Set of Rules for Inquiring and Settling Claims DavidShield Medical Insurance Policy

October 2017

The set of rules specified below is intended to present the manner of handling and settling medical claims filed to our company as well as to update you on your rights when filing a medical claim.

The set of rules are according to the instructions of the Commissioner of Insurance in the State of Israel.

1. Definitions

Commissioner's circular
circular number 5-9-2011 issued by the Commissioner of Insurance, Capital Market Division at the Ministry of Finance, dealing with the provisions specified below on handling medical claims.

Appeal
appeal by an insured to DavidShield regarding the manner of filing a medical claim or receiving information about the procedures for handling medical claims.

Claim/medical claim
a demand submitted to the DavidShield Company for reimbursement of medical expenses and realizing the insured's rights according to the policy's terms or the provisions of the law, submitted after the 1st of June, 2011.

Claim form
a document on behalf of DavidShield used for specifying the insurance event, circumstances and other details that DavidShield requires in order to inquire a medical claim.

Insurance policy
a medical insurance policy issued by DavidShield through Phoenix Insurance Company Ltd and accordingly purchased by the insured.

Insured
as defined in the insurance policy.

2. Procedures for inquiring and settling medical claims

A. Appeal by the insured regarding filing a claim:
An insured who contacts DavidShield regarding the manner of filing a claim will receive the following details/documents:

1. A verbal explanation about filing a claim and if he or she contacted DavidShield using another communication channel - a general explanation according to the channel used (email, Facebook, internet website etc).
2. The set of rules and procedures for inquiring and settling claims in this document or a link to the location on the internet website for reviewing this document will be sent to the insured according to his or her choice.
3. A form for filing a claim will be sent to the insured or the insured will be referred to the suitable location on the internet website for downloading a claim form.
4. The insured will be guided to review the paragraph discussing the period of limitation for filing a medical claim and will be referred to the relevant location on the internet website.
5. The insured will receive a specification of all the information and documents required for the claim (a claim form that has also been filled in by a doctor, receipts for payments made and any detail

necessary in order to inquire the insured's claim).

B. An insured sent a medical claim (after an initial appeal as said or no appeal at all)

1. Once the medical claim is received, the details of the claim will be entered in the system and as early as possible, the insured will receive a letter or notice that includes at least the following details:
   a. A letter specifying the set of rules for inquiring and settling a claim (this letter) or a referral to the suitable location on the internet website.
   b. Complete details of the received claim, including dates of receiving the claim, date of the medical service, name of medical service provider, details of the insured and any other information mentioned in the claim documents sent by the insured.
   c. Details of all the documents received (for example: claim form, receipt from a medical provider and details thereof, medical summary etc).
   d. If any information or documents are missing, the insured will receive complete specification of the missing information and documents that are needed in order to continue inquiring the claim.
   e. Notice of the period of limitation or referral through a link to the suitable location on the internet website.
2. If a claim was received in which the insured is not required to submit additional details and the claim is approved for payment, the documents mentioned in sections 1 (b)-(d) above will not be sent to the insured and a detailed notice of payment will be sent to the insured accordingly.
3. If a claim was received in which the insured is not required to submit additional details and the claim was rejected, the insured will receive notice of the rejection according to the provisions specified below regarding notice of rejecting a claim.

C. A claim with missing documents

1. If an insured sent a claim and DavidShield discovered that additional documents beyond those required in section b (1) (d) are missing, DavidShield will send the insured a request to supplement the missing documents with full specification of the missing documents, within 14 days from receiving the claim.
2. A notice of the limitation period will be attached to the request.
3. If the insured did not respond to the initial notice regarding the missing documents, another notice will be sent after 60 days. If the insured also failed to respond to the second notice, another notice will be sent after an additional 60 days.
4. If an insured did not respond to both notices regarding missing documents sent to him or her as said in section 3, DavidShield is entitled to stop sending additional notices provided that the second notice mentioned that it is the last notice.
5. If the insured approached the legal instances regarding the claim, sending notices for inquiring and demands for additional documents can be stopped.
6. If all documents needed in order to inquire a claim were received, the insured must be informed of the results of processing the claim within 30 days from the date of receiving all the documents.

D. Notice of continuing inquires

1. If the insurer needs to perform further inquiries regarding a certain claim, the insurer will give the insured a detailed, written notice indicating the reasons for needing the additional inquiry.
2. If the further inquiry requires additional documents (from the insured or a third party), the information needed must be specified in the notice as said in section d' 1.

E. Notice of payment of a claim

1. If it was decided to pay or partially pay a claim, suitable notice will be forwarded to the insured, which includes all the payment components and at least, the original amount of claim, amount approved for payment, details of deductible, deductions for coverage limits or UCR and manner of calculation.
   a. In a partial payment notice (part of the claim will be paid and part is rejected):
      1. For the paid part, proceed according to section e' (1).
      2. For the non paid part, issue a detailed notice of rejecting payment according to the following provisions regarding rejection of a claim.
   b. Every notice will include a paragraph specifying the insured's possibilities of appealing through the insurance company (such as an appeal to the Claims Department Director, Medical Manager and Public Complaints Representative) and the insured's right to appeal through external agents (appealing to the legal instances, the Ombudsman at the ministry

supervising insurance).

F. Notice of rejecting a claim

1. If it was decided to reject a claim, DavidShield will issue a detailed letter to the insured that includes all the reasons for rejecting the claim, including the relevant policy terms (including individual underwriting terms), the provisions of the law on which the rejection was based and any other argument justifying the rejection of the claim.
2. Additional reasons can be raised only if the initial rejection notice is based on claims of limitation or lack of validity of the policy. Furthermore, additional reasons can be raised if it becomes clear that the insurance company or DavidShield did not know or should have known of such reasons at the time of sending the initial notice.
3. Every notice will include a paragraph specifying the insured's possibilities of appealing through the insurance company (such as an appeal to the Claims Department Director, Medical Director and Public Complaints Representative) and the insured's right to appeal through external agents (appealing to the legal instances, the Ombudsman at the ministry supervising insurance).

G. Notice of compromise or ex-gratia payment

If it was decided to pay a claim as part of a compromise, the following details will be forwarded to the insured:

1. The suggested compromise offer in writing and the insured will be given reasonable time to review the offer (14 days).
2. A compromise offer will include at least all the following details: a description of the insurance event, reasons justifying the compromise, components of payments that are not disputable if any and the amount determined for the compromise.
3. A compromise will only be approved after the insured confirms it in writing.
4. Ex-gratia payment does not require the insured's approval, but is a legal payment of a compromise nature.
5. If a compromise was approved and notice of payment is issued - proceed according to the rules of section (e) regarding payment of a claim.

H. Notice of limitation of the claim

1. Notice regarding limitation of a claim will be attached according to the rules mentioned above in any document that so requires.
2. Every notice sent to the insured during the last year before the date of limitation of a certain claim, will include details of the claim that is about to be limited (even if the notice is not connected to this claim) and will include details regarding the claim such as: date of occurrence of the insurance event and date of limitation.
3. Notice as said in section 2 will include a paragraph indicating that the limitation race began on the date of occurrence of the insurance event.
4. If a limitation notice was not sent as said in sections h' 2 and h' 3 above, the period in which the notices were not sent will not be counted for purpose of the limitation but rather from the moment of fulfilling the terms mentioned in sections h' 2 and h' 3 and only during the last year for the limitation.

I. Inquiring a claim through an expert

1. If DavidShield found that in order to settle a claim its needs the assistance of a relevant expert, it will inform the insured about using an expert and if necessary it will inform the insured of his or her rights and allow the insured to seek an expert's opinion on his or her behalf.
2. Using a legal advisor or investigator investigating details regarding the claim are not considered experts and notice to the insured as said is not required.
3. An expert can be an external expert or an employee of DavidShield or the insurance company.
4. The expert's activity can be based on existing information or a personal meeting with the insured, all according to circumstances.
5. An expert's opinion will be explained and will include relevant details about the expert, including his or her profession, education etc.
6. If a decision regarding a claim was based on an expert's opinion, the insured will receive, together with the decision, the expert's opinion and details of all documents on which the expert relied.
7. A confidential opinion will not be submitted to an insured, but rather DavidShield or the insurance company must submit a letter to the insured specifying why confidentiality applies to the opinion of an expert on their behalf.

J. Subrogation and third party rights

1. If DavidShield decided to sue a third part as part of subrogation, a letter specifying DavidShield's intentions including all details of the claim and third

party defendants must be sent to the insured.
2. Once a decision is made in subrogation (including a verdict, arbitration or compromise), a copy of the decision must be forwarded to the insured within 14 business days.
3. If it becomes apparent that the insured has a right to sue, DavidShield will inform the insured of that right.
4. DavidShield or the insurance company do not represent the insured and are not bound by any consultation obligation.

K. Giving replies in writing

Every appeal in writing by an insured member will be replied to in writing according to the circumstances of the matter and in any case not later than 30 days from the date of appeal.

If any complaint, whether filed directly or through the Supervisor of the Capital Market (the Commissioner of Insurance), indicates a fault in the conduct by the Company or anyone acting on its behalf, and such misconduct indicates a system-wide problem, the Company shall conduct an investigation to identify similar cases in which the systemic flaw occurred.

If the Company finds similar flaws, it will learn from these cases and act to rectify them within a reasonable time. In this section, a "system-wide problem" refers to a material flaw, a recurring flaw, or a flaw that affects a group of members. The Company will document and maintain information about the investigation, the lessons learned, and the correction of any system-wide problems that were identified.

L. Copies

1. A copy of the policy will be sent within 14 days from the request to an insured requesting a copy of the policy.
2. An insured is entitled to receive copies of any document in his or her file, as well as documents signed by the insured or documents sent to the insured, within 21 business days from the request.

M. Keeping documents

1. Documents will be kept for 7 years after ending treatment thereof.
2. As long as the policy is valid and for 7 years from the date that treatment resulting from the policy ended (even after cancelling the policy), all the information must be kept.
3. In claims, the complete details of the claims must be kept including documents concerning the claim sent from the insured or to the insured, as well as any compromise, verdict etc.

N. Publishing the circular, rules and information letter for the insured

The Commissioner's circular, these rules and the information letter for the insured regarding filing a claim are published in the company's internet website at: www.passportcard.co.il

O. Reservation of laws

In any case of contradiction between the above provisions and the provisions of the law, the provisions of the law will prevail.