

Dear Student,

Thank you for your health insurance request through the website of the Rothberg International School of the Hebrew University of Jerusalem. Your application is now being processed. If you answered "no" to all the questions, your application will automatically be accepted. If you answered "yes" to any question, then you must wait to receive final approval.

The Hebrew University of Jerusalem has chosen the Collective Health Insurance Policy issued by the Harel Insurance Company. This Policy includes many more medical services than those offered in the standard policy for students in Israel. It is an exclusive plan for the Rothberg International School students as well as for the foreign students studying towards a degree at the Hebrew University of Jerusalem. The benefits and exclusions of the policy and the Policy conditions are presented here.

In addition, we recommend that you check out our website www.yedidim-health.co.il. You are also invited to contact our office in order to get information to insure your laptop and personal belongings for an additional fee. Please note that this additional policy is not affiliated with the Rothberg International School.

For information on the procedure for obtaining medical assistance while in Israel see below: "HarelMedical Services In Jerusalem".

The Harel-Yedidim staff wishes you an interesting, and challenging period of study in Israel.

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Health Services in Jerusalem

Harel Insurance Company



Instructions for Obtaining Medical Services

1. Insurance policy number:

To receive medical services you must present your policy number and your ID as a copy of your passport

2. Hospital and emergency room:

In the case of any problem, first see a physician under arrangement with Harel to receive a referral to the hospital. In the case of a life-threatening emergency for which you are hospitalized, a referral will not be required.

3. Extending the insurance policy:

To extend your insurance policy, contact our office and ask for Renewal Forms. Every policy renewal requires new underwriting.

4. Prescribed medication:

Medicines are provided only by pharmacies under agreement with Harel. If there is no such pharmacy open in your vicinity, please contact our office and ask for permission and instructions.

5. Basic medication:

In many cases, mild medical conditions can be solved easily and inexpensively by purchasing Tylenol, Advil, Acamol, Strepsils and the like directly from a pharmacy.

6. Emergency dental treatment:

Emergency dental treatment is dental treatment done on an urgent basis only. Tel: 02-6256152.

7. The insurance is valid within the borders of the State of Israel, including the Israeli settlements and roads leading to them.

8. First class Travel Policy:

When traveling outside of Israel for academic purposes or vacation, purchase the First class, to assure continuity of coverage while abroad and when you return to Israel.

*We at the Harel-Yedidim office are pleased to serve you.
Do not hesitate to contact us*

Medical Clinics in Jerusalem:

1. Frenkel Emergency Medical Center (Yad Sarah)

Family Physicians, Pediatrics, Gynecologists (male and female gynecologists)
Orthopedics Services.

Please go directly during the opening hours

Opening Hours: Sunday – Thursday 6PM-11:30PM

Saturday: 1 hour after Shabbat ends until 11:30PM

Address: 124 Herzl St. Jerusalem

Telephone: *6447

2. Terem Immediate Care:

For urgent treatment 24 hours a day, please go directly to one of the Terem Clinics as follows:

■ Terem, Romema

15 Sarei Israel. City Court. Operates 24/7

Tel: 1-599-520520, Fax: 02-5503213.

■ Terem, Tayelet (southern Jerusalem)

6 Daniel Yanovsky St. Operates 7 days a week, 9AM - 11:30PM

Tel: 1-599-520520, Fax: 02-6738551.

■ Terem, Pisgat-zeev

158 Moshe Dayan St. Operates 24/7.

Tel: 1-599-520520.

3. Wolfson Family Medical Center:

A medical center staffed by a family physician and specialists.

9 Diskin St., Kiryat Wolfson

■ For an appointment with a family physician only, call 02-5610297 (multiple lines). Wait for the message in English.

■ Walk-in clinic (no appointment necessary), for minor problems only, between 7:30 and 9AM. Come directly to the clinic and register with the secretary.

4. Emergency Dental Treatment:

Initial emergency treatment will be provided free of charge, at the Hila Clinic, 16 Shlomzion Hamalka Street, Jerusalem. Telephone 02-6256152.

Opening Hours: Sunday – Tuesday: 9PM-6PM,

Wednesday - Thursday: 8AM-1PM

5. Specialists Doctors:

For an appointment with a specialist, please call 03-6386216.

6. Bikur Rofeh Clinic:

For appointments with a family doctor only.

22 Beit Hadfus St., Givat Shaul, Tel: 077-5540943

Open: Sunday 5PM - 1 AM, Monday & Thursday 6:30PM - 1 AM,
Friday 9AM - 2PM, Saturday 5:30PM - 1 AM.

7. Doctor's home visits & consultation with a doctor 24 hours a day:

Please call Bikur Rofeh Contact Center. Tel: 1-800-260-660

8. Pharmacies:

- Medi-Plus: 2 bar Ilan St 02-5822237
- Pharma C: 9 Diskin St . Tel: 02-5612361
- Arnona: 9 Leib Yaffe st. 02-6731901
- Medi-Plus: 10 Kanfei Nesharim st 02-6511155

For the addresses of additional pharmacies in Jerusalem, please contact the Harel Call Center.

Harel - Yedidim office

Sunday - Thursday 8AM - 3.30PM

Tel: 03-6386216, Fax: 03-6874534

Email: y_health@yedidim.co.il

Web: www.yedidim-health.co.il

After office hours you can call

Einat Cohen, Tel: 054-5297775

Meytal Assor, Tel: 052-2360037

Harel Contact center 24/7

Telephone Numbers

For the general Harel Call Center, call

1-800-414-422 or 03-754-7020

To send documents by Fax:

03-6874534



**Group Health Insurance Policy for Tourists in Israel
For The Hebrew University of Jerusalem**



December 2017 Edition

Health Insurance Policy for Tourists in Israel

Chapter 1: Definitions

In this policy and its appendixes, the following terms will have the meaning that appears next to them:

- 1.1 The Insurer:** Harel Insurance Company, Ltd.
- 1.2 The Policy:** An insurance contract, including all the general terms referring to each of the policy chapters, including the Insurance Details Page and any rider or appendix attached to it and those that are attached to it in the future, if they are attached with the consent of the Policyholder and the Insurer.
- 1.3 The Policyholder:** The Hebrew University of Jerusalem.
- 1.4 The Insured:** The applicant who is not a resident or a citizen of the State of Israel, his/her spouse and his/her children whose names are noted on the insurance proposal or in the list received from the Policyholder and whose name/s is/are registered on the Insurance Details Sheet, who are staying in Israel temporarily, all this according to the definitions in the specific policy.
- 1.5 Israel:** The State of Israel, including territories occupied by Israel.
- 1.6 Overseas:** Any place or country outside of the State of Israel, including a ship or plane one its way to or from Israel, with the exception of the areas of the Palestinian Authority.
- 1.7 Country of origin:** The country in which the Insured stays permanently.
- 1.8 The Insurance Proposal:** A proposal form in the wording determined by the Insurer that has been completed with all details, including a health condition statement, declaration of the beginning and end dates of the insurance period and waiver of medical confidentiality, signed by the Insured (or the guardian) specified on the proposal.
- 1.9 Insurance Details Page:** A page attached to the Policy which constitutes an integral part thereof and includes, among other things, the personal details of the Insured and the conditions required in order to adapt the insurance policy to the terms of the Insurance contract with the Insured. In the case of a conflict between the terms of the Policy and the terms specified on the Insurance Details Page, the terms on the Insurance Details Page shall prevail.
- 1.10 Insurance card:** A card issued by the Insurer in addition to the Policy, on which the personal details of the Insured are noted, which will be presented by the Insured to a medical institution in order to obtain medical services.
- 1.11 Date of inclusion:** The date on which the Insured was included in this insurance plan, as it appears in the data file of Insured persons and/or the insurance proposal that were sent to the Insurer.
- 1.12 Automatic inclusion:** Obligatory inclusion by the Policyholder that is made possible because the Policyholder fully finances the cost of the insurance.
- 1.13 Inclusion by consent:** Voluntary inclusion, which requires the prior consent of the Insured of his desire to be included in the insurance (because the Insured has some ownership of the insurance).
- 1.14 Insurance period or periods:** The period specified in the Policy and the Insurance Details Page attached to the Policy or a period shorter than that, shortened according to the instructions and terms of the Policy.

- 1.14.1 **Maximum period:** Up to 365 days, with an option for extension for a period of 365 additional days.
- 1.14.2 **Additional period:** An insurance period that has been extended, whether in the framework of the same insurance policy or as a new insurance policy, according to the instructions of Section 2.6 below.
- 1.15 **Qualification period:** An uninterrupted time period, beginning for every Insured on the date of his inclusion in the insurance and ending at the end of the period specified in each chapter or appendix or section added to the Policy. The qualification period will begin for every Insured one time only in successive insurance periods, and will begin anew every time the Insured is included in insurance anew. An insurance event that occurs during the qualification period is equivalent to an insurance event that occurred before the beginning of the insurance.
- 1.16 **Waiting period for the rider for coverage of pregnancy and for coverage of pregnancy and childbirth:** An uninterrupted time period that begins for each Insured on the date of his/her inclusion in the insurance and ends after the period specified as the waiting period in each chapter or appendix or section attached to the Policy. The waiting period will apply to each Insured only once during consecutive insurance periods, and will apply anew each time the Insured is newly included in the Insurance. Expenses that occur after the end of the waiting period in regard of an insurance event that occurred during that period will be covered.
- 1.17 **Insurance event:** A set of facts and circumstances, as defined in each of the chapters or appendixes or sections of the Policy, the existence of which gives the Insured the right to insurance benefits according to this Policy.
- 1.18 **Medical emergency:** Circumstances in which the Insured is in immediate life-threatening danger or in which there exists an immediate risk that he will be caused severe irreversible disability if not provided with urgent medical care.
- 1.19 **Accident:** A physical injury caused by the application of physical force only, as the result of a sudden, singular and unexpected event, caused directly by an external and visible entity, which constitutes, independently of any other reason, the sole direct and immediate cause of the occurrence of the insurance event. **To eliminate doubt, verbal violence and/or emotional pressure and/or the accumulation of small repeated injuries over a period of time that lead to disability shall not be considered an "accident."**
- 1.20 **Contracted service provider:** A general-government hospital and/or private hospital that has been approved in advance by the Insurer, and in addition, physicians, a medical institution, a laboratory, a physician, a hospital, a diagnostic center, a pharmacy and the like associated by agreement with the Insurer, the name of which is specified on the agreement with the Policyholder and/or the Insurance Proposal, **from which and solely from which the Insured will be entitled to receive the health services specified in this Policy, all this subject to the terms of the Policy.**
- 1.21 **Non-contracted service provider:** A general-government hospital and/or private hospital, physicians, a medical institution, a laboratory, a diagnostic center, a pharmacy and the like that are not associated by agreement with the Insurer.
- 1.22 **Medical service:** Surgery, medical tests, an appointment with the physician, hospitalization, the supply of medications and the like, all as specified in the Policy.
- 1.23 **General-government hospital:** A medical institution in Israel that is recognized by the qualified authorities as a general/government hospital only, with the exception of an

institution that is also a sanatorium and/or a recovery hospital and/or a recuperation center and/or a rehabilitative institution.

- 1.24 Day of hospitalization:** A stay of 24 hours in a hospital.
- 1.25 Private hospital:** A hospital in Israel that is not a general hospital and that is authorized by the Ministry of Health to perform surgery on a private basis.
- 1.26 Emergency room:** A place designed to provide urgent medical care that is approved by the qualified authorities in Israel to operate as an emergency room.
- 1.27 Hospitalization expenses:** The payment for hospitalization and medical services provided in a hospital during hospitalization for a period not exceeding 90 days, including payment for the room, operating room, intensive care, anesthetist, treatment by a physician, tests and medications provided as part of the hospitalization.
- 1.28 Medical expenses:** The payment for treatment by a physician, diagnostic tests, medications that are supplied to the Insured not in the framework of hospitalization and not in a sanatorium.
- 1.29 Physician:** A physician who is authorized and approved by the Ministry of Health in Israel to practice medicine.
- 1.30 Specialist physician:** A physician who has received a specialist license in a specific field of medicine who is authorized and approved by the Ministry of Health in Israel.
- 1.31 Anesthetist:** A physician who has received a license as an anesthetist who is authorized and approved by the Ministry of Health in Israel.
- 1.32 Medications basket:** All the medications included in the National Health Insurance Law (Medications in the Basket of Health Services) 5755 – 1995, as modified from time to time.
- 1.33 Prescription:** A medical document signed by a physician that confirms the need for treatment/medication and determines the manner of treatment, dosage, and length of time of the treatment required.
- 1.34 Medication:** A chemical or biological substance designed for treatment, prevention of deterioration (including prevention of the development of additional medical conditions) or prevention of its recurrence, as the result of disease or accident.
- 1.35 Pre-existing medical condition:** A set of medical circumstances that were diagnosed in the Insured prior to the date of inclusion in the Insurance, including those due to a disease or accident. In this matter, “diagnosed in the Insured” means by means of a documented medical diagnosis that existed during the six months prior to the date of inclusion in the Insurance.
- 1.36 Restriction due to pre-existing medical condition:** A general exclusion in the Policy that exempts the Insurer of its liability, or reduces the liability of the Insurer or the scope of coverage regarding an insurance event of which a significant cause was the regular course of a pre-existing medical condition and which the Insured incurred during the period to which the restriction applied.
- 1.37 Health Condition Statement:** The Health Condition Statement Form and Waiver of Medical Confidentiality of the Insured, signed by the Insured.
- 1.38 Claim:** A request from the Insured or from the Policyholder on behalf of the Insured for payment for services according to this Policy and/or for receipt of insurance benefits and/or for provision of a commitment to pay for services as said in this Policy.
- 1.39 Service call center:** A call center on behalf of the Insurer that provides a response to those Insured in all matters related to service providers, and which operates 24 hours a day.

- 1.40 Insurance fees:** The amount that the Policyholder and/or the Insured must pay the Insurer for this Policy.
- 1.41 Limits of Liability Table:** The maximum amount for payment of insurance benefits as set forth in detail in the terms of the Policy, including in each chapter or rider or section added to the Policy. To eliminate doubt and the instructions of the Policy notwithstanding, the limit of the insurance amount, if it exists, is relevant solely and exclusively for the chapter or rider or section alone, and will not limit or preclude the maximum amount for the Policy or according to several riders and/or chapters and/or sections.
- 1.42 Co-pay:** The Insured's portion of an expense regarding an insurance event. It is hereby clarified that the duty of the Insurer to make any payment according to a chapter or rider or section attached to the Policy will be according to the amount of co-pay by the Insured and only regarding expenses of the Insured beyond this co-pay.
- 1.43 The Insurance Law:** The Insurance Contract Law 5741 – 1981.
- 1.44 The Health Law:** The National Health Insurance Law 5754 – 1994.
- 1.45 Dollar:** United States Dollar
- 1.46 Index:** The Consumer Price Index published by the Central Bureau of Statistics or, in the absence of such publication, the index published by another official organization that replaces it, or any index designated specifically for health services.

2. Effective Dates of the Policy, Manner of Inclusion and Insurance Structure

2.1 Effective Dates of the Policy

- 2.1.1 This Policy will become effective as of the beginning date of the Insurance.
- 2.1.2 The Insurer undertakes that in the case that the first agreement period or additional agreement periods are not renewed, and the Policyholder chooses a new insurer to replace of the group tourist insurance agreement, the Insurer will act to fulfill all its undertakings according to this Agreement, professionally and in good faith, in full cooperation with the new insurer, for a proper and continuous transfer of the insurance program to the new insurer, and all this with care and concern for the wellbeing of those Insured.

2.2 Manner of Inclusion:

- 2.2.1 After completion of the Inclusion Form, which includes a Health Condition Statement and medical underwriting.

An Insured that removed himself from the Insurance and asked to insured by a different insurer after the date of his removal will be included after completion of a Health Condition Statement, which will determine the terms for his acceptance for the insurance and according to the customary insurance policy and insurance fees of the Insurer at that time.

2.3 Insurance Structure:

	Manner of payment	Basic Policy
The Insured	By the Policyholder/by means of personal collection	Inclusion by agreement
Spouse, child, close relative	By the Policyholder/by means of personal collection	Inclusion by agreement

2.4 Agreement Period:

The agreement between the Policyholder and the Insurer is from the date 1.1.2018 until the date 31.12.2022 (herein: the Relationship Period).

Principles for extension of the agreement period – one of the following:

- 2.4.1 Extension for an additional 5-year period, except in the case of notification of non-extension of the agreement by one of the parties 30 days before the end of the agreement.
- 2.4.2 At the end of the agreement period, the agreement will be renewed automatically every year for one additional year, unless one of the parties contacts the other in writing and notifies it of cessation of the agreement up to 30 days before the end of the agreement. Negotiations between the Policyholder and the Insurer regarding renewal of the agreement will not

constitute consent of the Insurer to continue the agreement according to these terms.

2.4.3 Negotiations regarding renewal by agreement of both parties – if the parties do not reach agreement, the agreement will be cancelled after notification of at least 30 days.

2.4.4 Changes may be made in the insurance fees and/or the terms of the insurance by agreement between the Policyholder and the Insurer during the insurance period/at dates set forth in the Policy. If the parties do not reach agreement – there is a possibility of terminating the agreement.

2.5 End of the Insurance Period:

Termination of the Insurance Period:

Termination of the insurance will become effective on the ending date of the Insurance Period or at the end of the month in which the Insurance Period reached its end, the earlier of the two under the following circumstances:

2.5.1 On the date of termination of the stay of the Insured in Israel.

2.5.2 At the time of return of the Insured to his country of origin.

2.5.3 At the time of death of the Insured.

2.5.4 At the time of completion of his stay in Israel on behalf of the Policyholder.

2.6 Extension of the Insurance Period

The Policyholder or the Insured may ask the Insurer to extend the insurance period for an additional period. Extension of the insurance period will be subject to approval of the Insurer in advance and in writing. It is hereby clarified that at the end of the insurance period, as defined in the Policy, the insurance will not be extended automatically.

2.7 Insurance Fees

2.7.1 The insurance fees will be as set forth in the agreement between the Insurer and the Policyholder.

The premium will be determined according to age group, and all this according to the scope of coverage/levels joined.

2.7.2 The date of payment of the insurance fees will be on the first of every month according to the date determined for payment by the Insurer.

2.7.3 To insurance fees that are not paid on time, linkage differences and interest, as set forth in the Adjudication of Interest and Linkage Law, 5721 – 1961, will be added from the day of onset of the delay until actual redemption of the insurance fees by the Insurer.

2.8 Manner of Payment of Insurance Fees

Medical Insurance for Tourists in Israel

Payment will be made according to one of the following options, as agreed upon in the Agreement: by means of the Policyholder, by personal collection, or in a combined manner.

2.9 Insurance benefits:

2.9.1 Payment of insurance benefits due to the Insured according to the Policy will be made in one of the following two manners:

2.9.1.1. To the service provider – The Insurer will grant the Insured a letter of financial commitment for the service provider, insofar as required and according to the terms of the Policy.

2.9.1.2. To the Insured (in the case in which the Insured is deceased – to his legal heirs) – based on the terms set forth in the Policy.

2.9.2 The date of payment of insurance benefits will be from the date of approval of the claim in the offices of the Insurer.

2.9.3 Insurance benefits will not surpass the insurance amount.

2.9.4 The right of the Insured to indemnification regarding a third party is transferred to the Insurer.

2.10 Claims:

2.10.1 Payment of insurance benefits if the following conditions hold:

2.10.1.1. Receipt of prior approval from the Insurer (on the dates determined for this purpose in the Policy) or retrospectively (according to the restrictions set forth in the Policy).

2.10.1.2. It is not necessary to obtain prior approval from the Insurer – according to the circumstances set forth in the Policy.

2.10.1.3. Signature of the Insured on a Waiver of Confidentiality and submission of the required details and documents.

2.10.1.4. The Insurer is permitted to conduct an investigation and perform medical examination of the Insured, as long as the examination is reasonable under the given circumstances and at the expense of the Insurer, and the Insured undertakes to undergo medical examinations as required by the Company and at its expense as said. It is clarified that this does not detract from the ability of the Insured to fulfill all the rights accorded him by force of the Policy at any time in court. The Insurer will be entitled to demand that the Insured provide every detail and/or medical document that is demanded by it or by a physician on behalf of the Insurer.

2.10.1.5. The Insurer is not liable for the quality of the services in the Policy and damages to the Insured and/or anyone on his behalf.

- 2.10.1.6. The Insured shall attach to the form for notice of an insurance event all the relevant medical documents regarding the insurance event, including diagnoses, a history of the event (anamnesis) and, if payments were made by the payer and/or by the Insured – receipts of payment. The Insured may submit the documents, among other ways, by e-mail, text message or a personal online account.
- 2.10.2 The Insurer is not liable for insurance benefits if the Insured deliberately did something that could prevent the Insurer from investigating its liability except to the extent that it would have been liable for them had the Insured not done that thing.
- 2.10.3 **Period of limitation:** The period of limitation of a claim for payment of insurance benefits for an insurance event according to this Policy is three years from the occurrence of the insurance event.
- 2.10.4 **Waiver of medical confidentiality:**
- The Insured will provide the Insurer with a waiver of medical confidentiality, signed by him, that instructs his physicians and/or any entity or medical institution, whether in Israel or abroad and/or the National Insurance Institute and/or the Ministry of Defense and/or any other government office and/or insurance company and/or HMO (*kupat holim*) to provide the Insurer with all reasonable medical information regarding the Insured that it holds (herein: **Waiver of Confidentiality form**).
- 2.10.5 **An insurance event covered by more than one insurance company and/or by a third party:**
- 2.10.5.1. If, with regard to an insurance event covered by this Policy, the Insured also had the right to indemnification from a third person, not by force of the Insurance Contract Law, this right will be transferred to the Insurer from the time of its payment of insurance benefits and at the rate of benefits it paid, and without detracting from the right of the Insured to first collect indemnification from the third party beyond the insurance benefits according to this Policy. If the Insured receives an indemnification amount from a third party that would have been due the Insurer according to this section, he/she must transfer it to the Insurer. If he/she reached a compromise, waiver, or other action that harms the right that was transferred to the Insurer, he/she must compensate it for that. The Insured undertakes to cooperate as much as required of him/her to fulfill the said right of the Insurer.
- 2.10.5.2. The Policyholder and/or the Insurer must cooperate with the Insurer and perform any act in order to enable the Insurer to

obtain the amounts that the Insurer paid for which a third party was liable.

2.11 Duty of Disclosure:

- 2.11.1 If, prior to entering into the contract, the Insurer presents the Insured, either on the insurance proposal form or in another written form, a questionnaire regarding a matter that could influence the willingness of a reasonable insurer to enter into the contract at all or to enter into it on the terms it contains (herein: essential matter), the Insured must answer it fully and honestly in writing.
 - 2.11.1.1. A broad question that incorporates different matters, without distinguishing among them, does not require an answer as said, unless this was reasonable at the time of entering into the contract.
 - 2.11.1.2. Concealment with the intention of fraud on the part of the Insured of a matter that he/she knew was an essential matter, is legally equivalent to giving an answer that is not full and honest.
- 2.11.2 If an answer that is not full and honest is given to a question on an essential matter, the Insurer is entitled, within three days of becoming aware of this and as long as no insurance event has taken place, to cancel the Policy by written notice to the Insured.
- 2.11.3 If the Insurer cancels the Policy by force of this section, the Insured is entitled to a refund of the insurance fees he/she paid for the period after the cancellation, after deduction of the Insurer's expenses, unless the Insured acted with the intention of fraud.
- 2.11.4 If an insurance event occurs before the Policy is cancelled by force of this section, the Insurer is not liable except for insurance benefits reduced by the relative rate, which is the ratio between the insurance fees that would have been paid as accepted in the Company according to the true situation and the insurance fees agreed upon, and the Insurer is completely exempt in each of the following:
 - 2.11.4.1. The answer was given with the intention of fraud.
 - 2.11.4.2. A reasonable insurer would not have entered into the contract, even for higher insurance fees, had it known the true situation; in this case, the Insured is entitled to a refund of the insurance fees he/she paid for the period after the occurrence of the insurance event, with the deduction of the Insurer's expenses.
- 2.11.5 The Insurer is not entitled to the above-said remedies in any of the following, unless the answer that was not full and honest was given with the intention of fraud:

- 2.11.5.1. It knew or should have known the true situation at the time of entering into the contract or it caused the answer not be full and honest.
- 2.11.5.2. The fact regarding which an answer that was not full and honest was given ceased to exist before occurrence of the insurance event, or did not affect its occurrence, the liability of the Insurer or its scope.
- 2.11.5.3. Insofar that the matter is one of compensation-type insurance benefits, the Insurer is not entitled to the above-said remedies if three years have passed since entering into the contract, unless the Insured acted with the intention of deception.

2.12 Absence of Insurer Liability for Actions and/or Omissions of the Physician: The Insurer will not bear any liability for actions and/or omissions of the service providers under contract with the health services and/or their outcomes, whether they were chosen by the Insurer or chosen by the Insured.

2.13 Cancellation of insurance: In the case of delay in payment of insurance fees, cancellation of the Policy will be carried out according to the instructions of the Insurance Contract Law, 5741–1981.

If the insurance policy is cancelled before the end of the insurance period, the Insurer will repay part of the insurance fees for the period that the Insured is no longer insured, subject to its duty according to the Insurance Contract Law and in the case of cancellation within less than two months from the beginning date of the insurance period, the proportionate insurance fees paid will be subject to deduction of handling fees in the amount of insurance fees for two months with regard to this Policy.

2.14 The Insurance Law: The instructions of the Insurance Contract Law, 5741–1981 will apply to this Policy.

2.15 Notices: The Policyholder/Insured must notify the Company of any change of address. A notice that is sent by the Insurer to the last address of the Policyholder/Insured known to it shall be considered a notice properly delivered.

2.16 Changes: The Insurer will be permitted to change the list of contracted service providers from time to time.

2.17 Jurisdiction: The exclusive and sole place of jurisdiction regarding any matter related to and stemming from this Policy is the authorized courts in Israel only, according to Israeli law, and no other court whatsoever shall have any authority. The law that applied to claims arising from and/or related to this Policy is the Israeli law.

2.18 Cancelled.

2.19 General Exclusions to the Policy:

The Insurer shall not be liable and shall not be obligated to pay insurance benefits due to an entire insurance event or part thereof in any of the following cases:

- 2.19.1 An insurance event that occurred prior to the beginning date of the insurance or after the end of the insurance period.**
- 2.19.2 Cancelled.**
- 2.19.3 A preexisting medical condition: as defined in Section 1.35 in the Definitions chapter.**
 - A restriction because of a preexisting medical condition concerning an insured whose age at the beginning of the insurance period is –**
 - Less than 65 years – shall apply for a period not exceeding one year from the beginning of the insurance period;**
 - 65 years or more – shall apply for a period not exceeding half a year from the beginning of the insurance period.**
 - 2.19.3.1. Specific restriction regarding medical condition**

The said in Section 2.19.3 notwithstanding, a specific restriction of the undertaking of the Insurer or of the scope of coverage regarding a specific medical condition listed on the Insurance Details Page for a certain Insured will be valid for the period specified on the Insurance Details Page next to that specific medical condition.
 - 2.19.3.2. If the Insurer is relieved of its undertaking due to the instructions set forth in Section 2.19.3 and the insurance contract is cancelled, and the Insurer believes that it would not have entered into that insurance contract, even for higher insurance fees, had it known of the preexisting medical condition of the Insured at the time of drawing up the insurance contract, the Insurer will return the insurance fees that the Insured paid for insurance coverage for which no insurance benefits were paid to the Insured; linkage differences will be added to the insurance fees.**
 - 2.19.3.3. If the Insured purchased insurance for worsening of an existing disease for additional insurance fees recorded on the proposal form, this exclusion will be cancelled and instead, the coverages and exclusions for Chapter 4, Sections 4.1.**
- 2.19.4 Psychotherapy and/or psychological treatments, except as specified in Section 4.11, psychiatric treatments, suicide or attempted suicide, self-injury.**
- 2.19.5 Alcoholism, drug use, with the exception of use of medical drugs according to a physician's instructions.**
- 2.19.6 Use of weapons.**
- 2.19.7 Rehabilitative treatments or hospitalization, rehabilitation.**
- 2.19.8 Transplant of an organ/s or limb/s, a malignant disease, hemophilia and/or diseases required blood transfusions, dialysis, C.F., M.S., stroke, C.V.A. or T.I.A.**
- 2.19.9 Sexually transmitted diseases, treatment of problems of impotence, sexual functioning disorders.**
- 2.19.10 Treatments at the Dead Sea given to psoriasis patients, genetic testing, nursing care hospitalization or nursing care services.**

- 2.19.11 a. Expenses of pregnancy and/or childbirth and/or expenses due to treatments/routine ongoing tests and/or complications of pregnancy and/or childbirth, except as specified in Section 4.12.
- 2.19.11 b. Monitoring prior to pregnancy and/or genetic counseling, expenses due to bed rest during pregnancy.
- 2.19.12 Fertility treatments and/or insemination and/or infertility, male and/or female fertility.
- 2.19.13 Wellbeing treatment of infants and/or children, well-baby clinic, vaccinations, monitoring or routine tests of children.
- 2.19.14 Treatment of learning disabilities, speech, etc.
- 2.19.15 The following types of treatments or services: physical therapy except as specified in Section 4.8, mechano-therapy, hydrotherapy, alternative therapy, homeopathy, alternative medications, healing programs, acupuncture, chiropractic, optometry, periodic testing, cosmetic or restorative surgery, experimental surgery, healing and/or gum surgery.
- 2.19.16 Medical or other aids, glasses and/or contact lenses, hearing aids and prostheses of any type whatsoever.
- 2.19.17 Experimental medical treatments of any type or kind, scanning tests, preventative treatments.
- 2.19.18 Treatments, tests and surgery outside the State of Israel.
- 2.19.19 Routine tests and/or monitoring and/or vaccinations that are not due to an active medical problem.
- 2.19.20 Experimental medications that have not been approved by the FDA and approved by any other qualified authorities recognized for authorizing medications in Israel.
- 2.19.21 Emergency room expenses – with the exception of that stated in Section 3.3.
- 2.19.22 Hospitalization expenses and/or expenses not during hospitalization that could have been deferred until the return of the Insured to his country of origin.
- 2.19.23 Medical services provided to the Insured not by means of contracted service providers of the Insurer, unless with the express written approval of the Insurer.
- 2.19.24 Treatment not approved by a physician.
- 2.19.25 The Insurer will not have any liability whatsoever for actions or omissions of service providers associated with the health services and/or their consequences, whether chosen by the Insurer or chosen by the Insured. In addition, the Insurer will not be liable for any case in which the Insured was denied and/or the Insured was prevented from requesting and/or prevented from receiving medical assistance.
- 2.19.26 The Insurer will not pay and will not be liable for an insurance event that occurred during the insurance period the treatment of which continued after the insurance period, except in the following cases:
 - 2.19.26.1. Hospitalization that began within the insurance period.
 - 2.19.26.2. Medical expenses not during hospitalization during a period of up to 90 days as defined in Chapter 3.
- 2.19.27 Participation of the Insured in extreme sports according to the list that appears on the Company website. For this matter, “extreme sport” is – fields of sport considered to be especially dangerous and that require high levels of

difficulty and/or physical effort of the participants in them. The list of the fields of extreme sports will be updated from time to time according to the list that appears on the Company website, www.harel-group.co.il (Tourist Insurance tab). This exclusion will be cancelled and instead, the coverages and exclusions in Section 4.9, Extreme Sports will apply.

- 2.19.28 Sports activity in the framework of a sports association registered according to the Sports Law 5748 – 1988 and/or professional sports and/or competitive sports activity that entails the payment of wages.
- 2.19.29 Active participation of the Insured in a race/races of cars and/or motorcycles (including snow bikes) and/or any other vehicles, including sailing vessel and/or driving/traveling in any vehicle on a race track, whether as part of a race or not.
- 2.19.30 A road accident and/or a work accident.
- 2.19.31 A sea, vehicle or air accident in which the medical service expenses apply to the person at fault and/or another Insurer.
- 2.19.32 Riding and/or use of a motorcycle as a driver and/or passenger with a driver who does not have a motorcycle driving license suitable for the type of motorcycle involved in the accident event.
- 2.19.33 The insurance event was caused or is the outcome of the service of the Insured in any type of security force, with the exception of an army and including the police forces, and an insurance event during military service that stems directly from activity of a military nature, including military or pre-military exercises/training of any type.
- 2.19.34 Passive participation of the Insured in an act of sabotage or terrorism of any type and/or in war and/or in a belligerent action of hostile forces, organized or not organized, unless the Insured is entitled to coverage of the medical expenses due to such an event from any other entity.
- 2.19.35 Medical expenses due to active participation of the Insured in activities such as: military actions or civil war, police work, underground or camouflaged activity, rebellion, riots, sabotage, fights, violence, terrorism, commitment of a crime, a misdemeanor, drug trade, activity without a valid license suitable for that activity as required (that is, a license for driving or flying a plane, or sports activity for with a license is required), or resisting arrest. strikes and/or illegal activity.
- 2.19.36 An insurance event caused by nuclear fission or nuclear fusion or radioactive contamination.
- 2.19.37 Consequential damage that is expenses arising from the loss and waste of time for any reason whatsoever, cancellation of a deal including suspension, delay, bankruptcy, loss of work days and wages, sick leave, loss of pleasure, emotional anguish, pain and suffering, nursing care assistance and so forth.
- 2.19.38 The Insurer will not pay in the case of an insurance event and/or claim and/or expenses and/or damage to a third party.
- 2.19.39 Expenses of traveling in taxis, permits, commission, charges, taxes, phone calls, faxes, legal expenses and fees, interest, bank expenses, fines, and so forth.
- 2.19.40 Kidnapping of the Insured.
- 2.19.41 Charges caused due to violations of the law by the Insured.

Chapter 3: Undertaking of the Insurer

3.1 General:

- 3.1.1 **Level of medical service:** The Insurer undertakes to provide the Insured according to this policy with the medical services to which the Insured is entitled for coverage of expenses according to medical judgement, of reasonable quality, within a reasonable time, and at a reasonable distance from his place of residence or from the location of the insurance event, as customary in the state of Israel.
- 3.1.2 **Insurance card:** The Insurer will issue every Insured a card that includes identifying details of the Insured as well as the phone number of the service call center of the Insurer or of the service provider. This card together with a passport or official photo ID of the Insured will serve as means of identification of the Insured and examination of his eligibility at the time of receiving the service.

3.2 The Insurer will pay the Insured expenses as follows:

Expenses during hospitalization and expenses not during hospitalization as specified below:

If the Insured is hospitalized in a general-government hospital in Israel, the Insurer shall pay for these expenses for a period not exceeding 120 days:

3.2.1 Expenses in general-government hospital in Israel:

- 3.2.1.1. Hospitalization of the Insured in a general-government hospital in Israel, the Insurer will pay for expenses as follows for a period not exceeding 90 days:
- 3.2.1.2. Hospitalization expenses, including x-rays, medications, physicians, surgeon, intensive care, an anesthetist, general hospital services (herein: "**hospitalization expenses**").
- 3.2.1.3. It is hereby clarified that the Insurer will pay hospitalization expenses to general-government hospitals or to a hospital recognized by the certified authorities in Israel as a public hospital. **And in any case, the Insurer will not indemnify the Insured and/or the service provider for hospitalization expenses if the Insured was hospitalized in a private hospital and/or received and/or paid for private medical services during his/her said hospitalization, unless the Insured received written approval from the Insurer in advance. Approval of the Insurer for hospitalization in a private hospital is at the sole discretion of the Insurer.**

3.3 Emergency room expenses in any of the general-government hospitals in Israel, solely in the cases listed below:

- 3.3.1 Referral by a physician.
- 3.3.2 A new fracture.
- 3.3.3 Dislocation of a shoulder or elbow.
- 3.3.4 An injury requiring stitching by means of sutures or other means of stitching.
- 3.3.5 Aspiration of a foreign object into the trachea.
- 3.3.6 Penetration of a foreign object into an eye.
- 3.3.7 Infants up to the age of two months with a fever of over 38.5 degrees Celsius.
- 3.3.8 Snake bite.

- 3.3.9 Transportation by ambulance to an emergency room from the street or another public space due to a medical emergency.
- 3.3.10 Approval by the Insurer.
- 3.3.11 The emergency inquiry ends in non-elective hospitalization.

The Insured shall not be entitled to indemnification from the Insurer for emergency room expenses that arise from any factor other than that said in this section above.

3.4 Medical expenses not during hospitalization, provided by a contracted service provider:

The Insurer shall pay the service providers directly for medical expenses incurred by the Insured outside the framework of hospitalization, as follows:

- 3.4.1 **Medical treatment/consultation:** Medical treatment/consultation solely by a contracted service provider.
- 3.4.2 **Laboratory tests, X-rays, bandaging:** Tests provided to the Insured solely by a laboratory and/or clinics.
- 3.4.3 **First aid:** First aid provided to the Insured by a first aid station of Magen David Adom solely in cases of emergency.
- 3.4.4 **Medications:** The Insurer will pay **only** for medications included in the medications basket that are prescribed by a physician and that are purchased at pharmacies contracted by the Insurer, up to the amount of the limit of liability of the Policy and up to the amount specified in the Limits of Liability table in the Policy.
- 3.4.5 **Ambulance expenses:** The Insurer will pay the expenses of transportation by ambulance in the case of a medical emergency after which the Insured is hospitalized, one time only during the entire insurance period and provided that the Insured is not entitled to coverage of this expense by any another entity.
- 3.4.6 **Emergency dental treatment:** The Insurer will pay the expenses of emergency and first aid dental care up to the amount of **\$400** and up to the amount specified in the Limits of Liability table in the Policy.

To eliminate doubt, the undertaking of the Insurer for medical expenses not during hospitalization, with regard to an insurance event that occurs within the insurance period and the treatment of which is not completed by the end of the insurance period, will continue for an additional period of 90 days after the end of the insurance period.

3.5 Special expenses:

Transportation of mortal remains: In the case of the death of the Insured, the expenses of transporting the corpse from Israel to the Insured's country of origin, up to the amount of the limit of liability in the Policy, up to the amount specified in the Limits of Liability table of the Policy, and provided that the expense is not paid by any other entity.

The Insurer will be entitled at any time to demand that the Insured return to his country of origin for the purpose of receiving medical treatment, provided that his return is possible from a medical point of view.

The undertaking of the Insurer for Chapter 3 shall not exceed a total amount of \$150,000 for the entire insurance period.

Chapter 4: Riders

Subject to the Conditions Specified in the Rider and Subject to the General Conditions, Definitions and Exclusions Specified in the Policy.

4.1 Worsening of an existing illness

Worsening of an existing illness is a sudden and unexpected change for the worse of an existing disease the treatment of which was necessary in Israel as emergency treatment **and which was stabilized with medication for 6 months prior to the arrival of the Insured in Israel. In the context of the worsening, there will not be coverage for a malignant disease, heart surgery/ies, catheterization, angiography (balloon) and/or any procedure to open a blockage in the coronary arteries, organ or limb transplant, implantation of a pacemaker, dialysis, MS and CF.**

Undertaking of the Insurer:

The Insurer will pay medical expenses during hospitalization and not during hospitalization due to worsening of an existing illness, subject to the cumulative conditions below, up to the amount of **\$30,000** and up to the amount specified in the Limits of Liability table in the Policy:

- 4.1.1 The Insured suffered the worsening during the insurance period, as defined in Section 1.14.**
- 4.1.2 The Insured was stabilized with medication due to the existing illness for a period of no less than 6 months prior to his arrival in Israel.**
- 4.1.3 The Insured was not hospitalized for the illness during a period of 6 months prior to his arrival in Israel.**

Limits of Liability table in the Policy.

4.2 Medical expenses overseas up to the amount of \$10,000 and up to the amount specified on the Limits of Liability table of the Policy.

In the case of an accident event that occurred for the first time in Israel, the Insured will be entitled to continued treatment overseas subject to the following provisions, cumulatively:

- 4.2.1 The medical treatments are provided as a direct and immediate continuation of an event that occurred during the insurance period.**
- 4.2.2 The Insured is not entitled to coverage of these expense by any other entity.**
- 4.2.3 The Insured is entitled to the type of treatments required according to the provisions of the Policy.**
- 4.2.4 The Insured and/or someone on its behalf applied to the Insurer in advance to receive its written approval to perform the treatment.**

4.3 Medical expenses in Israel as a result of an emergency psychiatric event:

The Insurer will bear medical expenses in Israel as the result of an emergency psychiatric event up to the amount of \$5,000 and up to the amount specified in the Limits of Liability table in the Policy.

4.4 Medical flight:

In the occurrence of an insurance event, the Insured will pay the Insured expenses for medical flight, subject to the following terms and definitions:

4.4.1 Definition: Medical flight.

Flight on a regular airline and/or a special plane accompanied by a medical team suited medically to the condition of the Insured, transported from Israel overseas, on the following conditions, **on the condition that a physician on behalf of the Insurer in coordination with the attending physician in Israel determined that there is liable to arise a need for medical intervention during the flight and on the additional condition that the medical flight is medically possible and necessary.**

4.4.2 The undertaking of the Insurer:

The Insurer will allow a medical flight as defined above, and, on the condition that it is in regard of an event for which the Insured would be entitled to a refund of medical expenses in the basic policy, and will transport the Insured overseas.

The means of transport will be determined by a physician on behalf of the Insurer in coordination with the attending physician in Israel, after receiving information about the medical condition of the Insured and treatment possibilities. **The liability of the Insurer according to this rider is conditional upon execution of the medical flight only by means of the Insurer and/or someone on its behalf.**

4.4.3 If the flight is approved by the Insurance Company and there is necessity for a traveling companion (who is not a member of the medical staff), the Insurer will bear the expenses of a traveling companion in tourist class, up to the amount specified in the Limit of Liability table of the Policy for this section.

It is clarified and emphasized that the undertaking of the Insurer according to this section is to arrange the medical flight as said, in any way or manner, insofar as this is at all possible under the circumstances of the time and place that the Insured is located.

The total maximum liability of the Insurer will not exceed the amount of \$12,000 and up to the amount specified in the Limits of Liability table of the Policy.

In the case of a psychiatric event, these expenses of the Insured and the traveling companion will be limited to the amount of \$3,000 and up to the amount specified in the Limits of Liability table of the Policy, and all this according to the terms specified in Section 4.4 above.

4.5 Expenses of air evacuation and rescue from the location of the event in Israel to a nearby hospital:

The Insured will bear these expenses up to the amount of \$50,000 and no more than the total specified in the Limits of Liability table in the Policy, on the following conditions, cumulatively:

- 4.5.1 It is not possible to transport the Insured by land evacuation.
- 4.5.2 There is an immediate urgent need to perform the evacuation without which the life of the Insured would be in danger.
- 4.5.3 The Insurer and/or someone on its behalf approved the evacuation in advance.

4.6 Emergency flight for a close relative:

In the case of an accident event after which the Insured is in a condition that he requires assistance 24 hours a day (approved by the Insurer in advance) or in the case that the Insured is hospitalized in Israel due to an event that requires invasive surgery and whose hospitalization exceeds 7 days, the Insurer will pay one close relative only the cost of purchasing a ticket to travel to Israel in tourist class, up to the amount of **\$2,000** and up to the amount specified on the Limits of Liability table.

4.7 Death or loss of organs or limbs (in Israel only):

Upon the occurrence of an insurance event, the Insurer will indemnify the Insured, subject to the conditions set forth in this section below and subject to the rules, definitions and exclusions specified in the Policy.

4.7.1 Additional definitions for Section 4.7:

4.7.1.1. Accident:

A physical injury caused by the application of physical force only, as the result of a sudden, singular and unexpected event, caused directly by an external and visible entity, which constitutes the sole direct and immediate cause of the occurrence of the insurance event. To eliminate doubt, verbal violence and/or emotional pressure and/or a CVA and/or the accumulation of small repeated injuries over a period of time that lead to disability will not be considered an "accident."

4.7.1.2. Loss of limbs or organs:

Total and complete loss, anatomical or functional, or an organ or limb or part thereof, due to an accident that occurred in Israel during the insurance period.

4.7.2 Undertaking of the Insurer:

If the insured incurs death or loss of organs in Israel during the insurance period, the direct cause of which is an accident, insurance benefits will be paid as follows:

- 4.7.2.1. **Death of the Insured:** In the cause of death of the Insured, the beneficiaries, and in the case that beneficiaries were not specified, the legal heirs of the Insured or the managers of his estate according to an inheritance order and/or a probate order will be paid insurance benefits in the amount of \$15,000 according to the amount specified in the Limits of Liability table of the Policy and **provided that the Insured is over the age of 18 years (inclusive) and up to the age of 75 (inclusive) on the date of occurrence of the accident.**
- 4.7.2.2. **Loss of limb/s or organ/s: incurred by an Insured up to the age of 75 (inclusive)** at the time of the accident of loss of an organ/s or limb/s (as defined in Section 4.14.1.2 above), he will be entitled to percentages of the amount specified in the Limits of Liability table of the Policy.
- 4.7.2.3. **For example: If the Insured incurs loss of a leg and the maximum insurance amount specified in \$6,000, the Insured will receive, in this case = \$6,000 x 40% = \$2,400.**

Pre-existing disability of the Insured prior to the beginning date of the insurance (according to medical documentation) will be deducted according to the rate of the pre-existing disability from the rate of loss of the organ or limb that entitles the Insured to payment according to this section.

Total and Complete Disability/Loss of:	Percentage of the disability
Ability to see in both eyes	100%
Ability to use both hands or both legs	100%
The right arm or the right hand	60%*
The left arm or left hand	50%*
One leg	40%
Sight in one eye	25%
Thumb on either hand	16%
Finger on the right hand	14%*
Finger on the left hand	12%*
Little finger on the right hand	12%*
Little finger on the left hand	10%*
Middle finger on the right hand	8%*
Middle finger on the left hand	6%*
Ring finger on either hand	6%
Big toe	5%
Any other toe	3%
Hearing in both ears	40%
Hearing in one ear	10%

*** In the case of someone left-handed, the converse: The left hand will be treated according to the same percentages specified for the right hand and injury to the right hand, according to the percentages for the left hand.**

The percentages specified in the above table refer to 100% loss of that organ or limb.

Organs that are not listed in the above table – in any case in which loss of organ/s or limb/s (as defined in Section 4.14.1.2 above), the amount of compensation will be determined according to the determination of a medical expert in the field and will be paid as a percentage of the maximum insurance amount specified on the Limits of Liability table for the Policy. For example: If the Insured incurs loss of an organ or limb as defined in Section 4.14.1.2 above and that organ or limb is not specified in the table above, and the physician determined that this is 10% disability and the maximum insurance amount specified in \$6,000, the Insured will receive, in this case = \$6,000 x 10% = \$600.

Pre-existing disability of the Insured prior to the beginning date of the insurance (according to medical documentation) will be deducted according to the rate of the pre-existing disability from the rate of loss of the organ or limb that entitles the Insured to payment according to this section.

The total undertaking of the Insurer according to this rider will not exceed \$15,000 and up to the amount specified in the Limits of Liability table in the Policy.

4.7.3 Exclusions to Section 4.14 in addition to the general exclusions in the Policy:

The Insurer will not pay insurance benefits according to this rider if the death or loss of organ/s or limb/s were caused directly or indirectly by or due to:

- 4.7.3.1. Plastic disability.**
- 4.7.3.2. An earthquake, volcanic eruption, nuclear fission, nuclear fusion, radioactive contamination.**
- 4.7.3.3. Active participation of the Insured in a police or underground action, or an insurance event in the course of military service that stems directly from activity of a military nature, including military or pre-military exercises/training of any type whatsoever, rebellion, revolt, disturbances, riots, sabotage**
- 4.7.3.4. Commitment of a crime, a misdemeanor, drug trade, activity without a valid license suitable for that activity as required (that is, a license to drive or fly a plane, or sports activity for which a license is required), or resistance to arrest.**
- 4.7.3.5. The participation of the Insured in an act of sabotage or terror of any type whatsoever and/or in war and/or in an act of war or regular or irregular hostile forces.**
- 4.7.3.6. Flight of the Insured in an aircraft, with the exception of flight of the Insured as a passenger on a civilian aircraft holding a**

certificate of fitness to carry passengers, subject to the liability of the Insurer in Israel alone.

- 4.7.3.7. **Intentional self-injury or suicide or attempt to do so, whether the Insured is sane or not.**
- 4.7.3.8. **Sports activity of the Insured in the framework of a registered sports association according to the Sports Law 5748 – 1988 and/or competitive sports activity and/or professional sports (that constitutes his main occupation and/or that involves monetary payment).**
- 4.7.3.9. **Sports activity of the Insured in extreme sports according to the list that appears in the Insurer's website. For this purpose, "extreme sports" refers to fields of sports considered to be dangerous and that include/require, among other things, high levels of difficulty and/or physical effort of those who engage in them. The list of extreme sports fields will be updated from time to time according to the list that appears on the Insurer's website www.harel-group.co.il (Tourists tab).**
- 4.7.3.10. **Use of explosives.**
- 4.7.3.11. **Deliberate self-endangerment, with the exception of self-defense and rescuing life.**
- 4.7.3.12. **Alcoholism or drug use by the Insured.**
- 4.7.3.13. **Death or disability as a result of medical or surgical treatment.**
- 4.7.3.14. **A work accident as defined in the National Insurance Act.**
- 4.7.3.15. **If the damage is caused as the result of a hostile act as defined in the Compensation for Victims of Hostile Acts Law, 5730 – 1970.**
- 4.7.3.16. **A road accident as defined in the Road Accident Victims Compensation Law, 5735 – 1975.**

4.8 Physical therapy:

The Insurer will pay the Insured for injuries that occurred during the insurance period and that are covered by the Policy, according to the instructions of a physician and with the Insurer's prior approval of the expenses for physical therapy. The coverage will be provided by a contracted supplier of the Insurer. **The maximum undertaking according to this section will not exceed the maximum amount for medical expenses in Chapter 3 - \$150,000 and up to 12 sessions a year and up to the amount specified in the Limits of Liability table of the Policy.**

Treatments carried out by a non-contracted supplier without the prior consent of the Insurer will be covered up to a maximum of 12 sessions a year and up to the amount of NIS 150 per session.

4.9 Extreme sports activity:

4.9.1 Additional Definitions for Section 4.9:

Extreme sports: Fields of sport that include/require of those that engage in them, among other things, high levels of difficulty and/or physical effort. The list of the fields of extreme sports will be updated from time to time according to the list that appears on the Company website, www.harel-group.co.il

4.9.2 The undertaking of the Insurer: The Insurer will pay the Insured hospitalization expenses, medical expenses and insurance benefits covered in the basic policy and that arise from participation of the Insured in extreme sports activity as defined above, carried out in Israel only.

4.9.3 Additional exclusions to Section 4.9 in addition to the existing exclusions in the Policy. The Insured will not pay for claims that arise from or related to:

4.9.3.1. Winter sports, winter skiing and/or snowboarding and/or snow sleds and/or snow bikes.

4.9.3.2. A claim that arises from and/or is related to the Insured woman being pregnant.

4.9.3.3. The participation of the Insured in extreme sports for which wages are paid.

The maximum liability of the Insurer according to Section 4.11 will not exceed the maximum amount of \$10,000 and up to the amount specified in the Limits of Liability table of the Policy.

4.10 Rider for routine checkups performed once a year for Insured who come into contact with radioactive substances or X rays in the framework of their studies or their work for the Policyholder:

The required tests for coverage: examination of an occupational physician, examination by an eye doctor, blood count, blood count – biochemistry, general urine, nurse's test.

The maximum undertaking according to this section will not exceed the maximum amount for medical expenses in Chapter 3 – \$150,000 and up to the amount specified in the Limits of Liability table of the Policy.

4.11 Rider for psychological treatments:

The Insured will be entitled during a one-year insurance period to up to 12 sessions of psychotherapy. The number of sessions will be proportionate to the number of months of the insurance period. **Coverage will not be given for a number of sessions that exceeds the number of months of the insurance period.** For example – in an insurance period of 6 months, the Insured will be entitled to a refund for 6 sessions. The Insurer will make the refund in return for receipts in an amount of up NIS 200 per session.

4.12 Rider for pregnancy and childbirth

4.12.1 **Preconditions for the Insurer's liability for pregnancy and childbirth:** The Insurer will be liable for medical expenses associated with pregnancy and childbirth of the Insured as set forth below, provided that the following conditions existed, cumulatively, for the Insured:

4.12.1.1. The Insured is insured under this Policy with the Insurer.

4.12.1.2. A waiting period of 3 months has passed since the beginning of the insurance.

4.12.1.3. **No coverage will be given** for childbirth expenses according to the National Insurance Law, 5755 – 1995.

4.12.2 **Expenses during pregnancy:**

Medical expenses during hospitalization in a hospital in Israel: If the Insured needs hospitalization in a hospital in Israel because of sudden deterioration and/or pathology during pregnancy and/or hospitalization expenses to terminate a pregnancy if continuation of the pregnancy endangers the life of the pregnant Insured woman or the life of the fetus, her entitlement to hospitalization according to Chapter 3 above and the expenses incurred by the Insurer due to this hospitalization will be part of the ceiling amount of insurance specified in the Limits of Liability table and up to the amount specified in the Limits of Liability table and up to the amount of \$150,000 out of the limit of liability of the Policy.

4.12.3 **Non-hospitalization expenses:**

4.12.3.1. Expenses for regular monitoring.

4.12.3.2. Expenses for ultrasound tests.

4.12.3.3. Expenses for regular laboratory tests.

4.12.3.4. If the Insured woman requires additional tests due to special risks or due to pathology of the pregnancy, the Insurer will bear the cost of these additional tests.

A precondition for liability of the Insurer is receipt of prior approval from the Insurer to perform these tests. Absence of a request by the Insured to the Insurer for prior approval by the Insurer may cause reduction in the amount of insurance benefits up to the amount that the Insurer would have paid if it had been given prior notice.

4.12.4 **Expenses of childbirth:**

The Insurer will bear the expenses of the Insured for a regular childbirth and/or a Caesarian section according to the provisions of this Policy up to 3

days of hospitalization in the case of regular childbirth and up to 7 days of hospitalization in the case of a complication during childbirth according to the written instructions of a physician.

If the newborn is ill or suffers a deformity, the scope of the coverage in regard of a newborn or infant will be up to 21 days only.

4.12.5 Special exclusions to Section 4.12 – in addition to the existing exclusions in the Policy in Section 2.19 above:

In addition to the above-said, the Insurer will not be liable for payment of insurance benefits according to this section in the following cases:

4.12.5.1. An event that occurs during the waiting period.

4.12.5.2. Medical treatment and/or treatment of any type that is related to the infant born and/or the fetus and/or the premature infant born, whether it is born by regular childbirth or by Caesarian section or by early childbirth, except as specified in Section 4.12.4.

4.12.5.3. Expense of bedrest pregnancy not during hospitalization.

4.12.5.4. Fertility or infertility treatments.

The undertaking of the Insurer in Section 4.12 will not deviate from the overall amount of \$150,000 out of the ceiling for coverage of Chapter 3 and no more than two pregnancies during the entire Insurance period. To eliminate doubt, if the Insured extended the insurance period consecutively, the extended period constitutes an integral part of the original insurance period.

Table of Limits of Liability for the Policy	
Coverage	Limits of Liability
Chapter 3: The limit of liability for medical expenses during hospitalization and not during hospitalization	\$150,000
Medical expenses during hospitalization	Up to 120 days of hospitalization
Medical expenses not during hospitalization	
Treatment, consultation with physician	Included in the limits of liability
Laboratory tests, bandaging, X-rays	Included in the limits of liability
First aid at a Magen David Adom station	Included in the limits of liability
Medications	Included in the limits of liability
Expenses for transport by ambulance	Included in the limits of liability
Emergency dental treatment	\$400
Transportation of mortal remains	Included in the limits of liability
Chapter 4: Riders	
4.1 Worsening of an existing illness	\$30,000
4.2 Medical expenses overseas	\$10,000
4.3 Medical expenses in Israel as a result of an emergency psychiatric event	\$5,000
4.4 Medical flight Expenses of transportation overseas as the result of a psychiatric event	\$12,000 \$3,000
4.5 Air evacuation and rescue from the location of the event to a nearby hospital in Israel	\$50,000
4.6 Emergency flight for a close relative	\$2,000
4.7 Death over age 18 and up to age 75 Total loss of organs or limbs due to an accident up to age 75	\$15,000
4.8 Physical therapy – up to 12 sessions per year Treatment by a non-contracted supplier up to 12 sessions	Included in the limits of liability in Chapter 3 Refund of NIS 150 per treatment
4.9 Extreme sports	Included in the limits of liability in Chapter 3
4.10 Routine tests for Insured who come into contact with radioactive materials or X rays	Included in the limits of liability in Chapter 3
4.11 Psychological treatments	A refund of up to NIS 200 per session and up to 12 sessions per year. The number of sessions will be calculated proportionate to the insurance period.
4.12 Pregnancy and childbirth – Waiting period of 3 months Childbirth expenses	Included in the limits of liability in Chapter 3 3 days hospitalization in the case of regular childbirth and up to 7 days hospitalization in the case of complications during childbirth