 for the entire insurance period	-	As prescribed in sub-chapter 7 for special terms
Nursing services after hospitalization	USD 50,000 for the entire insurance period	-	As prescribed by sub-chapter 7 for special terms
Special benefits	USD 1,000 for the entire insurance period	-	Not required

All benefits in this insurance policy are in the form of reimbursements and provide an additional layer of insurance to the mandatory national coverage, excluding chapter 9 (Welcome Home) which is reimbursements based and provide for an alternative insurance to the mandatory national coverage.

Health insurance include several types of coverages:

- Alternative insurance - private insurance which replaces services granted by the Israeli HMO and/or additional coverage provided by the Israeli Health Maintenance Organizations (HMO). In this insurance benefits will be paid regardless of the rights granted to the insured member in the basic public layers (i.e. from the first dollar).

- Supplemental insurance – private insurance under which insurance benefits are paid to the extent they are not covered by the basic public layer or the national HMO's supplemental insurance (known as AMS - Additional Medical Services).

- Add-on insurance – private insurance that includes services not included in the basic public layer or the national HMO's supplemental insurance. Under this type of insurance benefits are paid from the first dollar.

* Plans sold under the EURO are exchanged to USD as follows: USD 1.315 per EURO.

Deductibles

Deductibles for an insured member for all service covered under the insurance policy outside the territory of the state of Israel is USD 250 for each calendar year.
For insurance policies covering 4 insured members or more, the deductibles are calculated separately but in no case more than USD 1,000 for all insured members for each calendar year.

When medical services are granted in Israel by the "Clalit" HMO, the applicable deductible shall be the customary deductible in "Clalit" in accordance with the national healthcare insurance law.

If the medical services in Israel are provided by a vendor with which the insurer has no agreements with, or by a vendor outside the Clalit HMO, 20% deductible shall apply to services (the insurer shall pay 80% of the services and up to the usual, customary and reasonable rates in the market (UCR).

GENERAL TERMS FOR MEDICAL INSURANCE

In consideration of payment of applicable premium, the insurer shall reimburse the insured member for medical expenses paid for medical services and/or shall pay the medical vendor directly for an insurance event, all as defined and stipulated in the insurance policy, including the special terms chapter and the insurance certificate, for the insurance period, within the scope of the insurer liability in accordance with the insurance policy. Anything stipulated in this policy in male tense is also applicable to females.

CHAPTER 1 – DEFINITIONS

This insurance policy, any certificate as defined below and, in any appendix, attached thereto or connected in any way to this insurance policy, the following terms will be interpreted as follows:

1.1 **"Insurer" –** DavidShield Insurance Company Limited.

1.2 **"Insured" –** A person and/or his/her spouse and/or their children under the age of 18 years old whose names are designated in the Insurance Certificate and the main Insured Member stated in the Insurance Certificate is residing in the Host Country or intends to stay there and who does not hold citizenship of the Host Country.

1.3 **"Policy Owner / Holder" -** A person, a group of people or an association that enters into an insurance contract (Policy) with the Insurer and whose name is stated in the Insurance Certificate as the Policy Owner.

1.4 **"Proposal Form"** – A form that includes the insurance proposal in the wording to be specified by the Insurer when all the details have been completed including a health declaration and waiver of medical confidentiality signed by the Insured Member. A declaration made over the telephone by the Insured Member shall be regarded as a declaration that he has signed on.

1.5 **"Insurance Policy" –** This insurance contract between the Policy Holder and/or the Insured Member and the Insurer including the Proposal Form, the Insurance Certificate, the Tables of Member Cost Sharing and Benefit Maximums, date of inception of the insurance, the amount of the premium and date of payment, etc.

1.6 **"Insurance Certificate" –** The page with the insurance items attached to the Policy including, inter alia, the Policy number, name of the Policy Holder, the name of each Insured, the designated country, the country of origin, date of inception of the insurance, the amount of the premium on the date of joining and the currency in which the Proposal was computed, date of payment, verification form, etc. that form an inseparable part of the Policy.

1.7 **"The "Tables of Member Cost Sharing and Benefit Max" –** Summarized tables that itemize the extent of the insurance cover, the medical services, the total insurance benefits payable, and the Insured's cost sharing including the deductible, covered under the Insurance Policy which is an integral and inseparable part of the Insurance Policy.

1.8 **"Age of the Insured Member" –** The age of the Insured Member is calculated in complete years as the difference between the date of the Insured Member's birth and the date in which his age is to be determined. Six months and more will add a full year to the Insured's age. The Insured Member's age, for the purpose of determining his benefits under the Insurance Policy, in the last year of the insurance period shall be determined by the Insured Member's date of birth.

1.9 **"Insured Event" –** A medical and/or other service provided to the Insured Member following a medical need as specified in each section of this Insurance Policy.

1.10 **"Date of Occurrence of the Insured Event" –** The actual date on which the Insured Member has received the medical and/or other service.

1.11 **"Waiting Period" –** Any period, specified in days or in months, that may be specified in the Sections of this Policy commencing on the date of inception of the Insurance and during which the Insured will not be given the medical treatment within the framework of the insurance cover pursuant to the Policy.

1.12 **"Pre-existing Medical Condition" -** A set of medical conditions diagnosed in the Insured before the date on which he joined the Insurance, including as a result of an illness or an accident. In this matter – "were diagnosed in regard to the Insured" – in a documented medical diagnosis or in a documented medical procedure that was conducted in the six months that preceded the date on which he joined the Insurance.

1.13 **"Restriction on account of a Pre-existing Medical Condition" –** A general classification in the insurance contract that releases the Insurer from liability or reduces the Insurer's liability or the extent of cover, because of an Insured Event that effectively occurred to the Insured during the course of a previous medical condition, and that occurred to the Insured in the period in which the restriction applied.

1.14 **"Country of origin" –** The State of Israel and/or any country of which the main Insured is a citizen that differs from citizenship in the Country of Destination.

1.15 **"Country of destination" –** The country in which the Insured intends to stay, according to his declaration in the Proposal Form, for a period in excess of 90 continuous days or in which he is already staying and, in reliance of such information, the Insurer has agreed to accept him for this Insurance.

1.16 **"Deductible" -** A sum of money as indicated in the Table of Member Cost Sharing that forms part of or the total expenses for an Insured Event, cumulative in any calendar year, that was effectively paid by the Insured and that represents a threshold only in excess of which will the liability of the Insurer be applicable, according to this Policy.

1.17 **"Coinsurance"-** A sum of money or proportion of a sum of money that the Insured will pay for a medical service as prescribed in the Table of Member Cost Sharing, according to the medical service plan selected by the Insured, that will be deducted from the Insurance Benefits, in excess of the Deductible, to the maximum prescribed in the Table of Member Cost Sharing.

1.18 **"Copayment" –** The amount prescribed in those Sections of this Policy that is paid by the Insured in addition to and independently from and with no connection to the Deductible, Coinsurance or the maximum amount of the Insured's expenses.

1.19 **"Medical Expenses" –** Payments for medical services extended to the Insured, as a result of an Insured Event, for essential, suitable and appropriate medical services that are consistent with the specified price levels of similar medical service providers for the same medical services (UCR – Usual, Customary, and Regular).

1.20 **"Premium" –** any payment(s) the Policy Holder and/or the Insured are obligated to pay the Insurer, according to the terms of the Policy.

1.21 **"Surgical Procedure" / "Surgery" –** 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 Insured. Within this context, the following will also be deemed to be 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 ultrasound.

1.22 **"Elective Surgery" –** A surgical procedure for which the need was expected and the admission of the Insured to a hospital for the surgical procedure that was not on the basis of a referral from the emergency room as an urgent event, but on the referral of the Insured for the surgical procedure by an outpatient specialist physician (including the outpatient clinic of the hospital).

1.23 **"Major Surgical Procedure" –** Brain surgery and/or spinal surgery and/or heart surgery and/or other similar procedure that necessitates hospitalization for a period in excess of 96 hours. In this matter, a Caesarian operation that entails hospitalization for a period in excess of 96 hours will not be deemed as a major surgical procedure.

1.24 **"Transplant" –** The surgical amputation or removal from the body of the Insured of a lung, heart, kidney, pancreas, liver and any combination thereof, and the transplant of a whole or part of an organ that was taken from the body of another person in the place thereof or the transplant of bone marrow from another donor in the body of the Insured. Transplant will include also the transplant of an artificial heart at the stage at which the procedure ceases to be defined as experimental in Israel. The transfer of an artificial heart prior to the transplant of a heart from the body of another person, will be deemed as one Insured Event.

1.25 **"Implant" –** Any accessory, natural organ or part of a natural organ, or an artificial organ, artificial or natural joint implanted or assembled in the body of the Insured as a step in and during a surgical procedure that is covered within the framework of the Insurance (for example: a lens, a hip joint, etc.) other than dentures or a dental implant, during a transplant (as specified above in clause 1.25).

1.26 **"Diagnostic Medical Tests" –** A laboratory test (for example: a blood test, discharge examination, cells test, etc.) an x-ray, E.C.G., imaging tests – ultrasound, computerized tomography, magnetic resonance tests (MRI), scanning, PET, and any other test that is required according to the accepted medical criteria for the diagnosis of the Insured's illness or to determine the method of treating it.

1.27 **"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 Israel or overseas, respectively, in the country in which he is engaged in the practice of medicine; but not a DPM and/or therapist or a person who engages in the practice of medicine but does not answer one of the above descriptions.

1.28 **"Specialist Physician" –** A physician in Israel or overseas who has been authorized by the competent authorities of the country in which he practices his profession in a certain field of medicine and holds a license number as a specialist.

1.29 **"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 aim of the hospitalization.

1.30 **"Hospital" –** A medical institution in Israel or overseas that is recognized, by the competent authorities in the country in which it is located, as a public or private hospital.

1.31 **"Medical Institution" –** A medical institution in Israel and/or overseas including a clinic, laboratory, diagnostic centers, pharmacy, etc.

1.32 **"Medical Services" –** A surgical procedure, medical examination, medical treatment, visit to a doctor, hospitalization, provision of medications and similar; all as specified in one of the Sections of this Policy.

1.33 **"Network Provider" –** A physician, hospital, medical institution, pharmacy etc. that has entered into an agreement with the Insurer and the name of who will be indicated from time to time in the list in the possession of the Insurer and that will be revised and publicized, from time to time, by the Insurer.

1.34 **"Non-Network Provider" –** A physician, hospital, medical institution etc. that has not entered into an agreement with the Insurer.

1.35 **The "List of Network Providers" –** A book, booklet, disc, Internet site and/or other magnetic media that contains names of all the Network Providers.

1.36 **"List of Medications" –** A list of medications to be specified from time to time by the Insurer that will be no less than the list of medications approved in the National Health Law, 5754 – 1994 (hereafter: the "Health Law").

1.37 **"Customer Service Center" –** A call center or Internet site of the Insurer, details of which are specified on the Insured's card. The purposes of the service center are to coordinate the service to the Insured with the service provider, for verification of the Insureds' eligibility for the medical service, coordination of pre-authorization of the Insurer, etc.

1.38 **"Israel" –** The State of Israel and/or the territories in Judea, Samaria and the Gaza Strip that are under Israeli control and/or the territories as stated that are under Palestinian control in which Israel has an interest.

1.39 **"Overseas" –** Any country other than Israel.

1.40 **"Currency" –** The type of currency prescribed in the Insurance certificate and other appendices to the policy.

1.41 **"Foreign Currency exchange" –** An amount in Shekels that is the equivalent of the foreign currency at the representative rate published by the Bank of Israel that is known at the date of payment.

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

1.43 **"Insurer's Prior Authorization" –** Authorization granted in writing by a director on behalf of the Insurer and/or DavidShield Life Insurance Agency (2000) Ltd. for the receipt of a medical service and finance thereof, however not an authorization to carry out any specific medical procedures because of the condition of the Insured's illness.

1.44 **"Prescription Drug" –** A medication that cannot be purchased other than with medical authorization from a physician and an official prescription issued by the physician and that cannot be purchased without a prescription.

1.45 **"Co-Pay for a Physician / Medications / Emergency Room / Emergency Centers"** – Co-Pay – a fixed sum of money as appears in the Table of Member Cost Sharing, that is paid for any medical service and/or purchase of medications, for any visit or prescription drug and for each Insured separately that is paid for any medical service and/or purchase of medications, for any visit or prescription drug and for each Insured separately.

CHAPTER 2 – GENERAL CONDITIONS

2.1 The Cover

The Insurer will pay the Service Provider and/or will indemnify or compensate the Insured on the occurrence of an Insured Event for the Medical Services that the Insured received as specified in each one of the Sections of this Policy, all this being subject to the conditions of the Policy and its exclusions.

2.2 The Validity of the Insurance

This Insurance will take effect from the date prescribed in the Schedule subject to the following cumulative conditions.
In order to dispel any doubt, if money has been paid to the Insurer's premium account before the Insurer's consent has been granted as aforesaid, pursuant to the Policy, such payment will not be deemed as the consent of the Insurer to effecting the Insurance pursuant to the Policy.

2.2.1 The applicant for the Insurance has forwarded to the Insurer a standing order to the bank or to a credit card company that has been signed by the applicant for payment of the premium and the first amount was paid for the premium due according to that prescribed in the Schedule.

2.2.2 Adding a family member to the policy, whose name is not specified on the insurance certificate, is contingent on the signing of a health declaration by the Policy Holder or the Insured (as applicable) attributed to the additional family member and with the consent of the Insurer.

2.3 The Insurance Period

Insurance period is as detailed in the policy certificate with regards to any Insured Member.

2.4 Payment of the Premium

2.4.1 The Policy Holder and/or the Insured will pay for each of the Insureds under the Policy, for each month of the Period of Insurance of each Insured, the premium due as prescribed in the Schedule, as adjusted as stated below in clause 2.5. The premium will be paid for each new Insured that may join the Policy and will be determined at the time that he joins the Policy.

2.4.2 The premium will be paid monthly, in advance.

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 account of the Insurer, the date on which the Insurer's account is credited at the bank will be deemed to be the date on which the premium is paid.

2.4.4 A premium paid in arrears will be debited with interest as customary in the insurance company at that time, subject to the Interest and Linkage Law (5721) 1961.

2.4.5 The premium, the insurance benefits and the amounts of the Insurer's liability as specified in the Policy, its Appendices and Schedule will be specified according to the currency and/or linkage to the currency indicated in the policy certificate (as stated in clauses 1.41 and 1.42).

2.5 The Premium

2.5.1 The premium paid for this Policy will be determined according to the age of the Insured on the date on which he joins the Insurance and at the start of each additional year of Insurance according to the age of the Insured at that date, respectively.

2.5.2 In addition to clause 2.5.1 above, the Insurer may change the premium and/or the deductible, coinsurance, and/or copays, yearly, after December 31; subject to confirmation by the Israeli Commissioner of Insurance of receipt of the request for change; and subject to written notice given to all the Insureds 60 days before the date of the change. The above changes will be made for all Insureds in the same group of age, gender, and country of destination.

2.6 Prior Notice

2.6.1 Indemnification of the Insured pursuant to this Policy is contingent on prior notice given on behalf of the Insured to the Service Center as soon as possible before or after the occurrence of the Insured Event.

2.6.1.1 Pregnancy and childbirth – the Insurer will be notified within the first three months of the pregnancy.
2.6.1.2 Hospitalization – the Insurer will be given notice of a minimum of 72 hours before hospitalization and a maximum of 48 hours after emergency hospitalization.
2.6.1.3 Any operation and/or surgical procedures.
2.6.1.4 Any medical treatment in a hospital.
2.6.1.5 Nursing services as detailed in chapter 7, sub-chapter 17.
2.6.1.6 MRI, PET Scan or any other similar imaging test
2.6.1.7 Hospitalization in a hospice.
2.6.1.8 Transplants as detailed in chapter 7, sub-chapter 14.
2.6.1.9 Family unification as detailed in chapter 10.

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 the failure to give prior notice by the Insured when prior notice was required.

2.6.3 In order to receive prior authorization from the Insurer, the Insured will notify the 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 date specified for receipt of the medical service as specified in each one of the Sections of the Policy, respectively.

2.6.4 The provisions of this clause will not apply to an emergency service provided in respect of which the Insured is obligated to give the Insurer notice within 48 hours of the time that the service was provided.

2.6.5 In order to dispel any doubt, any direction given by the Service Center in Israel and/or in the USA and/or anywhere else in the world, 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 aforesaid. 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 Insured's ID Card

2.7.1 Every Insured who is eligible for medical service within the framework of this Policy will receive an ID Card that contains the name of the Insured and his personal details.

2.7.2 The Insured will be asked to present the ID Card in addition to a photo ID that enables him to be identified by any Service Provider.

2.7.3 Compliance with this provision is a pre-condition for 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 ID Card confirms the eligibility of its holder for medical service, it does not necessarily confirm of an in-force Policy of the Insured.

2.8 Receipt of Medical Services

Medical services under the Policy will be provided as specified below:

2.8.1 The Insurer will indemnify the Insured for expenses for medical services effectively provided to the Insured in respect of receipt of a medical service and/or medical services that were submitted for payment by the Service Provider, all this being subject to all the conditions of the Policy, its provisions and exclusions.

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

2.8.2.1 Receipt of a Medical Service by a Network Provider

2.8.2.1.1 The Insured will apply to receive a medical service from a Service Provider whose name is indicated in the List of Network Providers. The insured will pay the deductible, coinsurance, and copays as indicated on the Table of Member Cost Sharing for Network Services. The Insurer will pay the insurance benefits only in excess of the amount effectively paid by the Insured on account of the deductible, coinsurance, and copays.

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

2.8.2.1.3 The total coinsurance paid by the Insured for himself and/or for his family members that are included in the Policy according to his family status, is subject to a coinsurance maximum by calendar year as indicated in the Table of Member Cost Sharing.

2.8.2.2 Receipt of Medical Service through a Non-Network Provider

2.8.2.2.1 The Insured may, at his discretion, apply for receipt of a medical service from a Non-Network Provider, other than in those Sections of this Policy in respect of which it is obligatory to obtain the service through a Network Provider.

2.8.2.2.2 On this track, the applicable deductible, coinsurance, and copays are indicated on the Table of Member Cost Sharing for Non-Network providers and services. The Insurer will pay the insurance benefits only in excess of the amount effectively paid by the Insured on account of the deductible, coinsurance, and copays.

2.8.2.2.3 On this track, the Insured will bear the payments of the coinsurance as specified on the Table of Member Cost Sharing. The total coinsurance paid by the Insured for himself and/or for his family members that are included in the Policy according to his family status, is subject to a coinsurance maximum by 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.

2.8.2.3 In order to avoid 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 cases in which there is no Network Provider defined as a clinic (a single physician or a group of physicians – Chapter 7 - Special Terms, Sub-Chapter 1 of this Policy) within traveling distance of 25 kilometers from the place at which the Insured is located.

2.8.2.3.2 In cases in which there is no Network Provider that is not a clinic (hospital, laboratory, medical center, x-ray, or imaging institutes, etc.- Chapter 7 - Special Terms, Sub-Chapters 2, 3, 4 and 5 of this Policy) within traveling distance of 75 kilometers from the place in which the Insured is located. In the above situations, compliance with the provisions of Paragraph 2.8.2.1 and all its paragraphs is effective.

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

2.8.4 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, the copays, and the special deductibles and subject to the terms of the Policy, its exclusions and exceptions.

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

2.8.6 In order to avoid any doubt, it is made clear that the amounts paid by the Insured and that have accumulated in the matter of the deductible and coinsurance in any calendar year will relate only to that calendar year.

2.9 Medical Examination

Within the framework of clarifying the Insured's claim and the Insurer's liability in respect thereof, the Insured will, if necessary, make himself available for a medical examination by a physician acting on behalf of the Insurer. Provided that the examination is reasonable under the circumstances and at the expense will be covered by the insurer; It is clarified that the Policy Holder may at any time seek to exercise his rights conferred on him by virtue of the Policy in court.

2.10 Delivery of Documents and/or Waiver of Medical Confidentiality
Within the framework of clarifying the Insured's claim and the Insurer's liability in respect thereof, the Insured 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/or Service Giver and to any other body and/or institution to deliver all information that concerns his medical condition to the Insurer.

2.11 Coordination of Medical Treatment
Within the framework of clarifying the Insured'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 Insured'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 Insurer in accordance with the Policy, and on a detailed request having been given in writing to the Insured for the refund of these payments, the Insured 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 pursuance to the Policy.

2.13 Right of Subrogation

2.13.1 If the Insured has a right of indemnity because of an Insured Event against any third party for any reason whatsoever, 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 Insured to collect any indemnity from the third party that exceeds the benefits that the Insured received from the Insurer.

2.13.3 If the Insured receives indemnification 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 has made a settlement, waiver or other action that prejudices the right that he transferred to the Insurer, he 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 insured would not claim indemnification or compensation because of a family relationship.

2.14 Maintaining Continuity of Rights

2.14.1 The Insured will be entitled to continuity of insurance rights so that on his return to Israel for a period that exceeds 90 days, he will be entitled to continuity of alternative insurance cover from the Insurer to the extent of the insurance cover contained in the most comprehensive health policy that the Insurer offers at that time, but not exceeding the insurance cover contained in the basic policy, or in a policy that contains less insurance cover, as selected by the Insured.

2.14.2 Continuity of the Insured's rights will be maintained so that the Insured will not be required to undergo a new procedure to obtain insurance including completion of a health declaration, waiting period and qualifying period. Continuity of rights will be maintained as stated on condition that the Insured notifies the Insurer of his wish for alternative cover no later than 30 days from the date of cancellation of the Policy. The premium for the new insurance cover will be paid in accordance with the terms of acceptance and underwriting as determined by the Insurer as regards the Insured at the date of accepting him for insurance according to the policy.

2.15 Miscellaneous

2.15.1 The Insurer may, from time to time, alter the list of Network Providers.

2.15.2 The Insurer may not alter the conditions of the Policy including the special terms and the benefit maximums other than with the prior consent of the Commissioner of Insurance of the State of Israel. The changes will take effect 60 days after the Insurer notifies all Insureds under the Policy of the changes.

2.16 Jurisdiction

The laws of the State of Israel shall apply to this Policy and to any dispute that is derived from it and jurisdiction is vested exclusively in the competent courts of law in Israel.

2.17 Limitations

The period of limitation for a claim for insurance benefits pursuant to the Policy is 5 years from the date of occurrence of the Insured, and in case of a minor, 5 years after his 18th birthday.

2.18 Taxes and Levies

The Policy Holder or the Insured, as is the case, is obligated to pay all the governmental and other taxes that apply to this Policy or that are imposed on the premium and the insurance benefits and all the other payments that the insurance 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, whether in the State of Israel or in the designated country.

2.19 Status of the Policy Holder

The Policy Holder declares that he is the agent of each separate Insured for purposes of this Policy and that any notice that is sent to him by the Insurer in regard thereto will be deemed to have been delivered by him to each Insured.

2.20 Cancellation of the Policy and Changes in its Conditions

2.20.1 The Insurer may alter the conditions of the Policy if a law is enacted in the future that prevents the Insurer, whether directly or indirectly, whether completely or partially, from indemnifying the Insured in accordance with or as stated in the Policy, upon giving 45 days prior notice.

2.20.2 The Insurer may cancel this Policy if during the period of insurance the Insured stays in the country of origin for a period that is in excess of 90 days, unless the Insured has obtained authorization for a more prolonged stay in advance and in writing from the Insurer; and if the Insured becomes a citizen of the designated country. The Insured will notify the Insurer of a change in his citizenship immediately on receipt of the target citizenship.

2.20.3 If the premium or any part thereof was not paid on the due date and not paid within 15 days after the Insurer has demanded payment thereof in writing from the Insured or the Policy Holder, the Insurer may notify the Policy Holder and/or the Insured in writing that the Policy will be cancelled after another 21 days have elapsed if the amount that is in arrears is not paid beforehand.

2.20.4 The aforesaid will not derogate from the Insurer's right to cancel the Policy according to the provisions of the Policy and/or the provisions of any law.

2.20.5 The Insurer may offset the Insured's debt from payments of the insurance benefits to which the Insured is entitled.

2.20.6 The Insurer may cancel this Policy by virtue of the Insurance Contract Law and for a violation of any duty to disclose (Chapter 4 below).

2.20.7 The Insured may cancel the Policy on giving notice to the Insurer that is to be delivered 3 days before the date of cancellation. In such case, the Insurer will not be obligated to insurance benefits or any liability under the Policy from the date of its cancellation.

2.21 Notices

2.21.1 Any notice from the Insurer to the Policy Holder and/or the Insured 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. The Insured and/or the Policy Holder undertake to notify the Insurer through the Service Center of any change in address and no claim that he makes that any notice did not reach him will be considered if it is sent to the last address of which the Insurer was notified.

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

2.21.3 Any alteration to the Policy, if required, will take effect only after it is included by the Insured in the Policy and/or in an appendix to revise the Policy that is issued by the Insurer.

2.22 Multiple Insurance

2.22.1 The Insurer shall be liable, individually, to the Insured for the full amount of the insurance benefits up to the ceiling set in the Policy, even if the Insured was entitled to cover the expenses paid for an insurance case also under another health insurance policy between that insurer and another insurer.

2.22.2 In policies where insurance benefits are paid in accordance with the amount of damage caused, the insurers will bear the burden of their liability, according to the ratio between the insurance benefits ceilings relating to the insurance case as they are fixed in the insurance policies.

2.23 Policy Owner Statement

2.23.1 The Policy Holder declares and warrants that for the purposes of his policy, he acts faithfully and diligently for the benefit of the insureds alone and that he has no benefit

CHAPTER 3 – WAITING PERIOD CONDITIONS

3.1 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 period specified below. The waiting period for a new Insured that may join the Policy, after its inception, will apply from the date on which he joined this Policy.

3.2 The insurance cover for monitoring pregnancy, pregnancy risks, childbirth, childbirth complications, abortion, diseases emanating from the Insured's pregnancy, treatment of a fetus, treatment of a newborn child during the first 31 days of his life, will take effect only after a waiting period of 12 continuous months from the date of inception of the insurance. (See also Chapter 7 and Sub-Chapter 9 and 10 below and the Tables of Member Cost Sharing and Benefit Maximums as they concern pregnancy and childbirth).

3.3 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 that there is no previous medical history of the above as defined in paragraph 1.12 of Chapter 1. (See also Chapter 7 and Sub-Chapter 4 below and the Tables of Member Cost Sharing and Benefit Maximums as they concern treatment of Mental Health).

3.4 A pre-existing medical condition – subject to the fact that the Insurance Proposal Form has been completed by the Insured as to his state of health before joining the Insurance, it is made clear that a Medical Service for a pre-existing condition, as defined above in paragraph 1.12, will be covered only after a waiting period as defined below:

3.4.1 An Insured who is under the age of 65 on the date of inception of the insurance – the waiting period will be 12 continuous months from the date of inception of the insurance.

3.4.2 An Insured who is aged 65 or over on the date of inception of the insurance – the waiting period will be 6 continuous months from the date of inception of the insurance. (See also Chapter 4 below and the Tables of Member Cost Sharing and Benefit Maximums as they concern a previous medical condition.)

CHAPTER 4 – DUTY OF DISCLOSURE AND PRE-EXISTING CONDITIONS

4.1 Obligation to Disclose

4.1.1 This Policy is issued on the basis of the Insurance Proposal, the notices and declarations delivered in writing and/or over the telephone to the Insurer by the Policy Holder and/or the Insured and they form an inseparable and material part of the Policy. The accuracy and integrity of the above information, answers, notices and declarations are material to the validity of the Policy.

4.1.2 If the Policy Holder and/or the Insured provide answers to material questions that are inaccurate or incomplete, or if facts were not brought to the knowledge of the Insurer that may have influenced the Insurer on whether to accept the Insured for the Insurance or to accept him on the conditions specified in the Policy, the following provisions will apply:

4.1.2.1 If the Insurer is informed before the occurrence of the Insured Event, the Insurer may cancel the Policy on giving written notice to the Policy Holder and/or the Insured 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 Insured acted with the intent to deceive.

4.1.3 If the Insured Event has occurred before the Insurance is cancelled by virtue of this paragraph, the Insurer is obligated only to reduced 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 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 Insured's true condition. In such case, the Policy Holder is entitled to a refund of the premium paid for the period after the occurrence of the Insured Event, after deducting the Insurer's expenses.

4.1.4 In addition to that stated above in paragraph 4.1.3, and in the instances prescribed in paragraphs (a) and (b) above, the Insurer may claim the return of all insurance benefits paid to the Insured for Insured Events during the period from the date of inception of the Insurance until the date of cancellation of the Policy.

4.2 Pre-Existing 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 pre-existing medical condition (1.12 in the Definitions Section).

4.2.2 Exclusion of any prior medical condition as regards an Insured whose age upon the date of inception of the insurance is:

1. Under 65 – will be valid for a period that does not exceed one year from the date of inception of the insurance.

2. 65 or over – will be valid for a period that does not exceed six months from the date of inception of the insurance.

4.2.3 If the Insured was asked at the time of his acceptance for insurance, on making the declaration of health, as to a certain health condition that is included in the definition of a pre-existing medical condition as defined above, the Insured will disclose in the declaration of health, whatever he was asked. If the Insured is asked about a previous medical condition and did not disclose facts about his condition to the Insurer, the legal provisions as to the rules of disclosure will apply to the Insurance.

4.2.4 If the Insured notifies the Insurer of a specific medical condition, the Insurer may limit his liability and/or the extent of cover because of a specific medical condition and this restriction will take effect for the period recorded in the “Schedule” alongside that specific health condition.

CHAPTER 5 - EXCLUSIONS AND RESTRICTIONS TO THE POLICY

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 Insured and/or a third party may suffer as a result of the Insured's selection of and/or referral by the Insurer to a physician, a family physician, a specialist, a surgeon, an anesthetist, a hospital or any other Network or Non-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 either directly and/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 act 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 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 state of siege, boycott all subject to the following terms:

A. The Insured, taking a risk, enters a place and / or area known to be fighting or revolting.

B. The Insured is an active partner in fighting or insurgency.

C. The Insured ignored the risk at first, clearly knowing that he was endangering himself.

5.1.2.2 The accidents specified below, if the Insured is obligated to purchase insurance cover for the events specified below according to the law of the designated country and/or the country in which the accident occurred and/or if he was obligated to obtain cover or purchase it according to the law of the designated country and/or if the Insured 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 as meant by the Compensation for Victims of Road Accidents Law, 1975 or any other law that may replace it.

5.1.2.2.2 A work accident as meant by the National Insurance (Integrated Version) Law, 1995 or any other law that may replace it.

5.1.2.2.3 Hostile acts as meant by the Victims of Hostile Acts (Pensions) Law, 5730 – 1970 or any other law that may replace it.

5.1.2.2.4 An accident during the Insured's military service including service in the reserves.

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 Insured was of sane mind or not.

5.1.5 Any exposure whatsoever to ionizing radiation, radioactive pollution, nuclear processes, military nuclear matter or any nuclear waste whatsoever or any chemical substance whatsoever subject to the following terms:

A. The insured, taking a risk, enters a place and / or area known to be fighting or revolting.

B. The insured is an active partner in fighting or insurgency.

C. The insured ignored the risk at first, clearly knowing that he was endangering himself.

5.1.6 An induced abortion and its results if the abortion was carried out for mental reasons and/or reasons of social welfare and/or social and/or economic reasons and/or reasons of family planning.

5.1.7 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 Insured received any compensation whatsoever.

5.1.8 Without derogating from the general nature of that stated in paragraphs 5.1.2.1 and 5.1.2.2, an accident and/or an injury and/or a wound as a result of parachuting, gliding, diving, sky-diving, use of surf-gliders, or surfboards, 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 permitted and marked sites and routes and any extreme sport in which the Insured puts himself at risk in any significant manner.

5.1.9 An accident at sea, in a vehicle or in the air for which the expenses for the Medical Service are applicable to the party responsible for the injury and/or another insurer.

5.2 Special Exclusions
The Insurer will not pay insurance benefits for an Insured Event that is connected either directly and/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 in the designated country, or that are undergoing a trial, investigation or examination but that have not come into regular use at the date on 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 that was not arranged by a physician.

5.2.4 Treatment carried out by a person who is not a member of the staff of a hospital and/or clinic.

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

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

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

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

5.2.9 Medical service carried out or given by a close relative of the Insured other than with the prior consent of the Insurer in writing.

5.2.10 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 intersection of the cornea if the main purpose is to correct myopia, long-sightedness or astigmatism.

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

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

5.2.13 Medical treatment and medical accessories as specified below: orthopedic shoes, orthopedic aids prescribed by a physician that are meant to be attached or placed inside shoes (such as insoles, heel lifts), treatment for the feet and weak feet, deformities of the feet and flat feet (pes planus), instability or lack of balance and treatment for 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).

5.2.14 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 medical treatment that causes loss of hair (for example, chemotherapy) for which cover is provided by the Insurer within the framework of this Policy.

5.2.15 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 the diagnosis of illness or for the diagnosis of sleep disturbances.

5.2.16 Exercise programs whether prescribed or recommended by a physician or not.

5.2.17 Costs of travel or accommodation, other than expenses for transportation by a local ambulance that ends in hospitalization, emergency evacuation and benefits provided within the framework of implants.

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

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

5.2.20 Adjustment of the body shape for the improvement of a person's psychological, mental or emotional well-being, for example a sex reassignment operation.

5.2.21 Treatment or surgery for cosmetic or esthetic purposes such as a nose operation, an operation for a breast increase / decrease, scar removal.

5.2.22 Any medication or treatment that encourages or prevents pregnancy, including an abortion for socio-economic reasons, use of pills to prevent pregnancy, artificial fertilization, fertilization treatment and/or impotency and/or sterilization and/or a procedure to reverse sterilization.
Any medication or procedure whether it increases, improves impotency or impaired sexual functioning.

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

5.2.24 Temporomandibular treatment (TMJ).

5.2.25 A circumcision other than for medical reasons.

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

5.2.27 Artificial or mechanical implantations that are intended as temporary or permanent replacements of human organs.

5.2.28 Expenses for keeping a donor alive for a transplant procedure whether the transplant procedure is covered or not.

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

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

5.2.31 Treatment of the Insured for the exacerbation of a medical condition that from the start was covered under this Policy in respect of which the Insured was required to act according to the instructions of his physician but he did not obey the instructions of his physician, for example, taking essential medication, follow-up examinations and preventive treatment.

5.2.32 Vaccinations and treatments for immigration proposes

5.2.33 Receipt of medical services at the home of the Insured or outside a medical institution (other than an emergency or nursing service) without the prior consent in writing of the Insurer.

CHAPTER 6 – LIMITS OF LIABILITY OF THE INSURER

6.1 The limits of the Insurer's liability according to the Policy to each of the Insureds is up to the maximum sum prescribed in the Table of Benefit Maximums that is attached to this Policy.

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 Insureds, throughout the period of insurance, is up to the maximum sum prescribed in the Table of Benefit Maximums.

6.3 The limits of the Insurer's liability for each of the Medical Services covered by this Policy is in accordance with the medical expenses as stated above in paragraph 1.19 but no more that the limit of the Insurer's liability for the total of each of the Medical Services.

6.4 The Tables of Benefit Maximums and Member Cost Sharing that are attached as an inseparable part of this Policy should be studied.

SECTION 7 – SPECIAL CONDITIONS – MANNER OF RECEIPT OF THE SERVICES

Without derogating from the general nature of that stated in Chapters 1- 6 and in addition thereto, the Insurer will indemnify the Insured for medical expenses for Medical Services and/or will pay the Provider directly up to the maximum of the Limits of the Insurer's Liability for Insured Events as follows:

Wherever the $ 5,000,000 general policy ceiling is mentioned, the cumulative ceiling is for all insurance cases for the entire term of the insurance. Where there is a reduced ceiling, the reduced ceiling will apply and not the general policy ceiling.

Sub-Chapter 1 – Visit to a Family Physician, a Pediatrician, a Specialist
The insurer's liability limit: The general policy ceiling - up to $ 5,000,000
The Insured Event: – A visit by the Insured to a family physician and/or a pediatrician and/or a specialist or any physician as defined in paragraph 1.28 of this Policy, for the purposes of a diagnosis and/or advice and/or treatment regarding the Insured's state of health.

Sub-Chapter 2 – Diagnostic Medical Tests
The insurer's liability limit: The general policy ceiling - up to $ 5,000,000
The Insured Event: - A visit by the Insured and/or sending a specimen to a laboratory or a visit by the Insured to x-ray or imaging institutions for purposes of diagnosis or treatment that derives from the Insured's state of health. Diagnostic medical tests define in chapter 1.27

Sub-Chapter 3 – Medical Hospitalization
The insurer's liability limit: The general policy ceiling - up to $ 5,000,000
The Insured Event: – Hospitalization of the Insured 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 Insured's state of health, including the surgeon's fee, the anesthetist's fee, operating room expenses, and/or for childbirth including post-natal 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, a nurse and auxiliary nurse but does not include telephone, a television and other ancillary services that are not involved in the medical treatment.

Sub-Chapter 4 – Mental Disorders and Psychiatric Hospitalization
Insurer Liability Limit: Up to $ 10,000 per calendar year; Up to $ 20,000 per insurance period.

Waiting period of 12 months from the policy start date.
The Insured Event: - Medical treatment and medication for the Insured's state of health that derives from mental disorders that were diagnosed in the Insured by a specialist.
Diagnosis and treatment of ADD or ADHD up to age 16, including medication subject to the terms in chapter 9 below.
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 appear in the Table of Benefit Maximums that is attached to this Policy. (See also Part 3 and Section 6 above).

Sub-Chapter 5 – Day Hospitalization
The insurer's liability limit: The general policy ceiling - up to $ 5,000,000
The Insured Event: - The daytime hospitalization of the Insured 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 derives from the Insured's state of health, that does not require hospitalization in a hospital and/or an intensive care unit.

Sub-Chapter 6 – Emergency Room (without Hospitalization)
The insurer's liability limit: The general policy ceiling - up to $ 5,000,000
The Insured Event: - Receipt of a diagnostic service and treatment that derives from the Insured's state of health in an emergency room of a hospital solely as a result of an emergency that does not allow the treatment to be delayed until visit is made first to a family physician or to a specialist.

Sub-Chapter 7 – Emergency Clinics
The insurer's liability limit: The general policy ceiling - up to $ 5,000,000
The Insured Event: - Receipt of a diagnostic service and treatment that derives from the Insured'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).

Sub-Chapter 8 – Transportation by Ambulance
The insurer's liability limit: up to $ 2,500 per insurance event
The Insured Event: - Transportation of the Insured by ambulance to an emergency room and/or between a hospital in which the Insured is hospitalized and another hospital as a result of medical circumstances that derive from the Insured's state of health that do not allow the Insured to reach the emergency room by any means of transport other 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 and/or an operation of the Insured following the time of his arrival by ambulance to the emergency room.

Sub-Chapter 9 – Purchase of Medication

The insurer's liability limit: The general policy ceiling - up to $ 5,000,000

The Insured Event: - The actual purchase of a prescription drug that is approved by the competent authorities in the designated country for use of the Insured, in order to treat the Insured's state of health as diagnosed by a specialist and as approved for use by the aforesaid.

The insurance cover will be provided for a prescription drug in accordance with the formulary list of medications that the Insurer will issue from time to time. The Insurer has the right to change the list of medications at the discretion of the Insurer, and on condition that the list of medications (whether generic or brand name) will not be less than the list of medications that is provided within the framework of the State Health Insurance Law as adopted in the State of Israel.

Financing the use of medication will apply to the Insurer after the Insured has reached the annual deductible as specified in the Table of Member Cost Sharing and subject to the copays of the Insured for each 30 day supply at the rates specified in the Table of Member Cost Sharing that is attached to this Policy.

Chronic prescription drugs will be supplied for a period of up to 90 continuous days for each prescription by means of a Network Supplier only and the copay/coinsurance will be charged for every 30 days' supply.

The Insured may purchase a medication that is non-formulary providing that it is purchased through a Network Provider. In this case the Insured will bear the copay/coinsurance at the rate prescribed in the Table of Member Cost Sharing that is attached to this Policy.

If the Insured has asked to purchase a medication that has a brand name, when a generic medication is available, the Insured will bear – in addition to his copay/coinsurance – the difference in cost between the two medications.

In order to avoid 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 in the designated country.

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 avoid 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.

Sub-Chapter 10 – Pregnancy and Childbirth
Insurer Liability Limit: Up to $ 30,000 cumulative limit for all insurance events in this subchapter and for the entire insurance period Waiting period of 12 months from the policy start date.
The Insured Event: - A normal state of pregnancy of the Insured including monitoring the pregnancy on the recommendation of a gynecological specialist, childbirth and treatment of the mother and child during the hospitalization after the birth, including treatment of the newborn child from the moment of his birth for the first 31 days of his life, routine post-natal medical monitoring of the mother.

In this matter "a normal state of pregnancy" – the course of the pregnancy until childbirth for which no medical intervention is required beyond the routine monitoring checks according to the accepted criteria in the designated country or country of origin, including a healthy child born of a vaginal delivery (including forceps delivery 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 this Policy.

Please study Sections 3 and 6 above.

Sub Section 11 – Complications of Pregnancy and Childbirth and Treatment of the Newborn Child Insurer Liability Limit: Up to $ 30,000 cumulative limit for all insurance cases in this subchapter and subchapter 10 above, and for the entire insurance period Waiting period of 12 months from the policy start date.

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 within the framework of the cover given to the insured mother, for which additional medical intervention is required beyond a standard delivery process as mentioned above (Sub-Chapter 10), including illnesses and/or defects that have their origins in the Insured and/or in the fetus and/or in the newborn child as a result of an abnormal pregnancy; post-natal medical monitoring of the mother, diagnosis and treatment of post-natal problems of the mother, diagnosis and monitoring of any medical problems of the newborn child for the first 31 days of his life, all within the framework of the cover provided to the insred 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 this Policy.

Sub-Chapter 12 - Routine Care of Baby and Child
The insurer's liability limit: The general policy ceiling - up to $ 5,000,000

The Insured Event: - General physical examinations, functional assessment, development checks, and receipt of recommendations regarding the need for diagnostic examinations and inoculations for the baby and the child, on the condition that at the time of the tests specified above, the patient examined was insured under the Policy.

Sub-Chapter 13 - Vaccinations
The insurer's liability limit: The general policy ceiling - up to $ 5,000,000

The Insured Event: Vaccinations of the baby and child from the date of his birth until the age of 16 (inclusive) to the extent customary in the designated country and subject to the instructions of a physician.

Inoculation of an adult of the age of 17 and above will be covered within the framework of this Policy at the request of a specialist and in any case within the framework of periodic check-ups and exclusions of the Policy (Sub-Chapter 15 below and paragraph 5.2.36 above).

Sub-Chapter 14 – Transplants
The insurer's liability limit: - up to $ 500,000 for transplants
Up to $5,000 for live donor
The Insured Event: A transplant carried out as described in Paragraph 1.25 above, including the medical expenses involved therein as specified in this Section.

The Insurer will pay the Service Provider expenses for a transplant up to the 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 acquiring and harvesting the organ in 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 this Policy.

All the aforesaid will be carried out only through 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 this Policy.
Before granting indemnity or compensation for a transplant, the insurer shall examine whether the transplant has been performed in accordance with the provisions of the Transplantation Law, including any of the following: 1) Taking the organ and transplanting it is done in accordance with the law applicable in that state; 2) The provisions of the law regarding the prohibition of organ trafficking are complied with.

Sub-Chapter 15 – Periodic Medical Examinations (Wellness)
The insurer's liability limit: - up to $ 500 per calendar year
The Insured Event: - A periodic medical examination of the Insured 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 in accordance with the gender of the Insured, 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.

Sub-Chapter 16 – Evacuation in a Medical Emergency
The insurer's liability limit: - up to $ 25,000 per event
The Insured Event: - Emergency transportation by air and/or sea, as a result of the Insured's state of health, to a hospital or to an airfield closest to the hospital to which the Insured is referred or transferred or to the country of origin at the discretion of the Insurer including any emergency overland evacuation that is necessary before the air or sea transportation 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 Insured is in need of essential medical treatment to save his life.
b. The essential medical treatment cannot be administered to the Insured in the place in which he is located.
c. Transportation other than emergency evacuation is likely to end in the death of the Insured.
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 a Network Provider and in no case by means of a Non-Network Provider.

Sub-Chapter 17 – Additional Medical Expenses.
Without derogating from that stated in Chapters 1 – 14 above and in addition thereto, the Insurer will cover the Medical Services below through Service Providers:

a. Artificial limbs, artificial eyes, voice boxes and breast prosthetics – basic functional accessories but not a replacement or repair; hiring 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 this Policy.
The insurer's liability limit: - up to $ 5,000

b. Physiotherapy and chiropractic therapy to a maximum of 24 treatments in a calendar year; The insurer's liability limit: - up to $ 50 per treatment

c. Radiation treatment and chemotherapy.
The insurer's liability limit: The general policy ceiling - up to $ 5,000,000

d. Hemodialysis and hospital charges for processing and giving blood or blood components, but not the cost of purchasing them;
The insurer's liability limit: The general policy ceiling - up to $ 5,000,000

e. Oxygen and other medical air supply.
The insurer's liability limit: The general policy ceiling - up to $ 5,000,000

f. Semi-anesthesia administered to the Insured by a physician.
The insurer's liability limit: The general policy ceiling - up to $ 5,000,000

g. Service for nursing care at the Insured's home, immediately after he 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
The insurer's liability limit: - up to $ 50,000

h. 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.
The insurer's liability limit: The general policy ceiling - up to $ 5,000,000

CHAPTER 8 - EXTENSION OF THE POLICY PERIOD

8.1 Introduction

This chapter guarantees, for no additional premium, and subject to the payment threshold of insurance benefits in the amount specified in the Table of Member Cost Sharing that is attached to this Policy, continuity of insurance cover for the Insured under the policy (hereafter: the "Base Policy") for which the prescribed period of insurance has expired or who has become a citizen of the designated country during the period of insurance, subject to the conditions and provisions listed below.

8.2 The Insured Event

A Medical Service and/or other service granted to the Insured following a medical need, as specified in each Section of the Base Policy commencing on the expiry of the period of insurance or on the date on which the Insured became a citizen of the designated country and subject to complying with the conditions and provisions prescribed in paragraph 3 below.

8.3 The Insurer's Liability

8.3.1 Subject to the threshold for additional insurance benefits in the total prescribed in the Table of Member Cost Sharing that is attached to this Policy, commencing from the expiry of the period of insurance in policies that contain a limited period of insurance as specified in the Schedule and/or commencing from the date on which the Insured becomes a citizen of the designated country, the Insurer will continue to bear liability for the Insured Events that are effectively created and/or that occurred during the period of insurance, this being for a period of 12 continuous months (hereafter: the "Extended Period").

8.3.2 This Section will remain in force throughout the Extended Period subject to compliance with all the following cumulative terms:

8.3.2.1 The Insured has purchased another medical insurance policy from another insurer (hereafter: the "New Policy").

8.3.2.2 The insurance cover in the New Policy includes cover for hospitalization, medications and physicians' visits.

8.3.2.3 A waiting period for receipt of service for an Insured Event that occurred during the period of the Base Policy was specified in the New Policy.

8.3.2.4 The period of insurance specified in the Base Policy has expired and has not been renewed by the Insurer.

8.3.3 In order to avoid any doubt, it is hereby made clear that the Insurer's liability throughout the Extended Period will be for medical service that is contained in the
New Policy for which a waiting period was determined, and not beyond the extent of the cover in the Base Policy.

8.4. General

8.4.1. In the event of a discrepancy between the provisions of this Appendix and the provisions of the Base Policy, the provisions of this Section will take precedence.

8.4.2 There is no change in the other provisions of the Base Policy.

CHAPTER 9 – WELCOME HOME

Additional cover for expenses for medical services in Israel as defined in the State health basket and that will be provided by the Health Fund and its suppliers only for the waiting period.

9.1. Introduction

This Section guarantees the Insured under the policy (hereafter: the "Base Policy") insurance cover for Medical Services and/or other services that are included in the Health Law that will be granted to the Insured following a medical need after his return to the State of Israel other than for purposes of a visit, for the waiting period specified in the Law, according to which he is not eligible for receipt of the Medical Service from the sick fund of which he is a member. All the aforesaid is subject to the conditions and provisions specified below.

9.2. Definitions

9.2.1 **The "Health Law" –** the State Health Law, 1994 and the regulations that were published or that will be published by virtue thereof.

9.2.2 **The "NH Law" –** the National Health (Integrated Version) Law, 1955 and the regulations that were published or that will be published by virtue thereof.

9.2.3 **"Eligibility for Service" –** the eligibility of the Insured to receive all the Medical Services including in the Health Law according to the type of cover contained in the Base Policy.

9.2.4 **The "Waiting Period" –** the period of time prescribed or that may be prescribed in the Health Law and/or the NH Law, during which in accordance with the provisions of the aforesaid laws, the Insured will not be eligible for service at the time of his return to Israel, after a stay outside the boundaries of the State of Israel. In order to dispel any doubt, it is made clear that the Waiting Period according to the provisions of this Appendix will not extend beyond 24 continuous months from the determinate date.

9.2.5 "**Service Provider" –** Clalit Health Services and/or other Service Provider that has an agreement with the Insurer, as published by the Insurer.

9.2.6 **The "Determinate Date" –** The date of the Policy Holder and/or the Insured's return to Israel for a stay that is in excess of 90 days.

9.3. The Insured Event

A Medical Service and/or other service that is included in the eligibility for service that is granted to the Insured following a medical need, during the Waiting Period subject to fulfillment of the conditions and provisions specified in paragraph 5 below.

9.4. The Insurer's Liability

9.4.1 Commencing on the determinate date and subject to the fulfillment of the provisions and conditions specified in paragraph 5 below, the Insured will be eligible for receipt of the Medical Service included in the eligibility for service by the Service Provider during the Waiting Period.

9.4.2 The Insurer will pay the Service Provider on the occurrence of an Insured Event for the Insured's expenses for the medical services included in the eligibility for the service.

9.4.3 In order to dispel any doubt, the Insurer's liability will apply only for the service included in the State health basket as defined in the Health Law and not beyond the cover included in the Base Policy.

9.5. Conditions of the Insurance

9.5.1 The Policy Holder and/or the Insured will inform the Insurer of his wish to operate the insurance cover included in this Section within 30 days of the determinate date.

9.5.2 Grant of eligibility as defined in this Insurance will replace the insurance cover contained in the Special Conditions Section in the Base Insurance.

9.5.3 The provisions of the General Conditions in the Base Insurance will apply in full also in regard to eligibility for service.

9.5.4 The Policy Holder and/or the Insured will inform the National Insurance Institute of his return to Israel other than for purpose of a visit and will arrange his payments to the Institute within 30 days of the determinate date. In order to dispel any doubt, it is made clear that the existence of this additional insurance does not exempt the Policy Holder and/or the Insured from paying the premiums for national insurance and/or state health tax that exist in their regard.

9.5.5 The Policy Holder and/or the Insured will be eligible for this additional insurance cover only if they have paid the premiums specified in the Base Policy for 12 continuous months before the determinate date.

9.6. Cancellation of the Additional Insurance

This additional insurance will expire on the occurrence of any of the following events, whichever is the earlier:

9.6.1. The Policy Holder and/or the Insured returns to Israel before payment of the premium in respect of this Appendix for a period of 12 continuous months before the determinate date.

9.6.2 If the Insured cancels the additional insurance stated aforesaid in paragraph 7.1, the premiums for the additional insurance will be refunded to the Insured after deducting the Insurer's expenses.

9.6.3 The legally specified waiting period has expired.

9.6.4 When the Base Policy is cancelled for any reason whatsoever.

9.7 General

9.7.1 In any instance in which this additional insurance is added to the Base Policy, at any time whatsoever, after the date of inception of the Base Policy, this additional insurance will take effect on the date of its addition to the Base Policy and subject to the general conditions of the Base Policy.

9.7.2 The date of inception of the insurance, as regards this additional insurance, will be deemed to be the date on which the Insured is accepted for this additional insurance by the Insurer as indicated in the Schedule.

9.7.3 In any instance of a discrepancy between the provisions of this Appendix and the provisions of the Base Policy, the provisions of this Appendix will take precedence.

9.7.4 Any reference to the Insured in the male gender will imply also the female within the context of this Policy.

CHAPTER 10 – SPECIAL BENEFITS

Sub-Chapter 1 – Family Unification

The Insured Event: - Indemnification of the Insured up to the Benefit Maximum for the purchase of a tourist class flight ticket for members of the Insured's Family who are first degree relations (spouse/ children of the Insured/ parents/ siblings) to fly them to the designated country in the event of major surgery (as defined in paragraph
1.23 in the Definitions Section) to be undergone by the Insured in the designated country, 15 days before the date of the major surgery until 30 days after the major surgery.

The Insured will deliver medical authorization to the Insurer from a medical specialist as to the major surgery that the Insured will undergo in the designated country.

Provision of the Service is through a Service Provider who has entered into an agreement with the Insurer.

In order to avoid any doubt, it is made clear that the provisions of this Section will not apply to Insured Events that are a previous medical condition or that are consistent with the definition of a pre-existing medical condition.

The insurer's liability limit: up to $ 1,000

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.