Harel Privet Medical Services Preferred Platinum

Insurance program includes the following Annexes / Terms Of Service:

No. 896	General Insurance Terms
Annex No. 804	Extended Surgery Coverage Insurance
Annex No. 931	Surgery Alternative Treatments Insurance
Annex No. 851	Private Surgery Abroad Insurance
Annex No. 929	In Israel and Abroad Transplant and Special Treatments Abroad Insurance
Annex No. 805A	Special Medical Consultation Insurance
Annex No. 904	Special Medications Insurance
Term of Service No. 934	Escort by a Personal Physician
Terms of service No. 907	Unique Medical Services
Terms of service No. 909	Living Healthy
Terms of service No. 908	Subscription for "Heart Event"
No. 877	Information According to "Proper Disclosure" Regulations + Premiums Table

The binding version of the policy terms, is the Hebrew version only

Harel Insurance Company Ltd.
Harel Building, Abba Hillel 3, POB 1951 Ramat Gan
www.harel-group.co.il 03-7549497 03-7547777 52118

General Insurance Terms
No. 896

It is hereby declared and agreed that in exchange for payment of premium, as detailed on the Insurance Details Page, subject to the terms, the provisions, the restrictions and the exceptions listed below and according to the Insured's declaration relating to him and / or his children, the Company shall indemnify the Insured and / or pay directly to the Service Provider/s of the service and / or compensate the Insured - all in accordance with Company obligations by each of the insurance Annexes, for all the Insurance Events in each Annex, but no more than the specified maximum amount on insurance set in the Insurance Details Page and / or in any Annex or article in which such an amount was set.

1. General Definitions

In the Policy and its Annexes the following terms will have the meaning interpreted alongside:

1.1 The Company:
Harel Insurance Company Ltd.

1.2 The Policy:
This insurance contract, including General Conditions relating to all of the Policy annexes, including the Insurance proposal, the Insurance Details Page and every Annex and addendum attached to it.

1.3 Payer:
The person or the corporation, contracting with the Company -
according to this policy in order to pay the premium, who is named in the Insurance Details Page and in the proposal.

1.4 The Insured:
Person named in the Insurance Details Page.

1.5 Insurance Proposal:
The proposal form constituting an application to join the Insurance according to this policy when it is filled with all details and signed by the Insured and / or by his/her spouse on his/her behalf and on behalf of single member of his family. The proposal will also include the Health statement filled and signed by the Insured and the bank direct debit order and / or other payment order, including credit card/s, for the payment of premiums.

1.6. Insurance Commencement Date:
The date specified in the Insurance Details Page as the "Insurance Commencement Date".

1.7. Period of Insurance:
Starting from the Insurance Commencement Date and for the Insured's entire life.

1.8. Insurance Premium:
Amount in respect of this policy that the Payer and / or the Insured have to pay the Company, under the terms of the Policy, as detailed on the Insurance Details Page.

1.9. Insurance Event:
Set of facts and circumstances described in each of the Annexes in the Policy which existence gives to the Insured the right to insurance benefits according to the Policy.

1.10. Qualifying Period:
A continuous time period, which starts for every Insured as of the Insurance Commencement Date and ends the end of the period specified in every Annex attached to the Policy. Qualifying period shall apply to each Insured only once during continuous insurance periods, and

shall apply again each time the Insured is joined into re-insurance, on non-consecutive insurance periods.

An Insurance Event that occurred during the qualifying Insurance Event is will be treated as an Insurance Event that occurred before the commencement of the insurance.

1.11. Wait Period:

Period beginning on the date of the Insurance Event and ends after the number of days specified as wait period on that Annex attached to the Policy.

1.12. Index:

Consumer Price Index published by the Central Bureau of Statistics or, in the absence of such publication, the index published by the other official body to come in its place, or some index aimed specifically for health services.

1.13. Insurance Year:

A period of 12 consecutive months, the first one beginning at Insurance Commencement Date as stated in the Insurance Details Page.

1.14. Insurance Details Page:

A page attached to the Policy that is an integral part of it, which includes the Policy number, personal details of the Payer and the Insured/s, Insurance Commencement Date, the insurance amounts, Insurance premium and so on.

1.15. Insurance Amount:

The maximum amount of Insurance benefit payments as detailed in provisions of the Policy in any Annex attached to the Policy and / or in the Insurance Details Page.

1.16. Insurance Law:

Insurance Contract Law, 5741 – 1981.

1.17. Health Law:

National Health Insurance Law, 5754 – 1994.

1.18. Health Maintenance Organization (HMO):

A corporation as defined in the Health Law; Health Maintenance Organizations recognized by the Minster of Health including: Clalit General Health Services, Maccabi Health Services, Meuchedet HMO and Leumit HMO.

1.19. Additional Health Services – "Shaban"):

Program for providing additional health services to the health services - according to the basket of services and payments as defined in the Health Law, managed by an HMO of which the Insured is a member, or by a legal entity established for that purpose.

1.20. Israel:

State of Israel, including territories held by Israel.

1.21. Abroad:

Any place or country outside the State of Israel, except for enemy states.

1.22. Hospital:

A medical institution recognized by the competent authorities in Israel or abroad as a general hospital only, except for an institution which is also a sanatorium, convalescent house, recovery house.

1.23. Private Hospital:

Hospital as defined above authorized by the Ministry of Health to perform surgeries privately.

1.24. Agreed Hospital:

Private hospital as defined above, which is in agreement with the Company, on the date the claim was filled by the Insured.

1.25. Surgery:

Invasive - penetrating action (Invasive Procedure) that penetrates through tissue and aimed to treat a disease and / or an injury and / or to repair a defect or deformity of the Insured.

In this context the following operations shall also be considered as surgery: intrusive - penetrating operations, including operation performed by use of a laser beam, for diagnosis or treatment, and also for inspection of internal organs through an endoscope, by catheterization, by angiography and also shock wave lithotripsy of kidney or gallbladder stones.

1.26. Agreed Surgeon:

A medical doctor who was authorized and certified by the competent authorities in Israel or abroad as an expert – Surgeon, who is in agreement with the Company on the date the claim was filled by the Insured.

1.27. Other Surgeon:

A medical doctor who was authorized and certified by the competent authorities in Israel or abroad as an expert surgeon, who is not an agreed surgeon.

1.28. Anesthesiologist:

A doctor who authorized and certified by the competent authorities in Israel or abroad as a certified anesthesiologist who is in agreement with the Company on the date the claim was filled by the Insured.

1.29. Nurse:

A nurse with a certifying diploma from the Ministry of
Health.

1.30. Agreed Service Provider:

A surgeon, a hospital and any physician or other body with which the Company has or will have an agreement, provided that that he / it was a party to the agreement with the Company at the claim was filled.

1.31. Deductibles:

The Insured's part of the expenditure caused by an Insurance Event. It is hereby clarified that the Company's liability for any payment according to the Annex, will be only after the deductible amount was paid by the Insured and only regarding the Insured's expenditures which are beyond the deductible amount.

1.32. Prosthetic / Implant:

Any accessory, a natural organ or part of a natural organ, or of an artificial organ, an artificial or natural joint, Implanted or installed in the Insured's body c
during and while a surgery covered under the Insurance (e.g.: lens, hip joint, etc.), except dental prosthesis, dental implant and implant during transplantation.

1.33. Dentist:

A person practicing dentistry according to a valid license from the competent authorities in Israel.

1.34. Periodentist:

A dentist as stated in the aforementioned definition with a specialty certificate in periodontology from the competent authorities in Israel.

1.35. Reservation Due to Previous Medical Condition:

General reservation in the Policy, exempting the Company from its liability, or reducing the Company's liability or the scope of coverage, for an Insurance Event for which a real factor was the normal course of a previous medical condition that occurred in the Insured during the period in which the reservation applied.

2. Validity of the Policy.

2.1. This policy will come into effect as from Insurance Commencement Date as indicated on the Insurance Details Page, After the initial insurance premium was paid, provided the from the day of signing the insurance proposal by the Insured and until the Insurance Period Commencement Date there was no change in the health of status of the Insured. If any payment were made to the Company on account of the insurance premium, before the Company's gave its consent to conducting the insurance, such payment shall not be considered as the Company's consent for conducting the insurance. The Company shall send, within 180 days from the receipt day of the initial premium, a rejection, or an application for information completion or a counter insurance proposal.

2.2. An Insured under this policy who reached the age of 21, will continue to be insured under this policy, with no need of a health statement or medical tests, be his medical condition whatever it will be. The aforementioned Insured will be detracted from the Policy provided that he or one of his parents, Insured under the Policy, requested the Company in writing within 90 days after the Insured reached the age of 21 to detract him from the Policy.

3. Disclosure Duty.

3.1. If a question regarding a fundamental issue was given an answer which was not full and frank, the Company may, within thirty days after it learned about it and as long as an Insurance Event has not occurred, cancel the Policy by a written notice to the Insured.

3.2. If the Company canceled the Policy under this Article, the Insured is entitled to a refund of premiums paid for the period after the cancellation, less the Company's expenses, unless the Insured acted with fraudulent intent.

3.3. If the Insurance Event occurred before the Policy was canceled by virtue of this Article, the Company is liable only for Insurance benefits relatively reduced by the amount of the ratio between insurance premiums that would have been paid as usual by it, as acceptable according to the real situation and between the agreed premiums, and the Company is totally exempt in any of the following cases:

3.3.1. The answer was given with fraudulent intent.

3.3.2. A reasonable Insurer would not have entered into that contract, even for larger premiums, had he known the true situation; in which case the Insured is entitled to a refund of Insurance premiums paid by him for the period after the Insurance Event less the Company's expenses.

3.4. The Insurer is not entitled to the above remedies, in each of these case, unless the answer that was not full and frank, was given with fraudulent intent:

3.4.1. He knew or should have known the real situation when the contract was made, or that was the one who caused the answer not to be full and frank;

3.4.2. The fact of which the answer that was not full and frank was given, ceased to exist before the Insurance Event occurred, or it did not affected that case, the Insurer's liability or its extent.

4. General Exceptions

Company shall not be responsible and shall not be obligated to pay insurance benefits for an

Insurance Event, all or part of it, in any of the following cases:

4.1. The Insurance Event occurred before the Insurance Commencement Date.

4.2. The Insurance Event occurred during the qualifying period.

4.3. An insurance for which an actual cause was a previous medical condition, that is: a set of medical circumstances diagnosed in the Insured before the date of his joining the insurance, including due to illness or accident; in this regard, "diagnosed in the Insured" - in a manner of documented medical diagnosis, or in the process of recorded medical diagnosis, which took place within six months prior to the date of joining the insurance. This exception shall be limited in time according to the Insured's age on the Insurance Commencement Date as follows:

A. Less than 65 years - the exception will be valid for a period not exceeding one year from the Insurance Commencement Date.

B. 65 years or more – The exception will be valid for a period not exceeding half a year from the Insurance Commencement Date.

Restriction due to a previous medical condition will not be valid if the Insured notified the Company on his previous health condition, and the Company, did not specifically restrict, on the Insurance Details Page, the specific health condition mentioned in the Insured's notice.

4.4. The Insurance Event occurred after the end of the insurance period.

4.5. Insanity, suicide or attempted suicide, self-inflicted damage, alcoholism, medications use except medical medications use by order of a physician.

4.6. Air - gliding, paragliding, parachuting, skiing, diving, flying any aircraft except civil flight in an aircraft with certification for passengers transport.

4.7. Direct or indirect result of the Acquired Immune Deficiency Syndrome (AIDS) including mutations and / or variations and / or other similar syndrome.

4.8. The Insurance Event was caused or is the result of the Insured's service in security forces of any kind, including in regular army or in army reserve service or in permanent army service.

4.9. Complications of pregnancy and / or birth, fertility and / or infertility.

4.10. Congenital malformation or disease, including hereditary diseases which were diagnosed in the Insured before his joining the insurance, subject to Article 4.3 aforementioned.

4.11. The Insurance Event was caused by a nuclear fissile or nuclear fusion or radioactive contamination or war action or military action.

4.12. Mental disorders and / or mental illness and / or mental treatments and / or psychological treatments.

4.13. Routine tests and / or monitoring and / or testing not due to an active medical problem.

4.14. Experimental therapies or treatments that are not acceptable by common medical standards.

5. Insurance Benefits

5.1. The Company shall be entitled at its discretion, to pay the insurance benefits or part thereof, directly to the Service Providers, or to pay them to the Insured in return for the original receipts. The Insured is entitled to receive from the Company, at his request, a written financial undertaking to the Service Provider which will allow him to receive medical service provided that his eligibility according to the Policy is not disputed.

5.2. Insurance benefits which are intended to fund medical treatments carried out outside the State of Israel will be paid for in the currency of country in which the payment should be made provided that the Company will submitted a permit for exporting foreign currency, if necessary.

5.3. Insurance benefits denominated in foreign currency and paid in Israel will be paid in ILS according to the sale rate (transfers and checks) of the aforementioned foreign currency which will be acceptable in "Hapoalim" bank on the date the payment will be prepared by the Company.

5.4. In case an Insured dies, the Company will pay the rest of the insurance benefits to the medical Service Provider to which the Company undertook to pay. In the absence of undertaking to the medical Service Provider or if there is surplus left after payment according to the undertaking the Company shall pay the surplus to the Insured's estate and / or to the Insured's heirs according to a probate order and / or a succession order.

5.5. The Insured will not be eligible for insurance benefits higher than the Insurance Amount.

5.6. If the Insured had, due to the Insurance Event, a right of compensation or indemnification towards a third party, not by virtue of an insurance contract, this right is transferred to the Company, from the time it Insurance benefits to the Insured, and in the amount of compensation it paid without prejudice to the Insured's right Insured to first claim first from a third party indemnity over the benefit payments he received according to this policy. If the Insured has received from a third party compensation or indemnification that the Company has the right for under this Article, he must transfer it to the Company. In any case of compromise, waiver or other act of the Insured, which derogates from a right that was transferred to the Company, he must compensate it for that. The Insured undertakes to cooperate with the Company as required of him, to exercise the Company's right as aforementioned. The provisions of this Article shall not apply if the Insurance Event was caused unintentionally by a person whom a reasonable Insured would not claim compensation or Indemnification from, due to kindred or employer and employee relationship between them.

5.7. If the Insured is entitled to expenses coverage payable under this insurance in full or in part in another policy of Insurance Company, the Company shall be liable jointly and severally with the other Insurance Company. The Insurers shall bear the burden of the obligation among themselves according to the ratio of the Insurance benefits.

6. Premium Payment

6.1. Payment dates of premiums will be at the beginning of each month - according to the date when its payment was determined by the Company.

6.2. If premium payment is made by a permanent bank order (checks service or credit card) crediting the Company's bank account or credit account will constitute premiums payment.

6.3. To premiums which are not paid on time there will be added index differentials and interest as determined in the Adjudication of Interest and Index Differentials law
5721 – 1961 from the date the payment delay started and until the actual repayment of premiums to the Company.

7. Changing Insurance Premiums and Terms

7.1. Premiums according to this policy will be determined in accordance with Insured's age at the time he joined the insurance. Premium will change every five years and from the age of 65 it will be constant, all depending on the table of premiums attached to this policy and subject to Article 9 hereinafter.

7.2. **The Company shall be entitled to change the premium and the terms of this policy to all Insured by this policy. This change shall be valid provided the Commissioner of the Capital Market, Insurance and Savings approved the change and it will come into effect 60 days after the Company gave the Insured a written notification about it.**

7.3. Change of premiums as provided in Article 7.2 above
we apply to all Insured in the plan and will not take into account changes in the Insured's health condition (if a change as aforementioned has occurred) for the period preceding such change.

8. Claims

The Company will pay the Insured the insurance benefits according to this policy or transfer them directly to the Service Providers in the agreement if all the following conditions are met:

8.1. The Insured notified the Company in advance about the Insurance Event and received the Company's approval that the Insurance Event exists and of its liability according to this policy. Receiving the Company's approval that the Insurance Event exists and of its liability, is an essential condition for the Company's liability. If an Insurance Event occurred and due to an emergency the Insured was prevented from notifying the Company in advance, the Company will pay the insurance benefits to the Insured after clarification and confirmation of its liability.

8.2. The Insured signed a written waiver of medical confidentiality and provided the Company with all the details and the original medical documents reasonable and other required by the Company to examine his claim.

8.3. The Insured provided the Company with the original receipts confirming actual payment made by him.

8.4. The Company shall be entitled to conduct at its expense all reasonable inquiry and examine the Insured by one or more doctors on its behalf as it deems fit.

8.5. The Company is not responsible for the quality of services medical and / or others given to the Insured under this insurance. The Company is not responsible for any damage caused to the Insured and / or any other person directly or indirectly due to the election of Insured and / or reference by the Company to providers of medical services and / or others and / or due to act or omission of the aforementioned.

9. Index Linkage

9.1. The determining insurance benefits, the premium and the deductible rate, if any, to be paid under the terms of the Policy by the Company and / or by the Payer and / or by the Insured as the case may be, are linked the index known on the 1st day of the month in which the actual payment was made.

9.2. Calculation of indexation will be the ratio between the index known on the 1st day of the month in which the actual payment

was made by the Company for the insurance amount when an Insurance Event occurs, or by the Payer and / or by the Insured regarding the payment of premiums, and between the index on Insurance Commencement Date that appears in the Insurance Details Page.

10. Policy Cancellation

10.1. Cancellation by the Company - this policy cannot be cancelled by the Company only in the following cases:

10.1.1. The Insured and / or the Payer does no / did not pay the premiums regularly. In such case the insurance will be canceled
according to the provisions of the insurance Contract Law.

10.1.2. The Insured concealed from the Company a substantive fact, as stipulated in the Insurance Contract Law.

10.2. The Insured intentionally did anything to prevent the Company from investigating into its liability or to encumber it, the Company will not owe insurance benefits higher than those it would owe if the aforementioned deed was not done.

10.3. Cancellation by the Payer and / or the Insured;

10.3.1. The Payer and / or the Insured may cancel the Policy at any time, by giving a written notice to the Company.

10.3.2. Cancelling of the Policy by the Payer and / or the Insured means cancellation regarding all the Insured listed in the Insurance Details.

10.3.3. If the Policy has been canceled as provided in Article 10.3.2 the spouse will be entitled to continue the insurance provided he / she informed the Company in writing about that not later than 90 days from the date the cancellation of the Policy notification was given.

11. Taxes and Fees

The Payer, the Insured or the beneficiary, as applicable, must pay to the Company the premiums and the government taxes and other applicable to the Policy or fees imposed on the premiums, on the insurance amounts and on all other payments that the Company is committed to pay according to the Policy, whether these taxes exist on the Policy editing or whether they will be imposed on a later date.

12. Obsolescence

Obsolescence period of a claim for payment of insurance benefits for an Insurance Event according to this policy, is three years from the date of the Insurance Event.

13. Insurance Law and Health Law

13.1. The provisions of the Insurance Contract Law, 5741 – 198 will apply to this policy.

13.2. In case there will be changes in the Health Law or in the basket of health services according to the Health Law, the Company will be entitled to make the necessary changes deriving from it in the Policy subject to the permission of the Commissioner of Capital Markets, Insurance and Savings.

14. Messages

The Insured and / or Payer have to notify the Company of any change of address by a registered letter. Message sent by The Company to the last address of the Insured known to it will be considered as a message given to him properly.

15. Changes

The Company may change from time to time the list of Service Providers in the agreement.

Extended Surgery Coverage Insurance
Annex. 804

In return for payment of the premium as stated on the Insurance Details Page, the Company shall indemnify the Insured and / or pay the Service Provider for his expenses, subject to the General Terms for the Policy, and to the provisions and exceptions set forth in this Annex.

1. Insurance Event

Insurance Event is the Insured's health condition requiring an operation which will be carried out by an agreed surgeon or another surgeon.

2. Insurance Benefits regarding an Insurance Event

The Company shall indemnify the Insured, fully and directly with the Service Provider in the agreement, or in return for the original receipts provided to it by the Insured, in respect of actual expenditures, actually incurred following the Insurance Event and provided that the maximum amount that the Company will pay shall not exceed the payment to Service Provider in the agreement:

2.1 **Private Hospital Surgeon Fees:**

2.1.1 Fees of a surgeon in the agreement will be paid in full - directly to the surgeon in the agreement.

2.1.2 **Another Surgeon -** payment to the Insured depending on the type of surgery performed by another surgeon, will be the amount actually paid by him, up to a limit amount prescribed and published on the Company's website who's web address is http://www.harel-group.co.il, for the surgery performed.

2.2 Consultation Before Private Surgery: The Company refunds the Insured's expenses for one prior consultation (before surgery) with the surgeon who performed the actual surgery.

2.3 Further **Consultation Before Private Surgery:** An Insured for whom a specialist doctor has determined a need of surgery covered - according to the terms of the Policy, shall be entitled to obtain a second opinion from a specialist doctor in this area, in regard of the need for surgery.

The second opinion will be given by a Specialist Physician - director or deputy head of department / unit, as will be determined by the Company, through referring the Insured to be examined by the specialist referral and / or by transfer of relevant medical documents for his review (at the Company's discretion).

2.4 Anesthesiologist Fees in an Agreed Hospital: The Company will pay directly the costs of the anesthesiologist doctor for the anesthesia performed on the Insured during a privet surgery or it will refund these costs to the Insured in accordance with the Company's fixed amount for anesthesiologist according to the surgery conducted.

2.5 Coverage of Hospitalization Costs in an Agreed Hospital in Case of Private Surgery: The Company will cover Hospitalization expenses in a room of two to three beds in an agreed hospital for a period not exceeding 30 days.

2.6 Operating Room Expenditures in an Agreed Hospital: The Company shall pay directly to the hospital the expenditures for operating room, according to the surgery performed, or refund these expenditures to the Insured.

2.7 **Pathological Examination Expenditures**: The Company shall pay directly to the hospital for pathological examination required in the case of a private operation, or shall refund these expenses to the Insured.

2.8 **Prosthetic / Implant:** if a surgery was carried out for the Insured in an agreed hospital, and during the surgery any prosthetic was transplanted in the Insured, the Company will participate in the aforementioned prosthetic's cost up to the amount specified in the Insurance Details Page.

2.9 **Privet Nurse During Surgery Fees**: A refund to the Insured up to the amount specified in the Insurance Details Page for each day of hospitalization in a privet hospital due to a surgery for a period not exceeding the number of days of hospitalization as specified in the Insurance Details Page.

2.10 **Ambulance Transportation Services to Hospital and Between Hospitals in Israel:** A refund to the Insured for ambulance services of Magen David Adom, or another ambulance service for the transfer of the Insured to the private hospital or from it or his transfer between hospitals due to surgery at a private hospital, up to the amount specified in the Insurance Details Page.

2.11 **Surgery in a Public Hospital:** If a surgery was performed Israeli public system, without the participation of the Company, the Company will pay the Insured a special compensation as high as 50% of the amount prescribed and published on the Company's website who's web address is http://www.harel-group.co.il, for the surgery performed.

2.12 **Surgery Performed in a Private Hospital, But the HMO is Participating in the Expenses:** If the HMO in which the Insured is a member paid all or part of the surgery expenses in the private hospital and thus the Company's expenses were reduced, the Company will compensate the Insured with the amount prescribed and published on the Company's website who's web address is http://www.harel-group.co.il.

2.13 **Surgery Performed Abroad:** If a surgery was performed abroad on the Insured, covered under this insurance, the Company shall refund the Insured his costs in Israel and by Israeli currency in accordance with the representative exchange rate on the day of the payment by the Company and within the scope of the Insured's eligibility according to this Annex in Israel.

3 **Payment in Case of Death During Surgery:**

If the Insured dies within 7 days after he/she underwent a surgery
covered in this Annex (day of the surgery plus 6 days) the Company shall pay his/her heirs according to a Succession Order and / or a Probate Order in addition to the insurance benefits an additional amount as stated in the Insurance Details Page. Provided that the Insured is over the age of 21 and under the age of 65.

4 **Payment in the event of Total Loss of Work Capacity as a Result of the Preformed Surgery:**

4.2 The Company shall pay the Insured monthly compensation as stated in the Insurance Details Page in the event of total loss of working capacity caused directly by the preformed surgery covered in this Annex provided the Insured over the age of 21 and under the age of 65 and that he was capable of working full-time right before the day of the surgery and / or 6 months before the surgery was performed.

4.3 The Insured will be considered completely unfit for work
for the purpose of this Article and entitled to receive monthly compensation if he will not be able to perform any work or occupation in his profession or in his occupation or in another reasonable profession or occupation fitting his training, his experience and his education and this for a period exceeding three months from the date of surgery (hereinafter: the Standby Period).

4.4 If the Insured was unemployed
at the time the Insurance Event has occurred, he will be considered completely unfit for work if he will be confined to his home due to occurrence of the Insurance Event.

4.5 The monthly compensation will be paid starting from the end of the Standby Period, for a maximum period of 24 months and in any case the payment will stop when the Insured reaches the age of 65.

4.6 If the Insured regains his work capacity he and / or the Payer must notify the Company immediately about it and the Company will discontinue the monthly compensation payment.

4.7 In case of loss of work capacity due to the same Insurance Event the Insured shall not be entitled for an additional payment period.

5 Particular Exceptions

General exceptions clause in the Policy to which this Annex was attached applies also to this Annex.

In addition to the aforementioned, the Company will not owe the insurance payment by this Annex in the following cases:

5.2 A surgery to repair a birth defect and / or deformity, Subject to Article 4.3 General Exceptions, in the General Insurance Terms.

5.3 Surgery related directly or indirectly with a purpose of beauty and / or aesthetics, including surgery to repair nearsightedness and intestinal reducing myopia, except surgery for breast reconstruction after mastectomy.

5.4 Surgery related to fertility and / or infertility.

5.5 Surgery due to injury that occurred during a paid professional sports activity and / or within a sport society.

5.6 Organ transplantation in Israel or abroad, and / or special treatments abroad.

5.7 Checking / testing, lab tests, x-ray, radiation treatments, chemotherapy or oncology treatments, hyperthermia treatment, injection, spraying testing/s, and imaging actions such as: MRI and CT When these are not part a surgery procedure.

5.8 Dental related surgery.

5.9 Pregnancy and / or birth related surgeries except abortion due to medical need and Cesarean Section.

6 Prerequisite for the Company's Liability

The Company shall pay the insurance benefits provided it approved in advance to the Insured the performance of the surgery by a surgeon in the agreement or another surgeon in a private hospital or in an agreed hospital and the time of surgery and everything is subject to the General Terms.

7 Annex Cancellation

This annex shall expire on the occurrence of any of the following cases, according to the earliest:

7.2 When the Elementary Insurance will be canceled.

7.3 When payment period ended.

8 Changes, Waivers or Deviations from Policy Terms

8.2 This Annex is subject to all the terms of the Policy to which attached.

8.3 Any change and / or waiver and / or deviation from the aforesaid in the Elementary Insurance of the Policy will apply in regard to this Annex only if it is expressly included in the Annex.

8.4 In case of conflict between the provisions of this Annex and what is stated in other Annexes of the Policy and / or what is stated in the provisions of the Policy's General Terms, the provisions of this Annex shall apply.

9. Qualifying Period

The qualifying period is of 90 days. In case of an abortion or a cesarean section, the qualifying period shall be of 365 days.

Surgery Alternative Treatments Insurance
Annex. 931

It is hereby declared and agreed that if the Insurance Details Page specifies that the Insured purchased this Annex, the Company will indemnify the Insured and / or will pay the Service Provider for his expenses, subject to General Terms of the Policy and to the provisions and exceptions specified in this Annex.

The Company will be liable under this insurance only if this Annex is Included in the Elementary Insurance Policy and also that the Elementary Insurance and this Annex were in full effect, when the Insurance Event occurred.

1. **Surgery Alternative Treatment**

1.1. Definitions

Surgery Alternative Technology - A non-surgical medical treatment performed as an alternative to surgery, which according to accepted medical standards is designed to achieve a similar result as the result of the surgery instead of which it is performed.

1.2. The Insurance Event

The Insured's medical condition **requiring the performance of surgery**.

1.3. Insurance Benefits Due to an Insurance Event

1.3.1. Surgery Alternative Technology in Israel and Abroad - An Insured in need for surgery, about which there is a recommendation of a specialist in the relevant field, for medical treatment using surgery alternative technology, will be entitled to coverage in Israel and abroad, according to the aggregate conditions listed below:

1.3.1.1. The Insured contacted the Company to receive its prior approval for the performance of the treatment using alternative to surgery technology.

1.3.1.2. Treatment using alternative to surgery technology will preformed on the Insured by a specialist physician specializing in the relevant field.

1.3.1.3. The performer of the treatment using alternative to surgery technology is authorized by law to perform the treatment, and in cases where there is licensing requirement to carry out the treatment, the performer of the treatment will have the appropriate license.

1.3.1.4. Treatment using alternative to surgery technology will be performed in a private hospital or a clinic in Israel as defined in Article 34 of the Public Health Ordinance (1940) which is properly registered in the clinics registry, or in a hospital abroad or in a clinic abroad certified for preforming the treatment the laws of the state in which they are located, and in cases where there is a licensing requirement to perform the treatment, the place where the treatment will be carried out, shall be certified and will have the appropriate license.

1.3.1.5. The Company shall be entitled, according to its discretion, to pay the insurance benefits, or part thereof, directly

to the performer of the operation using surgery alternative technology and / or to the place where the treatment technology using surgery alternative technology was conducted, or payable to the Insured against original receipts. In any case, the insurance benefits shall not exceed the maximum indemnification amount detailed in Article 1.3.1.6 hereinafter.

1.3.1.6. The maximum indemnification amount for a treatment and / or a series of treatments using surgery alternative technology shall not exceed the lower between the maximum indemnification amount stated in the Insurance Details Page or the cost of surgery that is replaced by the treatment using alternative to surgery technology. Cost of Surgery, means for the purposes of this Article, the total of all payments listed below:

1.3.1.6.1. Fees of the surgeon with whom the Company has an agreement for the performance of the operation in Israel.

1.3.1.6.2. The cost of operating room in a private hospital in Israel with which the Company is associated with in an agreement to conduct the surgery.

1.3.1.6.3. Costs of Hospitalization that would have been paid to a private hospital in Israel with which the Company is associated in an agreement.

1.3.1.7. Coverage for medical treatment using surgery alternative technology will include an indemnification for the Insured's expenses due to the following coverage:

1.3.1.7.1. Hire of a specialist for Further preliminary advice, relating to the implementation of the alternative treatment and / or giving advice after the performance of the treatment using alternative to surgery, up to the specified amount stated in the Insurance Details Page for counseling, minus the deductible amount of 20% for each consultation and up to two consultations for one Insurance Event, the first one before the alternative treatment and the second thereafter.

1.3.1.7.2. The fee of the doctor performing the treatment using alternative to surgery technology.

1.3.1.7.3. The costs of operating room or treatments room in a hospital or in a clinic, including accessories used in the course of treatment.

1.3.1.7.4. Costs of hospitalization in the Hospital where treatment using alternative to surgery technology is performed.

1.3.1.8. If a health care treatment using alternative to surgery technology was performed abroad, the Insured shall be entitled to cover by the aforementioned and up to a maximum coverage equal to 200% of the maximum coverage if the treatment was performed in Israel.

1.4. Special Exceptions to this Annex:
General Exceptions clause in the Policy to which this Annex was joined, also applies to this Annex. In addition to the aforementioned, the Company shall not be liable to pay Insurance benefits under this Annex in the following cases:

1.4.1. Medical procedures and / or use of any instruments which are not performed in the course of a surgery of the Insured, or in the course of treatments using alternative to surgery technology.

1.4.2. Transplantation of natural or artificial organ of any kind intended to replace an organ and / or part of an organ and / or designed to add an organ in place of an organ in the body of the Insured, except for Advanced Accessory.

1.4.3. Alternative to surgery technology which is a chemical and / or biological medication any kind and type, except for implants that include a mechanism for medication secretion in the Insured's body.

1.4.4. Expenses covered under the Elementary Insurance Policy, including surgeon fees, hospital, operating room, testing pathology, imaging tests performed during surgery.

1.4.5. Experimental or research treatments or treatments which are unacceptable according to common medical degree standards.

1.4.6. Prevention and survey treatments and / or tests.

1.4.7. Treatments and / or tests that are not for diagnosis and / or treatment of the Insured's medical condition that requires surgery.

1.4.8. Treatments related to pregnancy and / or birth and / or fertility and / or infertility.

1.4.9. Complementary medicine therapies.

1.4.10. Physiotherapy treatments, paramedical treatments - and chemotherapy treatments.

1.4.11. Treatments using alternative to surgery technology which were not yet actually performed in the Insured and / or for the undertaking of the treatment performer for future treatments using alternative to surgery technology.

1.5. Qualifying Period

The qualifying period for the covers under this Annex is of 3 months.

2. Cancellation of the Annex

This Annex shall expire, in any of the following cases, according to the earliest:

2.1. When the Elementary Insurance will be canceled.

2.2. Upon termination of the premium payments in accordance with the provisions of the Insurance Contract Law and with the provisions of Article 10 of the General Insurance Terms.

3. Changes, Waivers or Deviations from Policy Terms

3.1. This Annex is subject to all the terms of the Policy to which it was attached.

3.2. Any change and / or waiver and / or deviation from the aforesaid in the Elementary Insurance of the Policy will apply in regard to this Annex only if it is expressly included in the Annex.

3.3. In case of conflict between the provisions of this Annex and what is stated in other Annexes of the Policy and / or what is stated in the provisions of the Policy's General Terms, the provisions of this Annex shall apply.

Private insurance Abroad surgery
Annex. 851

In return for payment of additional premiums as stated in the Insurance Details Page, the Company will indemnify the Insured and / or will pay the Service Provider for his expenses, subject to General Terms of the Policy and to the provisions and exceptions specified in this Annex.

The Company will be liable under this insurance only if this Annex is Included in the Elementary Insurance Policy and also that the Elementary Insurance and this Annex were in full effect, when the Insurance Event occurred.

1. **Definitions**

Medical Expenses Related to Surgery: surgeon fee, hospitalization of up to 30 days, operating room, pathological examination, prosthesis up to the amount specified in the Insurance Details Page.

Medical Flight: flight in a regular aircraft service or in a special aircraft, Escort by an medical staff medically suitable to the Insured's medical condition, being transferred from Israel Abroad or vice versa, provided that according to accepted medical criteria it was stated that medical intervention might become necessary during the flight, including transfer by land vehicle from the airport to the place of the surgery performance.

2. **Prerequisite to the Insurer's Liability**

Coverage of private surgery abroad allows the performance of a privet operation abroad subject to that, the operation was approved in advance by the Company.

3. Insurance Event

Insured's health condition requiring surgery that the Insured chose to have performed in a hospital abroad.

4. Surgery Coordination

In case an insurance event occurs, the Company will directly pay the service provider and / or indemnify the Insured for medical expenses related to the surgery as follows:

4.1. If a surgery covered according to this Annex was performed on the Insured abroad, after the contract with the medical service providers and the surgery coordination were made by the Insurer, the Company will indemnify the Insured for his medical expenses in relation to surgery in Israeli currency in accordance with the representative exchange rate on the date of payment by the Company.

4.2. If a surgery covered according to this Annex was performed on the Insured abroad, without the contract with the medical service providers and the surgery coordination being made by the Insurer, the Company will indemnify the Insured for his medical expenses in relation to surgery in Israeli currency in accordance with the representative exchange rate on the date of payment by the Company, but not more than the costs of the surgery that would have been paid by the Company to a service provider abroad which is associated with it in an agreement, in the country were the surgery was performed or in a similar country.

5. Insurance Benefits Due to Insurance Event

5.1. If an Insurance Event occurs, the Company will directly pay the service provider the and / or indemnify the Insured for medical expenses related to the surgery, according to the provisions of Article 4 aforementioned

5.2. In addition to the provision of Article 5.1 above, the Company will also will cover the following expenditures:

5.2.1. Medical Flight Expenses Cover - In the case of need for a medical flight of the Insured abroad in order to carry out the surgery or his return to Israel after the surgery, the Company will cover the costs of Medical flight up to the amount Specified in the Insurance Details Page.

5.2.2. Corpse Airlift Expenses Coverage - The Company will cover corpse airlift to Israel expenses after a surgery, if the Insured died heaven forbid during his stay abroad provided that he passed away within a period within a period not longer than 3 days, after his release from the hospital abroad.

5.2.3. Bringing an Expert to Perform the Surgery in Israel – If for medical reasons the Insured, cannot be transferred abroad he will be entitled to reimbursement of expenses for bringing an expert surgeon from abroad to Israel. maximum amount of Insurance in regard of this Article shall not exceed the amount specified in the Insurance Details Page.

5.2.4. Guidance and Information - The Insured will be entitled to receive advice and guidance from the Company's representatives regarding the medical Service Providers relevant to the Insurance Event.

5.2.5. Providing Advice and Assistance Arrangements for their Stay Escort - the Insured is entitled to receive advice and guidance from the Company's representatives regarding arrangements for their escorts stay abroad near the hospital. It is clarified, the Company shall not carry the costs of the escort's stay with the exception of cases specified in Article 5.2.10.1

5.2.6. Travel Insurance for the Escort – The Insured will be entitled to purchase the Company's abroad travel insurance for an escort at 35% discount of the Company's rates at the time. The discount will be given for a period no longer than 10 days.

5.2.7. Transfers of the Insured and an Escort -

The Company shall cover the travel expenses of the Insured and his escort from the airport to the hospital and back.

5.2.8. LIFE-ON-KEY -

If an Insurance Event occurs, the Insured will be entitled to a service of saving his medical documents required for surgery on a Disc On Key and to have access to the documents through the Internet. Transfer and saving of the documents
will be carried out as follows:

5.2.8.1. The Insured shall transfer the medical documentation to the Service Provider,

5.2.8.2. The Service Provider shall edit the required documents for the purpose of adapting them for saving.

5.2.8.3. The Service Provider shall establish a medical record on the Life On Key system, including the possibility of access through the Internet.

5.2.8.4. The Service Provider will save a copy of the documents on a Disc On Key mobile accessory which will be sent to the Insured with the secret access code through the Internet.

5.2.8.5. The Insured will be entitled to medical record update after the performance of the surgery abroad.

5.2.8.6. The Insured shall be entitled to have his documents will be kept in the system for a period of 24 months.

Eligibility of the Insured for this coverage is conditional on the existence of a written LIFE ON KEY Terms of Service document in the Elementary Insurance program.

5.2.9. Flight Expenses Cover – on Insurance Events for which the Insured was flown abroad on a medical flight, the Company will cover the Flight expenses of one escort, and in case where the Insured is a minor the Company will cover the flight expenses of two escorts by a regular commercial flight, to the place where the surgery is performed and back. The maximum Insurance amount for the purposes of this Article, shall not exceed the amount specified in the Insurance Details Page.

5.2.10. Other covers for Insurance Events, For which the Insured had been hospitalized continuously after surgery for a period exceeding 10 days or Insurance Events for which the Insured was flown abroad on a Medical flight:

5.2.10.1. Cover of Stay Costs – The Company will cover the costs of staying for one escort, and in the case where the Insured is a minor, the Company will the costs of staying for two escorts for the entire period of hospitalization. The maximum Insurance amount for the purposes of this Article, shall not exceed the amount specified in the Insurance Details Page, for a maximum period of 30 days.

5.2.10.2. Private Nurse –The Company will cover the Insured's expenses for hiring a private nurse for a period not exceeding 8 days and providing that the services were provided within 30 days after the performance of the surgery abroad. The Insured will be entitled to reimbursement at 80% of his actual costs, up to the amount specified in the Insurance Detail Page .

For avoidance of doubt, this coverage will be given to the Insured in his home or in a hospital, in Israel or abroad.

5.2.10.3. Recovery Expenses – The Company will cover the costs of the Insured's recovery as prescribed by the surgeon who actually performed the surgery, and this in a recognized recovery institution in Israel for a period not exceeding 10 days and providing that the services were provided within 30 days after the surgery was performed abroad. . The Insured will be entitled to reimbursement at 80% of his actual costs, up to the amount specified in the Insurance Detail Page.

5.2.10.4. Continued Medical Monitoring Abroad –

The Company will cover the medical expenses actually made by the Insured for medical tests and consultations abroad required by surgeon who actually performed the surgery, and performed after the performance of the surgery, and as a direct continuation of it, providing that they were made within 90 days of the performance of the surgery. The maximum Insurance amount for the purposes of this Article, shall not exceed the amount specified in the Insurance Details Page.

5.2.10.5. Rehabilitation Expenses –

The Company will cover the expenses of the Insured for up to 12 rehabilitation treatments after the performance of the surgery, and as a direct continuation of it, providing that they were made within 90 days of the performance of the surgery. The Insured will be entitled to reimbursement at 80% of his actual costs, up to the amount specified in the Insurance Detail Page for each treatment.

Rehabilitation treatments for the purposes of this Article are speech rehabilitation therapy, rehabilitation exercise, occupational therapy, Physiotherapy.

6. Special Exceptions

General exceptions clause in the Policy to which this Annex was attached as well as any exceptions and conditions of the surgical coverage apply also to this Annex.

In addition to the aforementioned, the Company will not owe Insurance Benefits payment – according to this Annex, in the following cases:

6.1. Transplants in Israel and abroad and special treatments abroad that cannot be performed in Israel.

6.2. An Insurance Event that occurred to an Insured who spends most of the year (183 days) outside the State of Israel.

7. Special Terms of this Annex

7.1. When the Insured becomes aware of the need for surgery which he wishes to perform in the hospital abroad, he shall inform the Company immediately and shall submit to the Company the hospital's name and the address of the hospital abroad, in which he is interested in having the aforementioned surgery and all additional details related to the surgery.

7.2. The Company shall not be liable for any damage caused to the Insured and / or anyone else due to the Insured's election and / or his referral by the Company to medical services provides and / or others and / or due to an act or omission of the aforementioned including, for not performing surgery abroad on the date set therefor, for any reason. It is clarified that there is nothing in the aforementioned to derogate from the Company's liability, under the terms of this Annex, to cover the surgery at the time it rescheduled to.

8. Cancellation of the Annex

This Annex shall expire, in any of the following cases, according to the earliest:

8.1. When the Elementary Insurance will be canceled.

8.2. Upon termination of the premium payments.

9. Changes, Waivers or Deviations from Policy Terms

9.1. This Annex is subject to all the terms of the Policy to which it was attached.

9.2. Any change and / or waiver and / or deviation from the aforesaid in the Elementary Insurance of the Policy will apply in regard to
this Annex only if it is expressly included in the Annex.

9.3. In case of conflict between the provisions of this Annex and what is stated in other Annexes of the Policy and / or what is stated in the provisions of the Policy's General Terms, the provisions of this Annex shall apply.

10. Qualifying Period

The qualifying period is of 90 days.

In Israel and Abroad Transplant and Special Treatments Abroad Insurance
Annex. 929

In return for payment of premiums as stated in the Insurance Details Page, the Company will indemnify the Insured and / or will pay the Service Provider for his expenses, subject to General Terms of the Policy and to the provisions and exceptions specified in this Annex.

1. Definitions

1.1. **Transplantation**: an organ transplant as defined in one of the Articles 1.1.1 – 1.1.4, which a specialist of a relevant medical field, has determined according to accepted medical criteria the need for transplant performance.

1.1.1. Surgical resection or removal from the body of the Insured, of lung, heart, kidney, pancreas, liver, and any combination of them, and a transplantation of a whole organ or part of an organ that were taken from the body of another person instead, or bone marrow from another donor transplant in the Insured's body.

Transplantation will also include an artificial heart transplant, in the level it ceased to be defined as an experimental procedure in Israel In case where the implanted artificial heart transplantation is a procedure preceding a transplantation of a heart from the body of another person, it will be considered as a single Insurance Event.

1.1.2. Surgical resection or removal from the body of the Insured, of lung, heart, kidney, pancreas, liver, and any combination of them, and a transplantation of a whole organ or part of an organ that were taken from the body of an **animal** instead, in the level it ceased to be defined as an experimental procedure in Israel, the U.S.A. or in the EU.

1.1.3. Surgical resection or removal from the body of the Insured of the **ovary or intestine**, and a transplantation of a whole organ or part of an organ that were taken from the body of another person instead. Coverage under this Article will be granted in cases where there are no alternative treatment or surgery in Israel.

1.1.4. A bone marrow transplant and / or stem cells of umbilical cord blood and / or peripheral blood derived from the Insured himself, performed in Israel only.

1.2. **Special Medical Treatment Abroad:** surgery or medical treatment abroad for which two conditions out of the conditions detailed in Articles 1.2.1 – 1.2.4. hereinafter are met and two doctors who experts on the relevant medical field, have determined, according to the accepted medical criteria the need and the manner for the special treatment:

1.2.1. The special treatment is not performed by Medical services in Israel and has no alternative treatment or surgery in Israel.

1.2.2. Prevention of the special treatment poses a substantial risk to the Insured's life.

1.2.3. Standby time in Israel for the special treatment is longer than the Standby time abroad, and because of that there may be caused to the Insured a substantial worsening in his medical condition, which endangers his life and / or due to which there will be caused to the Insured a permanent disability rate of at least 40% according to its definition in the National Insurance Law (Consolidated Version) 5755 - 1995, or any other law who may come in place.

1.2.4. Prospects of success for carrying out the special treatment abroad are significantly higher, according to accepted medical criteria, than the chances of success carrying out the treatment in Israel.

1.3. **Alternative Treatment** - medical treatment carried out in Israel which - according to accepted medical standards enables to achieve the same medical result achieved by another medical treatment that cannot be performed in Israel provided that it does not involve severe physical results to the patient, meaning side effects more severe or damage to the Insured, which diminish the Insured's quality of life.

2. The Insurance Event

The Insurance Event is the medical condition of the Insured which requires performing a transplant in Israel or abroad, or special medical treatment abroad.

3. The Insurance Amount

The maximum insurance amount for entire Insurance Period of the Insured:

3.1. **For transplant as defined in Articles 1.1.1 and 1.1.2 performed by Service Provider in the agreement** - full coverage.

3.2. **For transplant as defined in Article 1.1.1 performed by a Service Provider who is not in the agreement** – as stated in the Insurance Details Page, but no more than the maximum transplant price in the country where the transplant takes place.

3.3. **For transplant as defined in Article 1.1.2 performed by a Service Provider who is not in the agreement** – as stated in the Insurance Details Page, but no more than the maximum transplant price in the country where the transplant takes place.

3.4. **For transplant as defined in Article 1.1.3** – as stated in the Insurance Details Page, but no more than the maximum transplant price in the country where the transplant takes place.

3.5. **For transplant as defined in Article 1.1.4 –** medical costs detailed in Article 4.1.4 will be covered, subject to the maximum amounts and to the deductible amount detailed in Article 4.1.4.

3.6. **For special treatment abroad coordinated by the Insurer -** If special treatment was performed in the Insured after the contract with medical Service Providers and coordination of treatment were made by the Insurer - full coverage.

3.7. **For special treatment carried out abroad care without the Insurer's coordination** - The Company will indemnify the Insured for the full expenses incurred by him in practice, in Israeli currency in accordance with the representative exchange rate on the day of payment by the Company, subject to payment of the deductible amount to be paid by the Insured
at 20% of actual expenditure and in any

case not more than the amount specified in the Insurance Details Page.

It is clarified, that the Company's liability under this Article is for the pay the expenses beyond the deductible amount paid by Insured.

4. Company's Obligation

If an Insurance Event occurred the Company will pay insurance benefits for coverage listed below, and up to the detailed maximum amounts, and in total the insurance benefits will not exceed the maximum amounts set out in Article 3 above. Insurance benefits
are as follows:

4.1. Indemnity Option for Transplant –

A. Service Provider in the Agreement - the Company will pay the full indemnification, directly to the Service Provider in the agreement in regard of the Insurance Event which occurred.

B. Service Provider Who is Not in the Agreement - the Company will indemnify
The Insured for actual medical expenses listed hereinafter which he actually paid to the medical Service Provider. Payment will be made against original receipts detailing the medical operations performed in the Insured, the amounts collected thereon, and hospitalization and surgery, original reports including the details of all operations, but no more than the maximum insurance amount as indicated in paragraph 3 aforementioned.

4.1.1. Payment to physician and medical institutions for the Insured's medical assessment before performing the transplant or the special treatment.

4.1.2. Payment of expenses for medical activities required for harvesting the implanted organ, its preservation and transfer to the place where the transplant is performed.

4.1.3. In the case of bone marrow transplantation according to Article 1.1.1, and subject to the Insurance Event occurrence, testing for bone marrow donor expenses or medical expenses Involved in producing bone marrow and / or stem cells from umbilical cord blood and / or peripheral blood originating from another donor, that are required for the transplantation, up to the amount specified in the Insurance Details Page.

4.1.4. In the case of bone marrow transplantation according to Article 1.1.4, and subject to the Insurance Event occurrence, medical expenses involved in producing of bone marrow and / or stem cells will be paid
up to the amount specified on the Insurance Details Page, subject to deductible amount of 10% of the actual expenditure, but not more than the deductible amount specified in the Insurance Details Page.

4.1.5. Payment for hospitalization abroad, up to 60 days before performing the transplant or special treatment and up to 305 days after the implementation, Including; medical staff fees medical tests, laboratory services, pharmaceuticals, and physiotherapy treatments the Insured needed for medical reasons after transplantation or special treatment, within the hospitalization.

4.1.6. Surgeon fees and operating room expenses during transplantation or the special treatment.

4.1.7. Payment of expenses for travel abroad ticket on a regular commercial flight in the economy department of the Insured and one escort, or two escorts if the Insured is a minor, and the expanses of their return to Israel.

4.1.8. Payment of expenses for a special medical flight abroad, if the Insured for medical reasons was unfit to be transferred abroad in a normal commercial flight, up to the specified amount in the Insurance Details Page. Notwithstanding the aforementioned, if the special medical flight was coordinated by the Company, full coverage will be granted.

4.1.9. Payment for expenditures of land transport from the airport to a hospital abroad and back, for the Insured who was flown abroad on a special medical flight.

4.1.10. Payment for reasonable staying expenses of the Insured and one escort, or two escorts if the Insured is a minor, in the place of performance of the transplant or the special treatment abroad, up to the amount specified in the Insurance Details Page.

4.1.11. Payment for continuation treatments due to the performance of the transplant or the special treatment, up to the amount specified in the Insurance Details Page.

4.1.12. Payment for the transfer of an Insured's corpse to Israel, if he died, heaven forbid, during his stay abroad.

4.1.13. Payment for all expenses involved in bringing an expert to perform the special treatment in Israel - if the Insured cannot be transferred abroad for medical reasons, up to the amount specified in the Insurance Details Page.

4.1.14. **Monthly Pension For a Transplant Candidate**
If an Insurance Event occurred, an Insured person who due to his medical condition is bedridden and requires the services of an attendant, will be entitled to a monthly allowance as stated in the Insurance Details Page, and this for the period until the actual transplant takes place and no more than 6 months. Insured, as aforesaid, who is hospitalized in a hospital, will be entitled to 50% of the amount specified in the Insurance Details Page.

4.2. One-Time Compensation Possibility for Transplant Only –

If an Insured performed a transplant as specified in Article 1.1.1 which the Company did not participate in funding, whether by directly indemnifying the Service Provider, or by indemnifying the Insured for his expenses or by paying the HMO and / or another party, the Insured will be entitled to a one-time compensation in the amount specified in the Insurance Details Page, after transplant was performed abroad.

For avoidance of doubt, when an Insurance Event occurs as specified in Article 1.1.1, the Insured can choose and notify the Company in writing about his choice, but only in one of the

two options for insurance benefits as detailed above.

4.3. Indemnification For Special Treatment Abroad - will be carried out - according to the provisions of sections 4.1.1 and 4.1.5 – 4.1.12.

4.4. Recovery Pension

4.4.1. If the Insured performed a transplant which the Company participate in funding, whether by directly indemnifying the Service Provider, or by indemnifying the Insured for his expenses or by paying the HMO and / or another Insurer, the Insured shall be entitled to a monthly amount as stated in the Insurance Details Page, which will be paid to the Insured after the transplant in Israel or from the day of his return to Israel, for a maximum period of 24 months.

4.4.2. If the Insured performed a transplant abroad, without the Company's involvement, and received a one-time compensation according to Article 4.2 aforementioned, he shall be entitled, in addition to the compensation, to a reduced monthly amount, as specified in the Insurance Details Page, which will be paid to the Insured from the day of his return to Israel, for a maximum period of 6 months.

4.4.3. If the Insured performed special treatment abroad, under this insurance, he will be entitled to a one-time compensation, as stated in the Insurance Details Page, after the performances of the special treatment abroad and his return to Israel.

4.5. It is clarified that a repeated transplant and / or special medical treatment that will be required due to the Implementation of an Insurance Event as an initial action constitute an integral part of the initial Insurance Event.

5. Cancellation of the Annex

This Annex shall expire, in any of the following cases, according to the earliest:

5.1. When the Elementary Insurance will be canceled.

5.2. Upon termination of the premium payments.

6. Changes, Waivers or Deviations from Policy Terms

6.1. This Annex is subject to all the terms of the Policy to which it was attached.

6.2. Any change and / or waiver and / or deviation from the aforesaid in the Elementary Insurance of the Policy will apply in regard to
this Annex only if it is expressly included in the Annex.

6.3. In case of conflict between the provisions of this Annex and what is stated in other Annexes of the Policy and / or what is stated in the provisions of the Policy's General Terms, the provisions of this Annex shall apply.

7. Qualifying Period

The qualifying period is of 90 days.

Special Medical Consultation Insurance
Annex. 805 (A)

In return for payment of premiums as stated in the Insurance Details Page, the Company will indemnify the Insured and / or will pay the Service Provider for his expenses, subject to General Terms of the Policy and to the provisions and exceptions specified in this Annex.

1. Insurance Event

If a serious illness (as described hereinafter) was discovered in the Insured, he will be entitled to two counseling sessions with medical specialists in the relevant field. The Company will pay the Insured for his expenses as stated in the Insurance Details Page.

2. Definition of Serious Diseases:

2.1. Cancer:

2.1.1. The presence of malignant cells tumor growing in an uncontrolled manner and piercing and spreading into surrounding tissues or
into other tissues.

Cancer shall include leukemia, lymphoma and Hodgkin's disease.

2.1.2. **Cancer shall not include:**

A. Skin Diseases of Type: BASAL CELL CARCINOMA & HYPERKERATOSIS.

B. Skin Diseases of Type: SQUAMOUS CELL CARCINOMA unless it spread to other organs.

C. Cancer diseases in the presence of the AIDS disease and / or HIV positive (including KAPOSI SARCOMA).

D. Chronic lymphocytic leukemia (C.L.L).

2.2. Chronic Renal Failure:

Chronic irreversible dysfunction of two kidneys requiring constant connection to hemodialysis or to inter-abdominal (Peritoneal Dialysis) or necessitates kidney transplant.

2.3. Stroke:

Any cerebral event (cerebrovascular), expressed by neurological disorders or neurological deficit, lasting more than 24 hours and includes necrosis of brain tissue, cerebral hemorrhage, obstruction or embolism from an out-of-the-brain origin and evidence of a permanent and irreversible neurological damage, supported by changes in the CT or in the MRI test, lasting for at least 8 weeks and determined by a specialist in neurology. All this except vertebral-basilar failure and
TIA.

2.4. A Heart Attack:

Necrosis of part of the heart muscle due to some stenosis or occlusion of coronary blood vessels that restricts blood supply to that part.

Diagnosis of a heart attack must be based on two of the three cumulative tests following:

2.4.1. Typical chest pains.

2.4.2. New changes that have occurred on ECG typical to myocardial infarction.

2.4.3. Increase in the level of heart muscle enzymes to pathological values.

2.5. Blindness:
Total and irreversible loss of eyesight in both eyes, as determined by an expert eye doctor.

2.6. Permanent and Total Disability:

2.7. Insured will be considered as having a permanent and total disability if due to injury or illness he was completely and permanently deprived of the opportunity to engage in any employment or do some work for reward or profit. Without prejudice to the generality of the aforesaid, complete and permanent loss of sight of both eyes, or complete and permanent loss of the use of two limbs, will be considered permanent and total disability for this matter.

3. Cancellation of the Annex

This Annex shall expire, in any of the following cases, according to the earliest:

3.1. When the Elementary Insurance will be canceled.

3.2. Upon termination of the premium payments.

4. Changes, Waivers or Deviations from Policy Terms

4.1. This Annex is subject to all the terms of the Policy to which it was attached.

4.2. Any change and / or waiver and / or deviation from the aforesaid in the Elementary Insurance of the Policy will apply in regard to this Annex only if it is expressly included in the Annex.

4.3. In case of conflict between the provisions of this Annex and what is stated in other Annexes of the Policy and / or what is stated in the provisions of the Policy's General Terms, the provisions of this Annex shall apply.

5. Qualifying Period

The qualifying period is of 90 days.

Special Medications Insurance
Annex. 904

In return for payment of premiums as stated in the Insurance Details Page, the Company will indemnify the Insured and / or will pay the Service Provider for his expenses, subject to General Terms of the Policy and to the provisions and exceptions specified in this Annex.

1. Special Definitions for this Additional Insurance

1.1. **Medication** - a chemical or biological substance designed to treat the Insured's medical condition, and / or for recovery of the Insured and / or to prevent the worsening situation Insured's medical condition (including preventing development of other medical conditions) and / or prevent recurrence of the Insured's medical condition, due to illness or accident, which was approved by the competent authorities Israel and is included in the list of approved medications and / or by the competent authorities in one or more Recognized Countries.

1.2. **Approved Medication List** – list of the approved medications registered under the Pharmacists Ordinance and / or under the Pharmacists Regulations (Preparations), 5746, or legislation to come instead, and published by the competent authorities in Israel, as updated from time to time by the authorities.

1.3. **Recognized Countries** - USA, Canada, Australia, New Zealand, Switzerland, Norway, Iceland, One of the EU Member States before May 2004, or in the Centralized Procedure of the European Union (EMEA).

1.4. **A Specialist** - a doctor who was recognized as an expert by health authorities in Israel provided his expertise is in the relevant field required for the treatment with the medication.

1.5. **Medication Treatment** - taking a medication on prescription, in a one-time or an ongoing manner, not during surgery and / or hospitalization (excluding day treatment) at a general hospital.

1.6. **Basket of Health Services** - the complex of medical and medications provided by the HMOs to their members, in the framework and by virtue of the National Health Insurance Law or by virtue of other obligation between the HMO and all its policyholders, excluding commitments within the framework of the Additional Health Services program.

1.7. **Prescription** - a medical document signed by a specialist and / or a hospital physician, chosen by the Insured, which confirmed the need for medication treatment and determined how to use the medication, the dosage and the duration of treatment.

1.8. **Pharmacy** – an institution authorized according to law to sell and market medications to the general public (hereinafter the Service Providers).

1.9. **Approved Maximum Price** - amount approved from time to time by the competent authorities for collection in return for a medication.

1.10. **Deductible Amount Per Prescription** - the Insured's share of the monthly

expenditure for prescription.
It is hereby clarified that the Company's liability to any payment according to this Annex will be only after the deductible amount was paid by the Insured and for the Insured's expenses beyond this deductible amount.

1.11. **OFF LABEL Medication** – medication which was approved for use by the competent authorities in one of Recognized Countries and / or by the competent authorities in Israel, for a different medical indication than that required for treatment of the Insured's medical condition and provided that the medication has been recognized to be effective treatment of the Insured's medical condition by at least one of the following:

1.11.1. Publications of the FDA

1.11.2. American Hospital Formulary Medication Information Service

1.11.3. US Pharmacopoeia - Drug Information

1.11.4. Drugdex (Micromedex) - provided that the medication meets the three aggregate following conditions (as appearing on the recommendations table):

1.11.4.1. Strength Of Recommendation - Is in group I or IIa.

1.11.4.2. Strength Of Evidence - is in category A or B.

1.11.4.3. Efficacy - Is in group I or IIa.

1.11.5. Medication recommended for treatment in at least one of the National Guidelines Published by one of the following:

1.11.5.1. NCCN

1.11.5.2. ASCO

1.11.5.3. NICE

1.11.5.4. ESMO Minimal Recommendation

1.12. **Orphan Medication** - a medication to treat rare disease
which was approved and / or recognized as an orphan medication in Israel and / or by the competent authorities in one or more recognized countries, except medicine developed for a particular person, for a particular genetic code, a certain genetic profile or specific structure of molecules and cells of the that same person.

1.13. **Experimental Medication** - a medication that is not approved neither by the competent authorities in Israel nor by the competent authorities in the Recognized Countries for treatment in medical indication required by the Insured. In this regard, it is clarified that off label medication and / or orphan medication as defined above shall not be considered an experimental medication.

2. The Insurance Event

The Insurance Event is the Insured's medical condition, requiring, by order of a physician, medication treatment.

Insurance benefits paid to the Insured on - under the terms of this Annex for:

2.1. Purchase of medications that are excluded from the basket of Health Services, and are included in the list of approved medications.

2.2. Purchase of medications that are excluded from the Basket of Health Services and are not included in the list of approved medications, and provided the necessary indication for treatment of the Insured's medical condition has been approved by competent authorities in one of the Recognized Countries.

2.3. Purchase of medications included in the basket of Health Services, for a different medical indication than that required for treating the Insured's medical condition, provided that the indication required for the Insured's treatment was approved by the competent authorities in Israel and / or by the competent authorities in one of the recognized countries.

2.4. **OFF LABEL Medications**
For Any Illness - purchase of OFF LABEL medications due to any illness.

2.5. **Orphan Medications** – purchase of medications that are not included the Basket of Health Services, known as orphan medication for an indication necessary for the Insured's treatment.

The condition for the Insurance Event existence is that the medication is not an experimental medication or a medical medication from the field of complementary medicine.

3. Company's Liability and Insurance Benefits

3.1. The Company shall indemnify the Insured for purchase of medications expenses against the original receipts and / or will pay directly to The Service Provider for the medication, to cover the required dose each time, minus the amount which the HMO participated in, if it participated, Minus the deductible amount per prescription which is set by the type of medication as indicated in Article 2 aforementioned up to the limit of maximum amount of insurance subject to the conditions as follows:

3.1.1. For medication as described in Articles 2.1 to 2.3 a deductible amount will be paid per prescription as detailed in the Insurance Details Page.

3.1.2. For medication as described in Articles 2.4 to 2.5 a deductible amount will be paid per prescription as detailed in the Insurance Details Page.

3.1.3. For medications whose monthly cost, according to the approved maximum price, as detailed in article 3.6 hereinafter, exceeds the amount specified on the Insurance Detailed Page, no deductible amount be paid.

3.2. It is clarified that the deductible amount per prescription is monthly, and shall apply to each month separately. **For the avoidance of doubt, it is clarified that any medication will be given a separate prescription and the dosage for each prescription shall be directed for treatment of up to three months at a time. Notwithstanding the provisions of clause 1.7 aforementioned, If the Insured was given a prescription for a period of less than three months, the Insured may present additional prescriptions signed by a physician who is not a specialist and / or a hospital doctor, chosen by the Insured, provided that once every three months the Insured will provide a prescription from a specialist and / or a hospital doctor.**

3.3. The maximum amount of insurance that the Company will pay for a claim and / or claims covered according to this Annex will be up to the amount specified in the Insurance Details Page. Once per

the period specified in the Insurance Details Page, the maximum amount of insurance shall be renewed in the following manner:

3.3.1. An Insured, which due to his claim and / or claims covered by this Annex was paid by the Company the full maximum amount limit of insurance, will be entitled to another maximum insurance amount as specified in Article 3.3 with the renewal of the aforesaid insurance amount.

3.3.2. An Insured, which due to his claim and / or claims covered by this Annex was paid by the Company the a part of the maximum amount limit of insurance, will be entitled to another full maximum insurance amount as specified in Article 3.3 with the renewal of the aforesaid insurance amount, which will replace the surplus of insurance amount left after the Company's payments.

3.4. The Company shall indemnify the Insured for expenses he actually had, against the original receipts and / or pay directly to Service Providers for the service and / or medical treatment involved in taking the medication for a period not exceeding 60 days and up to the amount stated in the Insurance Details Page for each day.

It is clarified, that the coverage under this Article shall be granted only in respect of taking medications, which the company indemnified the Insured for purchasing them, as detailed in Article 3.1 above.

3.5. Insured shall first apply to the Company for approval prior to the purchase of the medication when he holds a prescription. For avoidance of doubt, it is clarified that receiving such approval is an essential condition to the Company's liability under this Annex.

3.6. The maximum indemnity amount per medication shall not exceed medication the Maximum price for that medication approved by the competent authorities in Israel. Medication no approved price was set for by the competent authorities in Israel, an amount will be determined for that same medication, according to the maximum price approved in the Netherlands, by the known USD rate at the time of the actual purchase of the medicine. If the medication has no maximum price approved in the Netherlands, an indemnification amount will be determined according to the maximum price approved for that same medication in England by the known USD rate at the time of the actual purchase of the medicine.

4. Special Medication Coverage - UPGRADE

4.1. An Insured, who is entitled to medication coverage under this Annex for which the maximum price approved by the competent authorities in Israel exceeds the amount prescribed in the Insurance Details Page, and purchased the medication in the framework of the Additional Health Services program which is a member of, without filing a claim against the Company, shall be entitled to compensation according to one of the alternatives listed hereinafter, according to the highest one among them:

4.1.1. Compensation equal to the deductible amount paid by him in the framework of the Additional Health Services program, and no more the medication's maximum price approved by the competent authorities in Israel.

4.1.2. Monthly compensation in the amount specified in the Insurance Details Page for each month during the period in which the Insured took the medication, and purchased the medication within the framework of Additional Health Services program which he is a member of, without filing a claim against the Company.

4.2. An Insured who is entitled to medication coverage under this Annex for which the maximum price approved by the competent authorities in Israel does not exceed the amount stated in Article 4.1, but exceeds the deductible amount per prescription, according to this Annex, and purchased the medication in the framework of Additional Health Services program he is a member of, without filing a claim against the Company, shall be entitled to compensation in the deductible amount paid by him in the framework of Additional Health Services program, and not more than the maximum price of the medication, approved by the competent authorities in Israel.

5. Special Exceptions

General exceptions clause in the Policy to which this Annex was attached applies also to this Annex.

In addition to the aforesaid, the Company shall not be liable to pay

Insurance benefits - according to this Annex in the following cases:

5.1. Medication given during surgery and / or transplant performed in a general hospital, or during hospitalization in a general hospital.

5.2. Medication for cosmetic and / or aesthetic treatments.

5.3. Medication to treat mental illness and / or mental treatments.

5.4. Medication related to pregnancy complications and / or birth and / or fertility treatments and treatments against infertility.

5.5. Medication for the treatment of dental problems.

5.6. Insurance Event due to alcoholism and / or addiction to drugs prohibited by law and / or their use.

5.7. Treatment and / or medical services required due to a defect and / or congenital disease including hereditary diseases and / or previous medical condition according to paragraph 4.3 General Insurance Terms.

5.8. Preventive medication therapy in the framework of preventive medical service, treatment with vitamins and / or vaccines and / or food supplements.

5.9. Medication treatments not yet actually given to the Insured and / or Service Provider undertaking regarding future medication treatments.

5.10. Insured carries or will carry antibodies for Acquired Immune Deficiency Syndrome or hepatitis of any various kinds.

It is hereby clarified and emphasized that the indemnification will only be for the cost of the medication, and no indemnity will be given for the service and / or the medical treatment involved in providing the medicine, except for what is stated in paragraph 3.4 aforementioned.

6. Limitation of Company's Liability to Israel's Borders

The Company will not pay insurance benefits while the Insured stays outside the State of Israel.

If the Insured returned inside Israel's borders, he must prove his eligibility to benefits, and the Company will pay under the terms of this Annex, also for the period which he spent outside Israel's borders, If he was entitled to cover on this period.

7. Claim - Special Requirements

7.1. The Insured must give written notice to the Company as close as possible to the occurrence of the Insurance Event.

7.2. In the case of cessation of eligibility for insurance benefits, the Insured has to notify the Company immediately by a registered letter. Payments received unlawfully by an Insured, shall be returned to the Company.

8. Cancellation of the Annex

This Annex shall expire, in any of the following cases, according to the earliest:

8.1. When the Elementary Insurance will be canceled.

8.2. Upon termination of the premium payments according to the provisions of Article 10 of the Insurance General Terms.

9. Changes, Waivers or Deviations from Policy Terms

9.1. This Annex is subject to all the terms of the Policy to which it was attached.

9.2. Any change and / or waiver and / or deviation from the aforesaid in the Elementary Insurance of the Policy will apply in regard to this Annex only if it is expressly included in the Annex.

9.3. In case of conflict between the provisions of this Annex and what is stated in other Annexes of the Policy and / or what is stated in the provisions of the Policy's General Terms, the provisions of this Annex shall apply.

10. Qualifying Period

The qualifying period is of 90 days.

Terms of Service - "Escort by a Personal Physician"
No. 934

If it is stated in Insurance Details Page that this TOS (Terms Of Service) applies, the Subscriber shall be entitled to the services listed in this Terms of Service subject to the conditions and provisions detailed hereinafter.

This TOS is an integral part of the Policy to which it was attached.

The Service

Escort by a personal physician allows a Subscriber to receive about specific Medical Events, information further medical advice and escort during the process of diagnosing illness, when deciding on the treatment, during the stages of treatment and during the recovery. Subscriber dealing with a medical condition or a disease according to the defined below shall be assigned a Personal Medical Manager who is a specialist physician, a nurse as needed and a service coordinator. They will follow him and his family members through the medical decision-making process from the diagnosis and during the medical treatment and recovery stage for 3 months and all this subject to the conditions specified in the TOS hereinafter.

A. Definitions:

In this TOS the following terms shall have the meaning stated alongside of them:

1. **The "Company"** – Harel Insurance Company LTD.

2. **"Subscriber"** - a person who is entitled to receive the services of this TOS whose name and his identity certificate number are stated in the Insurance Details Page as a Subscriber to this TOS.

3. **"Insurance Details Page** - a page attached to the Policy that Includes information regarding the TOS.

4. **"Subscriber Fees"** - the amounts paid monthly as a condition for receiving services according to this TOS.

5. **"Child"** - a child under the age of 21 whose name and his identity certificate number are stated Insurance Details Page as a Subscriber.

6. **"Service Provider"** - the body with which the Company entered into a contract for providing the services as specified in this TOS.

7. **"Doctor"** - a person authorized by the competent authorities in Israel as a medical doctor and is named on the list of doctors under Regulation 34 of the Doctors Regulations, 5733 – 1973.

8. **"Specialist Doctor"** - a physician with a Specialist certificate issued by the Ministry of Health in the State of Israel.

9. **"Chief Sorter"** - is responsible for approval of eligibility of the Subscriber to service, according to medical conditions as specified in the TOS.

10. **"Personal Medical Manager"** - a doctor with a Specialist degree in internal medicine with whom the Service Provider entered into a contract, in regard of the provision of the services listed in this TOS.

11. **"Nurse"** - a nurse certified by the competent authorities in Israel with whom the Service Provider entered into a contract, in regard of the provision of the services listed in this TOS.

12. **"Social Worker"** – a social worker certified by the competent authorities in Israel with whom the Service Provider entered into a contract, in regard of the provision of the services listed in this TOS.

13. **"Service Coordinator" -** a person with appropriate training for the role of service coordinator. The service coordinator maintains the continuous contact with the Subscriber in regard of the service as specified in this TOS.

14. **"Medical Condition" –** a complex of medical circumstances existing in the Subscriber's body, due to illness or accident.

15. **"Medical Event"** - a medical condition as described in this TOS, which existence entitles the Subscriber with a right to realize the service as described and detailed in this TOS.

16. **"Medical Escort"** – Checking the integrity of the medical treatment process for the Subscriber.

17. **"Diagnosis"** - a doctor's final conclusion relating to a particular medical condition, concluded after taking anamnesis (details provided by the Subscriber regarding his medical condition), medical history, medical examination, and other tests as necessary.

18. **"Chronic Medical Condition"** - a medical condition that cannot be cured, which symptoms appear and develop over a period of 90 days at least.

19. **"Severe Medical Condition"** - a medical condition which symptoms appear suddenly, quickly and with Intensity.

20. **"Service Period"** – according to medical need and up to 90 consecutive days from the opening date of a service call and payment of the deductible amount as details in the different chapters of the service.

21. **"Service Center"** - a telephone service run by the Service Provider for the Subscribers to obtain services according to this TOS.

Telephone number of the Service Provider's service center for Harel Subscribers is: *5226

22. **"Determining Date"** - date of entry into force of this TOS for a Subscriber service, as appears in the Insurance Details Page.

23. **"Qualifying Period"** - a continuous time period,
beginning on each Subscriber's determining date and will end after 90 days. The qualifying period will apply for each Subscriber once during a continuous period of insurance, and shall re-apply every time the Subscriber will be re-admitted to the TOS, in non-consecutive service periods.
The Service Provider shall not provide a service as detailed in this TOS before the end of the qualifying period.

24. **"Deductible Amount"** - amounts which the Subscriber has to be charged himself as a condition for receiving services according to this TOS, as specified in the different service chapters. The deductible amount will be paid by the Subscriber directly to the Service Provider as determined by the Service Provider and in any case and manner it will definitely NOT be paid via the Company.

25. **"Urgent Medical Event"** - a significant change in the Subscriber's

health condition which requires evacuation to emergency room and / or hospitalization.

26. **"Insurance Year"** - a period of every 12 consecutive months, the first of which starts at the Insurance Commencement Date as stated in the Insurance Details Page.

B. Scope of Services:

This TOS allows a Subscriber to receive information, further medical consultation and escort in the process of diagnosing a disease before and during medical treatment and recovery from a medical condition.

The service includes:

1. Appointment of a specialist doctor who will serve as Personal Medical Manager. The personal medical manger will operate a paramedical team which includes a nurse and a social worker at his discretion.

2. . Concentration and review of the medical records (Intake) including preliminary assessment of the Medical Event by the Personal Medical Manager.

3. Personal meeting with the Personal Medical Manager. Further meetings will be scheduled according to medical need at the discretion of the Personal Medical Manager. The number of meetings shall not exceed 4 meetings unless there is a substantial medical need which justifies further meetings.

4. Referring medical records for further consultation as required according to the Personal Medical Manager's decision, to a specialist physician in Israel who is an expert in the relevant field or in the absence of knowledge or sufficient experience in Israel, to a specialist in that field in another country in the world.

5. Providing objective information during meetings as aforementioned that supports the medical decision-making process and shall be noted in the final medical report as specified in Article 12 hereinafter.

6. Recommendation to refer to suitable medical and paramedical parties for further advice / treatment. It is clarified that payment for counseling / treatment that the Subscriber was referred to by the Service Provider as aforementioned, is on the Subscriber's account.

7. Phone calls to coordinate with medical parties treating the Subscriber.

8. Escort for a Medical Event by the Service Coordinator and / or the medical and paramedical team.

9. Counseling to the Subscriber during hospitalization and / or after it including a visit during hospitalization and / or home call after an invasive treatment / surgery as needed and according to the sole discretion of the Personal Medical Manager.

10. Escort and counseling by a nurse as necessary in view of the Medical Event and according to the sole discretion of the Personal Medical Manager. The number of meetings with the nurse shall not exceed 4 meetings.

11. Escort by a social worker as needed in view of the Medical Event and according to the sole discretion of the Personal Medical Manager. The number of meetings with the social worker shall not exceed 4 meetings.

12. Summary of all medical documents to a concluding medical report by the Personal Medical Manager, which

includes recommendations for further treatment and medical monitoring, within 7 days after the end of service period for the Medical Event.

13. A telephone service center through which Subscribers' service call will be open and their affiliation with the TOS will be checked and also ongoing processing of patients requests. The center will operate 24 / 7 for urgent cases, including receiving messages about significant change in the Subscriber's medical condition, including the Subscriber's evacuation to a hospital and / or hospitalization.

For each Medical Event requiring management the Subscriber shall pay a deductible amount of 380 ILS. **Subscriber shall be entitled to receive services as specified in this TOS for period to be determined by medical need and not exceeding 90 days from the day of eligibility approval by the Chief Sorter as outlined in chapter C hereinafter.**

It will be possible to extend the said period of service, by approval of the Personal Medical Manager and subject to approval of the Service Provider in cases where there is a medical need requiring the extension of the period. Extension period will be considered as an extension of the same Medical Event and the Subscriber will be charged additional deductible amounts in coordination with the Subscriber.

In any case, the Subscriber shall not be entitled to receive service according to this TOS for more than one Medical Event during an Insurance year. If during the service period another Medical Event was discovered and / or obstruction of the existing Medical Event, it will be considered as a single Medical Event.

It is clarified that in any case the Service Provider and / or the Company are not committed in accordance with this TOS to provide the Subscriber any actual medical service or funding of such medical service, whether it is required or recommended by Personal Medical Manager or not, except the services listed in this article aforementioned.

C. Manner of Obtaining Services:

1. It is clarified that the prerequisites for obtaining services are that the Subscriber holds a valid health policy of the Company, that qualifying period in the TOS is over, that the Subscriber has not received service it is in the insurance year in which he requests the service, that the Service Provider confirmed that the Medical Event is Included in this TOS, and that the deductible amount was paid by the Subscriber.

2. In any matter related to obtaining the services according to this TOS, the Subscriber has to contact the Service Provider's service center.

3. If a Subscriber requires service according to this TOS, he or his representative shall apply by phone to the service center, identify himself by name or provide the Subscriber name, Identity certificate number, his address, telephone number where he can be reached and further details as requested. According to the instructions of the service representative the Subscriber will deliver all medical documents relevant to the event insofar as there are such, as follows: hospitalizations summaries, results and interpretations of tests, illness summaries, medical consultations treatments, laboratory tests, imaging tests, pathological answers and / or any other medical document. **Receiving these documents is a prerequisite for providing the service as detailed in this TOS.** Also, the Personal Medical Manager may periodically request the Subscriber copies of further medical records.

4. Chief Sorter will confirm the Medical Event by the TOS based on medical documents provided by the Subscriber shall assign to the Subscriber a Personal Medical Manager and a Service Coordinator.

5. Notification of approval / non approval of eligibility to service
shall be delivered to the Subscriber not later than 3 work days from the date of receiving all relevant medical documents to the event by the Service Provider.

6. Only after confirmation of eligibility for service, actual billing of the deductible amount will be made.

7. **Payment of the deductible amount is a condition**
for obtaining the service. If the deductible will not be paid As stated the Service Provider may decline to give the service for which such payment is required.

8. Period of Service - for approved Medical Event, the Subscriber will be entitled to service as detailed in this TOS for a period not exceeding 90 days of the day of event approval by the Chief Sorter. If the Personal Medical Manager determined that it is necessary to extend the medical service for an additional period of 90 days, it will be allowed subject to approval of the Service Provider and **with additional and Identical payment** of deductible amount.

9. The service center will be active all year round, 24 hours a day, excluding Eve of Yom Kippur beginning at 14:00 hours until the passage of two hours from the end of the Yom Kippur fast.

10. To a personal meeting with the Personal Medical Manager the Subscriber will arrive to the place by himself and at his own expense.

11. The service will be provided only within the territories of the State of Israel – **excluding Judea, Samaria and Gaza.**

12. **Notwithstanding the provisions in this TOS the Service Provider is exempt from giving the services according to this TOS In the case of a state of war or general mobilization, epidemic, earthquake, strike and any other force majeure that does not allow the provision of services.**

D. Eligibility to Obtain the Services

A Subscriber will be eligible for receiving this service if he meets one of the following criteria:

1. Un-Diagnosed Medical Event:

Un-diagnosed medical condition for which the medical clarification and consultation process in order to get a medical diagnosis started at least 90 days before application for service. The clarification process has to include consultation with two specialist doctors whom are experts in the field of expertise related to medical problem and at least one relevant medical examination from the list hereinafter: imaging tests (such tests as CT, MRI Etc. not just a regular X-ray and / or invasive tests, and / or complex laboratory tests (not including blood, feces and urine routine tests) and / or further auxiliary checks. Un-diagnosed medical conditions which symptoms are not specific (such as general fatigue and muscle pain) and signs of disease are not expressed in blood tests and / or imaging tests and after the Service Provider ascertained that the Subscriber underwent all the tests he needed to make under the circumstances of the medical condition, will not be treated within this TOS.

For avoidance of doubt it is clarified that in this case the Company and / or the Service Provider do not undertake to reach at the end of the process to a clear or final medical diagnosis.

2. Medical Event With Diagnosis in One of the Following Medical Categories:

The Subscriber will be entitled to receive service if meets the definitions of the following diseases and according to the prerequisites listed with the same disease, if mentioned:

2.1. Cancer –

2.1.1. The presence of malignant cells tumor growing in an uncontrolled manner piercing and spreading into surrounding tissues and / or into other tissues.

2.1.2. Medical Event does not include the following:
A. Skin disease of type: Basal Cell, Hyperkeratosis Carcinoma except reoccurring BCC or spread to other organs.
B. Cancer diseases in the presence of AIDS disease.

2.2. Severe or Chronic Liver Disease –

2.2.1. A group of different disease states factors affecting the liver and causing it injury at different levels (cellular, tissue, structure or function). Liver disease, for which service will be given within this TOS, can have a severe or chronic nature.

2.2.2. A Medical Event Does Not Include Any of the Following:

A. Liver disease as a result of alcoholism

B. Fulminant liver failure (Fulminant Hepatic Failure) meaning an acute liver failure, sudden, in a healthy person, or a flare-up of a stable chronic disease, resulting from necrosis of the liver cells as a result of acute infection and / or drug poisoning or for other reasons that are characterized by all the following symptoms: decrease in liver volume, necrosis of the liver, leaving only basic reticular tissue proven by histology, a new reduction in liver functions in the following blood tests - PT – or factor levels 5 and 7, deepening jaundice, hepatic encephalopathy, uncontrollable bleeding.

2.3. Kidneys Diseases –

A group of different disease states which affect the kidney and causing it injury at different levels (cellular, tissue, structure or function).Within the framework of this TOS Service will be given in case of chronic kidney disease only.

2.4. Chronic Gastroenterological Diseases - Group of chronic disease states that affect the functioning of the digestive system. Within the framework of this TOS service will be given to morbidity Involving the stomach, intestines and accessory organs including esophageal, liver, gallbladder and pancreas, gastroenterological

disease which has a chronic nature only.

Clarification process before contacting the service on according to this TOS should include clarification / advice from at least two specialists in a specialty field related to the medical problem.

2.5. Chronic Heart Diseases and Chronic Vascular Diseases-

Chronic heart and vascular diseases that harm heart system (heart diseases, coronary heart diseases), blood vessels, including arteries, veins and lymphatic vessels. Subscriber will be eligible for service as detailed in this TOS after clarification / advice with at least two specialists in the specialty field related to the medical problem. A Subscriber who is candidate to elective heart surgery which includes coronary artery bypass graft (CABG), to surgery for valve replacement or repair and / or aortic surgery and / or heart catheterization will be eligible to service as set forth in this TOS without prerequisite for a consultation with two specialist doctors as aforementioned.

2.6. Neurological Diseases and Invasive Procedures of the Central and Peripheral Nervous System –

A group of different disease states affecting the nervous system and causing injury at different levels (the cellular, the tissue, the structure, the electrical conduction or the function).

Within the framework of this this TOS service will be given to a case of neurological disease which has an acute or chronic character and providing that it has a nature that impedes the functioning in moderate and severe level according to NRC 2 or higher or EDSS 3 or higher in the case of multiple sclerosis.

Invasive Procedures Include:

A. Spinal surgery including treatment of tumors in the spinal cord, slipped disc in the spinal cord, spinal stabilization and treatment of spinal stenosis.

B. Radiosurgery: Treating brain tumors with focused radiation.

C. Hypophysis Surgery

D. Benign brain surgery and skull base surgery.

E. Treatments of vascular malformations and brain aneurysm, surgical treatments, endovascular treatments, brain catheterization.

F. Epilepsy surgery

G. Endoscopy neurosurgery

H. Surgery for treatment of head and spinal injuries.

2.7. Orthopedic Diseases –

2.7.1. A group of different diseases or injuries to the bones, joints, muscles and / or tendons which cause pain uncontrollable by medication and physiotherapy. The clarification process before referral to the service according to this TOS should include clarification / consultation of at least 90 days with at least two specialists with expertise in a

field related to the medical problem.

2.7.2. A Medical Event Does Not Include Any of the Following:

A. Subscriber's orthopedic diseases for which he is treated in hospitalization for less than 21 days, on the day of referral to service

B. Medical conditions in the field of orthopedics that are the outcome of injury or trauma as of the referral to service day, 90 days did not pass yet from the day of outcome of injury and / or trauma.

2.8. Repeated Plastic Surgery (invasive) Due to Unsuccessful First Surgery –

Repeated Invasive - Intrusive Procedure due to complete or partial failure of the first procedure, penetrating through tissue aiming to treat a disease and / or injury and / or to repair a defect or a deformity in the Subscriber.

2.9. Blood Diseases (Hematologic Diseases) –

A group of different disease states affecting the levels and various blood components (the cellular and the mural) and causing injury to it in various forms. Within the framework of this TOS service will be given in case of a blood disorder which has an acute or chronic nature. Clarification process before contacting the service according to this TOS must include clarification / consultation of at least 90 days with at least two specialists with expertise in a field related to the medical problem.

2.10. Rheumatologic Diseases –

A group of different disease states Affecting the joints system, causing injury at different levels (joint, articulation or function). Within the framework of this TOS service will be given in case of rheumatologic disease which is of acute or chronic nature. Clarification process before contacting the service according to this TOS must include clarification / consultation two specialist doctors with expertise in a field related to the medical problem.

2.11. Metabolic Diseases –

A group of different disease states, hereditary and chronic, resulting from injury to a single gene to a small number of genes (Inborn Error of Metabolism) and causing loss of energy, or damage to the building capacity and / or decomposition of building blocks of the cell, or mitochondrial damage.

2.12. Endocrine Diseases –

2.12.1. A group of different disease states Involving organs and glands which are responsible for production, storage and excretion of hormones that help in preserving and control over vital functions. Within the framework of this TOS service will be given in case of endocrine illness which has an acute or chronic nature. Clarification process before contacting the service according to this TOS must include clarification / consultation of at least 90 days with at least two specialists with expertise in a field related to the medical problem.

2.12.2. A Medical Event Does Not Include Any of the Following:

A. Diabetes

B. Shortness

C. Endocrine diseases which Only affect fertility.

2.13. Ear, Nasal, and Throat Invasive Procedures and Diseases (ENT) –

2.13.1. A group of different disease states affecting and causing damage in different levels of the nasal cavity and sinuses, ears, mouth, pharynx and throat, head and neck regions and the base of the skull.

Malignant and benign tumors removal surgeries and procedures in the regions of base of the skull, the head, the neck and trachea, reconstruction surgeries not for beauty and aesthetics purposes, ears surgery, hearing restoration surgery, endoscopic surgery of nasal and facial cavities, endoscopic surgery of the upper esophageal, surgeries of vocal cords and speech recovery.

2.13.2. A Medical Event Does Not Include Any of the Following:

A. Ears tubes Surgeries
B. Snoring Surgery
C. Surgeries for beauty and aesthetics purposes.

2.14. Skin Diseases –

2.14.1. A group of disease states that damage the skin. Within the framework of this TOS service will be given in case of a skin disease with a chronic nature Only. Clarification process before contacting the service according to this TOS must include clarification / consultation of at least 90 days with at least two specialists with expertise in a field related to the medical problem. Furthermore, the process of clarification, consultation and medical care has to start at least 9 months before referral to service.

2.14.2. A Medical Event Does Not Include Any of the Following:

A. Acne
B. Cutaneous Candidiasis (external)
C. Hair Loss
D. Sexually Transmitted Diseases

2.15. Diseases in the Field of Gynecology and Birth Delivery –

2.15.1. A group of disease states in the field of women's health involving the female sexual system. Within the framework of this TOS service will be given in case of gynecological which has an acute or chronic nature. Clarification process before contacting the service according to this TOS must include clarification / consultation with at least two specialists with expertise in a field related to the medical problem. The process of medical clarification and consultation has to start at least 6 months before referral to service.

2.15.2. A Medical Event Does Not Include Any of the Following:

Infertility and sterility problems of the man and the woman accept a medical event of 3 or more consecutive recurrent miscarriages.

2.16. Immunologic Diseases –

A group of states and chronic diseases that cause damage to the immune system which are mainly immunologic deficiencies (acquired or congenital) and auto-immunologic disease.

2.17. Lung Diseases –

A group of different disease states which causing lung injury in various forms and affecting various lung functions (volumes, flows and others). Within the framework of this TOS service will be given in case of a lung disease of acute or chronic nature. Clarification process before contacting the service according to this TOS must include clarification / consultation of at least 90 days with a specialist with expertise in a field related to the medical problem.

2.18. Infectious Diseases -

A group of different disease states caused by various pathogens (viruses, bacteria, parasites and others) with a long process of at least 21 days (from the beginning of the clarification of the disease). Within the framework of this TOS service will be given due to an infectious disease with acute or chronic nature.

A medical event will include an infectious disease with a course of at least 21 days and / or complication of an existing / previous infectious disease.

2.19. Eye Diseases –

A group of different disease states that require repeated surgical procedures and causing injury to various eye components (such as the retina) and affect different visual functions (e.g., the sharpness and the scope of vision). Within the framework of this TOS service will be given in case of eye diseases of acute or chronic nature. Clarification process before contacting the service according to this TOS must include clarification / consultation of at least 90 days with a specialist with expertise in a field related to the medical problem.

2.20. Orphan Diseases –

Rare diseases that affect a very small percentage of the
Population and approved by the World Health Organization as Orphan Diseases.

2.21. Integrated Morbidity-

Morbidity resulting from a combination of several diseases which to treat them requires a multi – disciplinary approach with coordination between at least two specialist doctors in different fields of specialization.

2.22. Diseases and Procedures in Pediatrics –

2.22.1. In addition to all of the aforementioned in the various medical categories, in the field of pediatrics a medical Event will include, in addition, the following medical conditions:

A. Elective surgery. Elective surgery means that the need for it is anticipated, and in which the Subscriber's admittance to the hospital to perform the surgery was not done by reference from the emergency room as an emergency case, but by reference of a specialist doctor from a clinic (including an external clinic of the hospital).

B. Chronic children diseases.

C. Diseases with genetic background.

D. Birth defects.

E. Illness / psychiatric diagnoses after a period of at least 6 months clarification and treatment and consultation with at least two specialist doctors with expertise in a field related to the medical problem.

F. Disorders of development after a period of at least 6 months of clarification and treatment at a child development institute and consultation with at least two specialist doctors with expertise in a field related to the medical problem.

G. Medical problem within hospitalization of more than 21 continuous days per each Medical Event.

H. Medical problem due to complication of surgery or procedure and / or medical treatment which requires hospitalization.

I. Atopic dermatitis of moderate level or higher.

2.22.2. A Medical Event Does Not Include Any of the Following:

A. Lung diseases of children:

Asthma, unless if this is a course of illness after consultation by two lung disease in children specialist doctors, without balancing the disease.

B. Children gastroenterology diseases: Failure to thrive disease in a child, eating disorders (such as bulimia, anorexia).

C. ADHD.

D. Ears tubes surgery.

E. Hernia surgery

F. All Medical Events in preterm infants during hospitalization and / or during the first 6 months of their life, according to the longest of two.

2.23. Medical Event In Hospitalization of More than 21 Consecutive Days –

2.23.1. Medical conditions within hospitalization of at least 21 continuous days for which there is no clear diagnosis and / or there is a controversy over the method of treatment (conservative / operative or other).

2.23.2. A Medical Event Does Not Include Any of the Following:

Medical conditions which at the time of referral to service, the Subscriber is a hospitalized patient in nursing and / or terminal condition.

2.24. A medical problem resulting from complication of surgery or procedure and / or medical treatment and which requires hospitalization

2.25. General Exceptions:

The Service Provider will not have to provide service according to this TOS in the following medical conditions:

2.25.1. Organ transplant in Israel or abroad

2.25.2. Medical conditions and / or procedures associated with fertility and / or infertility accept medical event of 3 or more consecutive recurrent miscarriages.

2.25.3. Psychiatric illness in adults and / or mental illnesses

2.25.4. Conditions directly and / or Indirectly related with a purpose of beauty and / or aesthetics, including obesity, except for breast reconstruction surgery after mastectomy

2.25.5. Medical conditions in the field of dentistry and mouth and jaw medicine

2.25.6. Direct and / or indirect result of the Acquired Immune Deficiency Syndrome (Aids).

2.25.7. Fibromyalgia Disease

2.25.8. Neuropathy Disease

2.25.9. Chronic Fatigue Syndrome

2.25.10. Total and irreversible blindness.

2.25.11. Stroke (CVA)

2.25.12. veins and varicose veins in the legs

2.25.13. Severe burns when the Subscriber is hospitalized in a medical facility

2.25.14. Allergies

2.25.15. Patients during hospitalization of less than 21 consecutive days.

2.25.16. Any disease that is not listed List of specified diseases Article D aforementioned.

E. **Responsibility**

The Company and the Service Provider will not be responsible in way for each of the following issues:

1. Tests, consultations, procedures and medical treatments to which the Subscribers will be referred.

2. Any damage, loss, forfeiture, expense or other outcome, of any kind and / or type whatsoever, including attorney's fees, caused to someone's body or property, including the Subscribers, in connection with the consultations, tests, treatments and medical procedures to which Subscribers were referred, either directly or indirectly, for any act or omission, including professional negligence or otherwise of other Service Providers referred to by the Service Provider and / or any other damage resulting from an act or omission of other Service Providers to which the Subscribers are referred by the Service Provider or whoever on his behalf.

3. Expenses of the Subscriber incurred for treatment that exceeds the Services listed in the TOS.

F. Validity of the TOS

1. Validity of the TOS with respect to each Subscriber will expire automatically on the earliest date among these:

   1.1. On the date of cancellation of the Insurance Policy for any reason.

   1.2. If the subscription fee is not paid on time, according to the Insurance Contract Law.

2. Notwithstanding the foregoing, in case of cancellation and / or termination and / or expiration of the agreement between the Company and the Service Provider in connection with providing services described in this TOS, for any reason, the Company may stop providing services according to this TOS to all Subscribers, After giving notice in writing to the Subscribers 60 days in advance.

3. Notwithstanding the foregoing, in case of cancellation and / or termination and / or expiration of the agreement between the Company and the Service Provider in connection with providing services

described in this TOS, the Service Provider is committed to complete providing services described in this TOS to Subscribers who are in the Service period and not more than three months of service including the period of advance notice to the Subscribers about the service stoppage.

4. It is clarified that on the date of expiration, cancellation or termination of this TOS, for any reason, any Subscriber's right to receive services under this TOS shall terminate.

   A Subscriber who began to receive a Service described in the TOS before the end of it but the service was not completed, his right shall terminate after completion of service.

G. Terms of Linkage to Index

1. All payments according to this TOS, including Subscription fees, are linked to the index in a manner that if the new index exceed the base index, the payment will increase by the rate of rise of the new index over the base index.

   1.1.1. "Index" means Consumer Price Index ("CPI") Including fruits and vegetables occasionally published Time by the Central Bureau of Statistics including the same index, even if published by any other body or official institution to come in place, whether it will be based on the same data on which the existing index is based or not. If the existing index will be replaced by another index to be published by a body or institution as aforesaid and that body or institute did not set the ratio between the other index and the replaced, the aforementioned ratio shall be determined by the Central Bureau of Statistics.

   1.1.2. "New index" means the index known on the day of Payment.

2. The Subscription fee amount is set in the Insurance Details Page. The aforementioned amount is linked to the base index and shall be updated every 12 months only and for the first time on December 1st 2010.

H. Miscellaneous

1. All payments under this TOS include VAT by the law. If the VAT rate will change, these payments will be updated accordingly.

2. Messages sent to the Subscriber, according to the last address submitted in writing to the Insurer shall be deemed as messages provided to the Subscribers.

3. The Subscriber and the Company undertake to inform in writing of any change in address, and they shall not be heard claiming that any message did not reach them if sent according to the last address given.

4. Any message to the Company shall be given in writing.

Terms of Service – Special Medical Services
No. 907

1. **Definitions**
In this TOS the following terms shall have the meaning stated alongside of them:

1.1. **"Service Provider"** – The Service Provider with whom the Insurer entered into contract for the purpose of providing the services listed In this TOS.

1.2. **The Insurer or the Insurance Company** – Harel Insurance Company LTD.

1.3. **The Insurance Policy** - Health Insurance Policy of the Insurer which includes TOS of unique medical services.

1.4. **Insured** - A person named in the Insurance Details Page of the Insurance Policy.

1.5. **Subscriber or Subscribing Family** – An Insured entitled
for services described in this TOS.

1.6. **Doctor** - A medical doctor who has been authorized and approved by the authorities in Israel and license to practice medicine.

1.7. **Therapist** - A clinical psychologist, who is entitled - by the law to give the Insured the relevant service and which Service Provider entered in contract with in connection with providing service to his Subscribers.

1.8. **Doctor - in - the - agreement** - a doctor who entered into agreement with a Service Provider to provide the service of night service provider, as defined hereinafter.

1.9. **The service center** – Telephone call center No**. 03-5688502** (multi-line).

1.10. **Index** - Consumer Price Index, published by the Central Bureau of Statistics.

1.11. **Base Index** - Index 10809 published on the day of July 15th 2008.

1.12. **Holiday** - Israeli holidays which are non-working-days.

2. Service of Family Health Telephone Information Center

2.1. The Service

2.1.1. The Subscriber shall be entitled to receive information services and other services as detailed below and those services only (hereinafter - "Information Services"):

2.1.1.1. **Pediatrics Information Services –** Providing general information on the telephone in the field of pediatrics by a doctor who has a title of specialist in pediatrics, who is allowed to engage in providing such service under any law in Israel.

2.1.1.2. **Family Medicine Information Services –** Providing general information on the telephone In the field of family medicine by a doctor who

has a title of specialist in family medicine, who is allowed to engage in providing such service under any law in Israel.

2.1.1.3. **Gynecology Information Services** – Providing general information on the telephone about infectious diseases In the field of gynecology, general information about various tests during pregnancy, information on osteoporosis, by a specialist in gynecology who is allowed to engage in providing such service under any law in Israel.

2.1.1.4. **Geriatric Medicine Information Services** – Providing general information on the telephone in the field of geriatrics, by a physician with title of specialist in geriatric medicine, who is allowed to engage in providing such service under any law in Israel.

2.1.1.5. **Psychological services – the "Hot Line"** - Psychological assistance on the telephone on the subjects of children, women and family, including adolescence age, various addictions and continued studies in educational institutions, by a psychologist who is allowed to engage in providing such service under any law in Israel.

2.1.1.6. **Diet and Correct Nutrition Information Services** - Providing information on the telephone In the field of diet and nutrition, by a clinical dietitian or a nutritionist who is allowed to engage in providing such service under any law in Israel.

2.1.2. The service center will be active to receive calls to the Information services - According to this TOS, to verify the applicant's eligibility to receive the information services and to refer the applicant to receive one of one of the information services, detailed in Articles 2.1.1.1 – 2.1.1.6 aforesaid.

2.2. **The Scope of The Information Services**

2.2.1. It is clarified explicitly that the services Stated in this Article are information services by telephone only, without meeting face to face with the Service Provider, and they will be granted in accordance with the professional discretion of the Service Provider and subject to the professional discretion of the Service Provider on the possibility to issue them in a telephone conversation without any inspection of the Subscriber or meeting him face to face. For the avoidance of doubt it is clarified that in any case the telephone conversation with the Service Provider will not be denied, and if according to the Service Provider's discretion service cannot be given without examining the Subscriber, the Service Provider himself shall notify the applicant about it.

2.2.2. It is clarified that the Information Services are not considered Emergency services, and that they do not come to replace a face to face consultation, wherever it is required.

2.2.3. The service center will be active to receive calls from the Subscribers to obtain the information services - according to this TOS 24 hours a day, all year round, except for the evening of Yom Kippur from 14:00 until two hours after the end of fasting.

2.2.4. The Information Services will be provided as soon as possible, not later than 30 minutes from the time of application of the Subscriber to the service center.

2.2.5. Information services will be provided without any limitation of the Subscriber's number of applications.

2.3. **General**

2.3.1. If the Subscriber requires information services as prescribed
In this TOS, he shall apply by phone to the service center using the phone number indicated above, identify himself by his name, his address, the phone number where he can be reached and the Subscriber's ID card No.

2.3.2. The service center will connect the Subscriber to the relevant Service Provider after making sure that the applicant is indeed a subscriber as defined above, who is entitled to receive the information services according to this TOS.

2.3.3. The Service Provider's commitment to the Subscriber in handling of a Subscriber's application to receive Information services will end on the earlier among the two events listed below:

2.3.3.1. Connecting the Subscriber to the relevant Service provider.

2.3.3.2. Cancellation of the request for any of the services by the Subscriber's message to the service center.

2.3.4. The Insurer and / or the Service Provider will not be responsible for professional negligence or otherwise, and shall not be liable in any way for any of the following issues:

2.3.4.1. Professional malpractice or another and / or any damage or loss caused to the Subscriber and / or any other person in connection with the service subject of this TOS.

2.3.4.2. Expenses made by the Subscriber for any treatment exceptional to the information services detailed in this TOS.

2.3.5. Without derogating from the generality of the aforesaid it is clarified that the Insurer and / or the Service Provider will not be responsible for any damage, loss to body or property caused to the Subscriber or to any other person while and / or as a result of providing the Information Services, whether by an act and / or by omission, whether the damage is direct or Indirect, and that the Service Provider and / or the Insurance Company are not the employers of Information services providers and will not be responsible to any Subscriber in any case and interest.

3. Night Doctor Visit Service

3.1. The Service

3.1.1. receive medical service as The Subscriber shall be entitled to receive medical service as specified in clause 3.1.2 below by one of the Doctors in the Agreement (hereinafter - Night Doctor Visit Service). Night Doctor Visit Service will be given in the Subscriber's home or any other populated place in which the Subscriber who needs the service shall be, or the Subscriber who needs the service will be directed to receive the Night Doctor Visit Service in one of the service centers of Night House-Call by a Doctor operated by the Service Provider, which is located near the place where the subscriber is (hereinafter - "Medical Center"), and this without any additional cost to the deductible amount stated hereinafter, all according to the Subscriber's choice (subject to activity hours of the Medical Centers as mentioned below). The aforesaid is subject to Articles 3.2.4 and 5.3 hereinafter.

3.1.2. Subscriber shall be entitled to follows:

3.1.2.1. Receiving the medical anamnesis (Medical Story) from the Subscriber.

3.1.2.2. Subscriber's physical examination Including the use of auxiliary equipment listed hereinafter: stethoscope, Tongue depressor, a flashlight, an otoscope, reflex hammer, blood pressure gauge, all as required at the professional discretion of the doctor in the agreement.

3.1.2.3. Setting a medical diagnosis.

3.1.2.4. ECG Test using cardio-beeper at the professional discretion of the doctor in the agreement.

3.1.2.5. Receiving initial medications for one day treatment all at the professional discretion of the doctor in the agreement.

3.1.2.6. Getting a prescription for medications at the professional discretion of the doctor in the agreement.

3.1.2.7. Referral for further treatment to the family doctor / pediatrician, who treats the Subscriber on a regular basis (and / or to another specialist doctor), at the professional discretion of the doctor in the agreement.

3.1.2.8. Referral of the Subscriber to a hospital emergency room, at the professional discretion of the doctor in the agreement.

3.1.2.9. Providing a medical certificate.

3.1.2.10. Free evacuation by ambulance - If the doctor - in - the - agreement who examined the Subscriber following his call for service, will decide on his evacuation by an ambulance, the Service Provider shall pay to the Subscriber the amount ambulance evacuation fee that

was paid by him and this within 30 days from the day of delivering the original receipt only of that payment to the Service Provider, provided that the Subscriber is not entitled to refund from the HMO in which he is Insured.

3.2. **General**

3.2.1. Night Doctor Visit Service - According to this TOS will be provided all year round from 20:00 to 07:00 the next day. On Fridays and holiday eves Night Doctor Visit Service will be provided continuously from 20:00 on Friday / holiday eve until 07:00 Sunday / the day after the holiday. Each call for service should be directed to the service center not before 20:00 and no later than 06:00 o'clock.

Medical centers will be operative between the hours of 20:00 to 24:00 and on Saturdays and holidays Also from 10:00 to 14:00.

Night Doctor Visit Service will not be provided on Yom Kippur eve and on Yom Kippur until two hours after the end of fasting.

3.2.2. If the Subscriber requires a Night Doctor Visit Service as prescribed in this TOS, he shall apply by phone to the service center using the phone number indicated above, identify himself the name, his whereabouts, the Subscriber's name and phone number of the Subscriber's residence (which is the subscription number of the subscribing Family specified at the Service Provider).

3.2.3. Night Doctor Visit Service will be provided subject to presenting an ID.

3.2.4. Night Doctor Visit Service is provided in any populated place in Israel. Night Doctor Visit Service will not be available in places that are beyond the Green Line. It is clarified that a subscriber living beyond the Green Line who requires the medical service, would have to arrive by himself and at his own expense to the doctor - in - the - agreement in an address delivered to him by a service center (a place geographically close to his residence). In the Golan Heights Night Doctor Visit Service will be provided in Katzrin or in any other settlement in the area.

3.2.5. After the visit the Subscriber or a member of his family, shall sign a review appendix in which he confirms that the doctor - in - the - agreement visited the patient at home or gave the Night Doctor Visit Service in the medical center.

3.2.6. If the Subscriber elects to obtain the service in the medical center the patient shall arrive to the medical center by himself and on his own expense.

3.3. Liability

3.3.1. The Service Provider's liability to the Subscriber when processing a Subscriber's application for a Night Doctor Visit Service shall end when the earlier among the two following events will occur:

3.3.1.1. The doctor's – in – the – agreement arrival to the Subscriber's home or the referral of the patient to the medical center close to his whereabouts, subject to the aforesaid in Article 3.2.4 and 6.3.

3.3.1.2. Cancelation of the application for a Night Doctor Visit Service by the Subscriber's notice to the service center.

3.3.2. The Insurer and / or Service Provider will not be responsible for medical malpractice or otherwise, and shall not be liable in any way for any of the following issues:

3.3.2.1. Medical malpractice or otherwise and / or any damage or loss caused to the Insured and / or the Subscriber and / or any person, whether direct damage or other indirect damage in connection with Night Doctor Visit Service subject of this TOS.

3.3.2.2. Expenses made by the Subscriber for treatment, exceeding the service detailed in this TOS.

3.3.2.3. Expenses made by the Subscriber for treatments or services by another physician who is not – in – the - agreement.

4. First Aid Services In Dentistry

4.1. The Service

4.1.1. The Subscriber shall be entitled to receive, at his sole discretion, emergency services and first aid in dentistry as detailed hereinafter, and only those services, and this by dental clinics throughout the Israel (the list of dental clinics can be obtained in the service center) (hereinafter – "First Aid Services In Dentistry"):

4.1.1.1. Extensive caries - temporary dental filling.

4.1.1.2. Open tooth cavity - temporary dental filling.

4.1.1.3. Exposed tooth neck - remedy to prevent sensitivity.

4.1.1.4. Acute inflammation of the dental pulp - uprooting of nerve or embalming (mummification) material.

4.1.1.5. Abscess from the tooth - abscess drainage and / or closure treatment.

4.1.1.6. Food Compression - gums treatment.

4.1.1.7. Tooth title Inflammation – washing and / or medication.

4.1.1.8. Gingivitis - local tartar removal scaling and / or medication.

4.1.1.9. Pain after tooth extraction - analgesia.

4.1.1.10. Dry socket – socket cleaning and / or medication.

4.1.1.11. Bleeding after tooth extraction or surgical procedure - stopping the bleeding.

4.1.1.12. Pressure sores under existing prosthesis - release of pressure sores.

4.1.1.13. Tooth crown fall – temporary paste.

4.1.1.14. Any further treatment due to teeth pain - treatment shall be granted for relief or stoppage of the pain.

4.1.1.15. Dental examination and photography of aching teeth.

4.1.1.16. Appropriate prescription for pain relief if the tooth cannot be treated at that time.

4.2. **General**

4.2.1. Any treatment exceeding First Aid Services In Dentistry will be given for fee, at the request of the Subscriber.

4.2.2. First Aid Services In Dentistry will be provided 24 hours a day, all year round, except for Yom Kippur eve from 14:00 until two hours after the end of fasting, and subject the following:

Between the hours of 20:00 to 08:00 AM the next day - will be given only in clinics that are on duty situated in Jerusalem, Tel - Aviv, Haifa and Beer-Sheba.

4.2.3. If the Subscriber requires First Aid Services In Dentistry, the Subscriber shall apply by phone to the service center using the phone number listed above, and deliver the information specified in Article 3.2.2 aforementioned. The service center will refer the Subscriber to the nearest dental clinic on duty. It is clarified that the First Aid Services In Dentistry will be provided only by a reference from the service center as stated above.

4.2.4. First Aid Services In Dentistry will be provided upon presentation of an ID.

4.3. **Liability**

It is hereby clarified that the dental clinics are the employers of the dentists who will give the First Aid Services In Dentistry according to this TOS, and they alone shall be responsible for any treatment that the dentists will give according to this this TOS.

Without derogating from the generality of the aforesaid it is clarified that the Insurer and / or the Service Provider will not be responsible in any way for any damage, loss to body or property caused to the Subscriber or to any other person during and / or as a result of providing the First Aid Services In Dentistry, either because of an act and / or due to an omission, whether direct or indirect damage, and that the Service Provider and / or anyone on his behalf which will organize the First Aid Services In Dentistry (except for the dental clinic itself) and / or including professional negligence or other of the Service Providers and / or any other damage resulting from an act or omission of the Service Providers.

5. Psychological Assistance and Advice Services

5.1. The Service

5.1.1. The Subscriber will be eligible for Psychological assistance and advice (hereinafter: "**Psychological Assistance and Advice Services**"), under which he will be entitled to face to face meetings with a Therapist

(hereinafter - "**Personal Counseling Sessions**").

5.1.2. It is hereby clarified that the Psychological Assistance and Advice Services are conducted only in private clinics, without the need for hospitalization or home day care or any other institutional intervention.

5.2. General

5.2.1. If the Subscriber requires Psychological Assistance and Advice Services as prescribed in this TOS, he shall refer by telephone to the service center using the phone number listed above, identify himself by his name, his address, the phone number where he can be reached and the No. of his identity card.

5.2.2. The Service Center will refer the Subscriber to a Therapist after making sure that the applicant is indeed a Subscriber as defined above, who is entitled to receive the Psychological Assistance and Advice Services according to this TOS.

5.2.3. Personal Counseling Sessions will be held with one of the therapists whom the Service Provider entered into an agreement with. It is clarified that the therapist who gave the initial consultation to the Subscriber, will not necessarily conduct the Personal Counseling Sessions with the subscriber, but he will be the one that will give to the Subscriber, the name of the Therapist who will perform the counseling sessions (hereinafter – the "**Therapist**") and his phone number, whether within the framework of the telephone counseling call or later.

5.2.4. The Subscriber himself has to contact by telephone the actual therapist to coordinate the date of the first Personal Counseling Session and the other sessions to follow.

5.2.5. The Personal Counseling Sessions will be held on the date that will be coordinated directly between the Subscriber And the actual Therapist as mentioned above. The first Personal Counseling Session will be held within one week after referral of the Subscriber to the Therapist. In urgent cases, at the sole and complete professional discretion of the Therapist the first counseling session will be held within the first two working days from the date of Subscriber referral to the actual Therapist, unless the Subscriber request that it will be held later.

5.2.6. Personal Counseling Sessions will be held on working days and on regular working hours of the Therapist.

5.2.7. Personal Counseling Sessions will be held upon presentation of an ID on the date of the first counseling session.

5.2.8. Personal Counseling Sessions will be held in the therapist's office and the Subscriber who requires the service would have to arrive by himself and on his own account to the Therapist. **It is hereby clarified that the service does not include**

consulting meetings in the Subscriber's home.

5.2.9. After the counseling session the Subscriber shall sign the review appendix in which he confirms that the actual Therapist held the Personal Counseling Session.

5.2.10. The Subscriber shall notify the service center on any change in his address and in his home phone number.

5.2.11. In case the Subscriber wishes to cancel any Counseling Session he shall directly inform the actual Therapist at least one working day in advance. For avoidance of doubt it is clarified that in case the Subscriber fails to notify about the cancellation of the Counseling Session at least one working day in advance, the Subscriber will be charged a handling fee for that Counseling Session.

5.3. Restrictions and Exceptions

5.3.1. The Subscriber shall be entitled at most to 12 Counseling Sessions per each Insurance Year.

5.3.2. The Therapists, at their sole and complete professional discretion, have the right, in a case they anticipate needs other treatment, not to deal with the Subscriber's appeal and to refer him to public emergency services.

5.3.3. The service according to this TOS will not be provided in a case which according to the therapist's sole and complete professional discretion, effective treatment of the problem requires hospitalization, treatment in day care center, intervention of a clinic or a combined treatment of several team members.

5.3.4. Psychological Assistance and Advice Service according to this TOS will not be provided in cases according to the therapist's sole and complete professional discretion, are cases of autism, mental retardation, chronic psychotic conditions, neurological disorders of development, drugs use and addiction and delinquency.

5.3.5. The Subscriber is entitled to seek to replace the Therapist, in which case the Service Provider Will do his best to direct the Subscriber to another Therapist with whom the Service Provider entered into agreement and provided that the replacement of the Therapist does not contradict the professional discretion of the original actual Therapist.

5.3.6. The Therapist has a sole and complete professional discretion to refer the Insured to another Therapist in the array of the Service Provider.

5.3.7. The Therapist has a sole and complete professional discretion to refer the Insured to another Therapist in the array of the Service Provider.

5.3.8. The service will not be provided in a place which

according to the therapist's sole and complete professional discretion, there is an organic background to the Subscriber's suffering or suspicion of organic background, which requires the according to provisions of any law, a doctor's examination near the beginning of treatment, unless the actual therapist was given a written confirmation by the doctor, which determines the required treatment.

5.3.9. The Service - According to this TOS does not include providing professional state of opinion for legal purposes.

5.4. Liability

5.4.1. The Service Provider's commitment to the Subscriber in processing a Subscriber's application for services call shall end when the earlier of the two following events will occur:

5.4.1.1. Referral of the Subscriber's application for counseling by the telephone or referral of the Subscriber to a Therapist for a Counseling Session, as the case may be.

5.4.1.2. Cancelation of Subscriber's application for counseling by the telephone, by the Subscriber's notice to the service center.

5.4.2. It is clarified that the Insurer and / or Service Provider shall not be liable for negligence professional or otherwise, of the actual Therapist or of the Therapist who gave the counseling by the telephone, as applicable, and the Insurer and / or Service Provider will not be responsible in any manner for any of the following matters:

5.4.2.1 Negligence professional or otherwise and / or any damage or loss caused to the Subscriber and / or to his parents and / or to any other person in connection with the service subject of this TOS.

5.4.2.2. Expenses made by the Subscriber for treatment, beyond the service specified
In this TOS.

5.4.2.3 Expenses made by the Subscriber for treatments or services by a professional who is not a Therapist as defined in Article 1.7 above.

5.4.3. Without derogating from the generality of the foregoing it is clarified, that the Insurer and / or the Service Provider will not be responsible for any damage, loss to body or property caused to the Subscriber, to his parents or to any other person during and / or as a result of providing the service, whether for an act or because of omission, whether direct or indirect damage, and that the Service Provider and / or the Insurer is not [responsible for negligence] and / or including professional negligence or other of the Service Providers and / or any other damage resulting from an act or an omission of the Service Providers.

6. **General**

6.1. The right to receive the service according to this TOS is individual, and

the Subscriber may not transfer it to another.

6.2. In case the Subscriber requests to cancel his appeal for any of the services subject of this TOS, the Subscriber shall inform the service center about it. For avoidance of doubt it is clarified that the Subscriber has to inform the service center about the cancelation of his application, even if gave notice about the cancelation to the doctor - in - the - agreement which contacted him by the telephone or to the provider of any of the Information Services.

6.3. Notwithstanding the provisions in this TOS, the Service Provider will not be obligated according to this TOS In the case of a state of war or general mobilization, general shortage of Service Providers or due to any other cause which is unforeseeable or which cannot be prevented by the Service Provider.

6.4. In any matter related to obtaining the services according to this TOS the Subscriber should first contact the service center.

6.5. The Subscriber shall notify the service center of any change in his address, in his home telephone number and of any Change in the members of the Subscribing Family.

7. Deductible Amount

7.1. Information Services will be provided absolutely free of deductible fee by the Subscriber to Service Provider.

7.2. Night Doctor Visit Service , will be given against payment of a deductible amount of 25 ILS for any given Subscriber that received a Night Doctor Visit Service within the framework of the same visit (whether a home visit or a visit in the medical center). The Subscriber shall pay the aforementioned deductible amount directly to doctor – in – the- agreement, which carried out the service.

In addition, the Subscriber will pay directly to the doctor – in – the - agreement consideration for a in bottles or medication in ampoules or injections, if case such medications as aforesaid were given to him by the doctor – in – the – agreement

7.3. The amounts stated above include VAT at the rate of 15.5%. If there will be a change in VAT rate these amounts will change accordingly.

7.4. The amounts stated above are linked to the base index and will be updated once every 12 months only and for the first time on January 1st 2009.

7.5. In case of non-payment of the deductible amount by the Subscriber, the Service Provider shall be entitled to stop providing the services to the Subscriber, after giving to the Subscriber and the to the Insurance Company a notice in writing about it.

8. TOS Validity Period

8.1. The validity period of the TOS will be of 12 months from the beginning date of the Insurance Policy's validity, and it shall be automatically renewed for additional periods of 12 months each, without the need for a health statement, or medical examination, be the Subscriber's medical condition as it may be, unless it will be decided by the Subscriber and / or the Insurance Company not to renew it.

8.2. This TOS will not be valid if Insurance Policy expires and / or if the Subscriber did not pay the extra premium for the right to obtain the services.

8.3. It is clarified that on the date that the validity period of this TOS ends, on the same date there will expire every right of the Subscriber according to this TOS, including in case that the Subscriber applied to the service center before the validity period ended, but did not receive an approval for the actual providing of the service.

Terms Of Service – Living Healthy
Preventive Medicine and Quality of Life Services
No. 909

1. **Definitions**
In this TOS the following terms shall have the meaning stated alongside of them:

1.1. **The Service Provider** – the Service Provider with which the Insurer to entered into an agreement for providing the services listed In this TOS.

1.2. **The Insurer or the Insurance Company** – Harel Insurance Company LTD.

1.3. **The Insurance Policy** - Health Insurance Policy of the Insurer which includes TOS of Preventive Medicine and Quality of Life Services.

1.4. **Insured** - A person named in the Insurance Details Page of the Insurance Policy.

1.5. **The Subscriber or the Subscribing Family –** An Insured who is entitled to receive the services subject of this TOS.

1.6. **The Service Providers** - Service Providers in one of the fields listed hereinafter, with which the Service Provider entered into arrangement for providing the services subject of this TOS.

1.7. **Doctor** - A medical doctor who was authorized and approved by the authorities in Israel and is licensed to practice medicine.

1.8. **Therapist** – A Therapist who is entitled by the law to issue the relevant service to the Insured, with whom the Service Provider entered into agreement in connection with providing service to his Subscribers.

1.9. **Dietitian** - a clinical dietitian with official authorization, with whom the Service Provider entered into agreement in connection with providing service to his Subscribers.

1.10. **Nutritionist** - An officially certified nutritionist, with whom the Service Provider entered into agreement in connection with providing service to his Subscribers.

1.11. **Clinical Speech Therapist** - An officially certified speech therapist with whom the Service Provider entered into agreement in connection with providing service to his Subscribers.

1.12. **Fitness Trainer** – A Trainer with certification from the Wingate Institute or from the Kibbutzim Seminar, with whom the Service Provider entered into agreement in connection with providing service to his Subscribers.

1.13. **Service Center** - Telephone Center No**. 03-5688502** (multi-line).

1.14. **The Index** - Consumer Price Index, published by the Central Bureau of Statistics.

1.15. **The Base Index** - Index 10809 which was published on July 15th 2008.

1.16. **Holiday** - Israeli holidays which are non-working days.

2. **Preventive Medicine and Quality of Life Services**

The Subscriber shall be entitled to receive services as follows:

2.1. **Diet and proper nutrition advice**

2.1.1. The service includes providing consultation regarding diet and correct nutrition, while matching a menu and a personal diet program.

2.1.2. The service is provided by a clinical dietitian or by a Nutritionist, according to the Insured's choice.

2.1.3. The service includes an initial consultation on the telephone by the performer of the treatment, and a series of 10 additional treatment sessions, for each Insurance Year, the duration of each session being about 45 minutes.

2.1.4. The service is provided in the Service Providers' clinic.

2.2. **Medical Weight Loss**

2.2.1. The service includes providing medical advice for losing weight and maintaining body weight over time. Within the framework of the service, the Subscriber will receive a personal service pack containing a list of food supplements a personal menu and advice regarding complementary activities (such as sports).

2.2.2. The service is provided by a certified doctor.

2.2.3. The service includes a series of 12 therapeutic sessions, per each insurance year. The duration of each meeting is about 45 minutes.

2.2.4. The service is provided in the Service Providers' clinic.

2.3. **Learning Disabilities**

2.3.1. The service includes advice and support by a clinical speech therapist, to diagnose and treat problems of learning disabilities in children up to the age of 14. The service is provided by qualified therapists of learning disabilities by corrective teaching and / or by the Elbaum method.

2.3.2. The service includes a series of sessions as detailed hereinafter:

A. Up to 2 sessions for diagnostic, each session's duration being 90 minute.

B. Up to 10 sessions for treatment, per each year of insurance. each session's duration is about 45 minute.

2.3.3. The service is provided in the Service Providers' clinic.

2.4. **Smoking Cessation**

2.4.1. The service includes rehab treatment for Smoking Cessation using acupuncture and in combination of herbs as needed.

2.4.2. The service is provided by a certified therapist.

2.4.3. The service includes a series of 10 treatment sessions for each insurance year. The duration of each session is about 45 minutes.

2.4.4. The service is provided in the Therapist's clinic.

2.5. **Stress Relief**

2.5.1. The service includes treatment to relieve tensions, in one of the following fields: Shiatsu, reflexology, tissues massage, Tui-na, Alexander technique, Yoga, Feldenkrais.

2.5.2. The service is provided by certified therapists.

2.5.3. The service includes a series of 10 treatment sessions for each insurance year. The duration of each session is about 50 minutes.

2.5.4. The service will be provided in the Insured's home.

2.6. **Personal Trainer - Fitness Care**

2.6.1. Service Includes providing physical fitness training lessons by a certified personal trainer while constructing a personal training program customized for the Subscriber, including body slimming, muscle strengthening and improving cardio – pulmonary endurance.

2.6.2. The service is provided by a certified fitness trainer.

2.6.3. The service includes a series of 10 workout sessions with a certified fitness trainer for each insurance year. The duration of each workout is about 60 minutes.

2.6.4. The service will be provided in the Insured's home.

2.7. **Fitness Centers Network**

The service includes eligibility for an annual discount Subscription in a Gym which entered into an agreement for this purpose with the Service Provider.

The full and updated list of fitness center is present in the service center. The list will be updated
from time to time.

3. General

3.1. If the Subscriber requires a service in one of the fields as prescribed in this TOS, he shall apply by telephone to the service center using the phone number specified above, identify himself by his name, his address, the phone number in which he can be reached and his ID No.

3.2. The service center will refer the Subscriber to the Service Provider after making sure that the applicant is indeed a Subscriber as defined above, who is entitled to receive the services according to this TOS.

3.3. Coordination of service delivery will be done within 48 hours from reception of the application (not including weekends and holidays).

3.4. After the counseling session or treatment, the subscriber shall sign a Review appendix in which he confirms that Service Provider performed the counseling session or
treatment.

3.5. Services according to this TOS will not be given in cases which according to the sole and complete professional

discretion of the Service Provider are cases that can endanger the health of the subscriber.

Service Providers, on their sole and complete professional discretion, have the right, in case they assess that the Subscriber needs another treatment, not to treat him.

3.6. The service does not include expenses of the Subscriber for purchase of medications, medicinal herbs and other materials recommended by the Service Provider for the treatment.

3.7. In case the Subscriber wishes to cancel his application for any of the services subject of this TOS the Subscriber shall inform the service center about it. For avoidance of doubt it is clarified that the Subscriber has to inform the service center about the cancelation of his application, even if he gave notice about the cancellation of his application to the Service Provider.

3.8. Without derogating from the generality of the foregoing it is clarified, that the Insurer and / or the Service Provider will not be responsible for any damage, loss to body or property caused to the Subscriber, to his parents or to any other person during and / or as a result of providing the service, whether for an act or because of omission, whether direct or indirect damage, including professional negligence or other of the Service Providers and / or any other damage resulting from an act or an omission of the Service Providers.

3.9. The Service Provider's commitment to the Subscriber in processing a Subscriber's application for service shall end when the earlier of the two following events will occur:

3.9.1. Referral of the Subscriber to the Service Provider.

3.9.2. Cancelation of Subscriber's application for service by the Subscriber's notice to the service center.

3.10. The Insurer and / or the Service Provider will not be responsible for professional negligence of the relevant Service Provider only, and the service provider and / or the Insurer shall not be liable in any way for any of the following issues:

3.10.1. Professional negligence or otherwise and / or any damage or loss caused to the Subscriber and / or to any other person in connection with the services subject of this TOS.

3.10.2. Expenses made by the Subscriber for a treatment exceeding the service detailed in this TOS.

3.11. Notwithstanding the provisions in this TOS, the Service Provider will not be obligated according to this TOS
In the case of a state of war or general mobilization, general shortage of Service Providers or due to any other cause which is unforeseeable or which cannot be prevented by the Service Provider.

3.12. The right to receive the service - according to this TOS Is individual, and the Subscriber may not transfer it to another.

3.13. Notwithstanding sections 2.5 and 2.6 the services detailed in them will be provided to Subscribers in settlements in Judea, Samaria, the Gaza Strip, and the

settlements of Jordan Valley and the Arava will be provided in addresses delivered by the service center, to which they will arrive by themselves and on their own expense.

4. **Deductible**

4.1. Subscriber must pay deductible amounts directly to the Service Provider as detailed hereinafter:

Meeting Type / Service Type	**First Meeting**	**Each further meeting (up to maximum number of meetings)**	**For each meeting beyond the maximum number of meetings**
Diet & Nutrition Advice	95 ILS	75 ILS	Non
Medical Diet	75 ILS	150 ILS	Non
Learning Disabilities A. Diagnostic sessions - - - - - - - - -	discount of 25% off from list price Service Providers in the Arrangement		
B. Treatment sessions	150 ILS	150 ILS	Non
Smoking Cessation	135 ILS	95 ILS	Non
Stress Relief	100 ILS	100 ILS	150 ILS
Personal Trainer - Fitness Care	100 ILS	100 ILS	125 ILS
Gym Network	25% off list price of Gym		

4.2. Foregoing amounts include VAT at the rate of 15.5%. If there will be a change in VAT rate these amounts will change accordingly.

4.3. The amounts above are linked to the base index but they will be updated once every 12 months only and for the first time on January 2009.

4.4. In case of non-payment of the deductible amount by the Subscriber, the Service Provider shall be entitled to stop providing the services to the Subscriber, after giving to the Subscriber and the to the Insurance Company a notice in writing about it

5. **Selecting Service Providers**

5.1. The Subscriber shall be entitled to choose the Service Provider from the list of Service Providers in the arrangement, depending on the desired field of service.

5.2. The Subscriber has the right to replace the Therapist, in which case the Service Provider will do his best to refer the Subscriber to another therapist with which the Service Provider entered into agreement, Provided that the replacement of the therapist does not contradict the discretion of the actual original Therapist.

6. TOS Validity Period

6.1. The validity period of the TOS will be of 12 months from the beginning date of the Insurance Policy's validity, and it shall be automatically renewed for additional periods of 12 months each, without the need for a health statement, or medical examination, be the Subscriber's medical condition as it may be, unless it will be decided by the Subscriber and / or the Insurance Company not to renew it.

6.2. This TOS will not be valid if the Insurance Policy expires and / or if the

Subscriber did not pay the extra premium for the right to obtain the services.

6.3. It is clarified that on the date that the validity period of this TOS ends, on the same date there will expire every right of the Subscriber according to this TOS, including in case that the Subscriber applied to the service center before the validity period ended, but did not receive an approval for the actual providing of the service.

Terms Of Service - Subscription for "Heart Event"
No. 908

1. **Definitions**

In this TOS the following terms shall have the meaning stated alongside of them:

1.1. **The Service Provider** – the Service Provider with which the Insurer to entered into an agreement for providing the services listed In this TOS.

1.2. **The Insurer or the Insurance Company** – Harel Insurance Company LTD.

1.3. **The Insurance Policy** - Health Insurance Policy of the Insurer which includes TOS of Subscription for "Heart Event".

1.4. **Insured** - A person named in the Insurance Details Page of the Insurance Policy.

1.5. **Subscriber –** An Insured who is entitled to receive the services subject of this TOS, after the occurrence of a Heart Event.

1.6. **Heart Event** - Myocardial infarction, angioplasty treatment with a balloon or a stent, valve surgery, heart transplant, arrhythmia, bypass surgery.

1.7. **The service center** - a national telephone applications center: 1599500567.

1.8. **Index** - Consumer Price Index, published by the Central Bureau of statistics.

1.9. Base Index - Index 10809 which was published on July 15th 2008.

2. Service Specification

The Subscriber will be eligible, during the subscription validity period and after the occurrence of a heart event, to receive the following services:

2.1. **Medical record** - a detailed medical interview in the Service Provider's center, including ECG test during which the medical history of the Subscriber and all the relevant information available about him are recorded. The information received will be stored in Service Provider's computers system for use when necessary. This information shall be updated after each change which will occur in the Subscriber's medical condition and of which the Subscriber will report in writing to the Company.

2.2. **Cardiac transmitter device –**

The Company will provide to the Subscriber a cardiac transmitter, which will allow the Subscriber to perform ECG signal telephone calls to the Service Provider's center. At the end of the validity period of the TOS or If the Subscriber will request to stop the subscription, he will return the instrument to the offices of the Service Provider in proper condition.

2.3. **National Applications Center Services** – A Service Center, in which will be conducted an assessment of the clinical situation description provided by the Subscriber, based on the analysis of EKG data obtained from the cardiac transmitter he possesses. In accordance with the assessment, the medical team in the center will guide the Subscriber. Each Subscriber's application to the Service Provider's medical center, including the decoding of the EKG chart, will be recorded in the Subscriber's personal medical record.

2.4. Evacuation Service by an Intensive Care Vehicle and by an Ambulance –

2.4.1. A Subscriber of evacuation service by Intensive Care Vehicle [ICV - "NATAN"] / Intensive Care Ambulance [ICA – "ATAN"] is entitled to an evacuation service by a vehicle of the Service Provider or on his behalf, subject to the availability of vehicles and the urgency of the call, from his home to a hospital near his home and that only in cases originating from a cardiac, a traumatic or a life-threatening problem only according to the service call received in the service center and according to the Service Provider's sole discretion.

In the case of non-availability of a Service Provider's vehicle, the Subscriber will be entitled to a coverage of the Payment for evacuation by a ICV / ICA of Magen David Adom ["MADA"] in the amount of difference between the actual cost of evacuation and the amount to which the Subscriber is entitled as an Insured of HMO or any other party.

It is clarified to the Subscriber that Magen David Adom will assist the Subscriber according to its own procedures and customary priorities, and that the Service Provider was not responsible directly or indirectly for the quality of service and care provided - by Magen David Adom, provided that the quality of service of Magen David Adom was not impaired due to an act or omission of the Service Provider.

2.4.2. Payment coverage by the Service Provider will be the difference between the cost of actual evacuation and the amount Subscriber is entitled to as an Insured of HMO or any Other party.

It is clarified that the Service Provider will not make any payment for evacuation in case that the evacuation was ordered not through the Service Provider's center and / or if the Subscriber refused to evacuate contrary to the recommendation of the Service Provider.

3. Applying to the Medical Center

Application to the medical center will be done by telephone. When in need the Subscriber or another person on his behalf shall call the service center and identify himself by providing the Subscriber's ID No. or the home telephone number of the Subscriber, the Subscriber's name (according to the order specified). Furthermore the applicant shall provide further details as requested. Application to the service center will be done in Hebrew or in English.

4. TOS Validity Period

This TOS will be valid as long as the Insurance Policy to which this TOS was attached will remain if force. Validity period of the TOS shall be of 36 months from time the Insurance Policy becomes valid and it will be renewed automatically for additional periods Of 36 months each, unless it is decided by the Subscriber and / or the Insurance Company not renew it for all those Insured.

5. Subscriber's Undertaking

5.1. The Subscriber permits the Service Provider may, According to this TOS, to make use of medical information registered with the Service Provider as he sees fit, for the performance of his duties and agrees that the above information If necessary, will be broadcast wirelessly, through telephone or otherwise. Subscriber also permits the Service Provider to record conversations with him or with his representative, all for the

purpose of service delivering medical service to the Subscriber.

5.2. For the purpose of updating the medical record the Subscriber will report to Service Provider in writing of any material change in his health condition and of any change in the medications he is taking and their dosage, and he shall provide to the Service Provider a copy summary of illness if necessary. The Subscriber declares that he understands he has to continue to be treated and reviewed medically according to the instructions of his doctors and that making the subscription subject of this TOS does not substitute the foregoing.

5.3. The Subscriber declares that he understood that providing medical information when registering and reporting about updates / changes are an essential component in the quality of service provided to him by the Service Provider, and that he will act in order to provide the information aforementioned.

5.4. The Subscriber warrants that he understood that the services provided according to this TOS can be provided to adults only.

5.5. A Subscriber who prior to his joining this TOS is a Subscriber with any Service Provider of Services after a heart event as defined in Article 1.6 above, shall not be entitled to services under this TOS, but to a 30% discount of the list price of the Service Provider's services at that same time.

6. **General**

6.1. The Service Provider undertakes the proper operation of a center for reception of application and initial diagnosis, equipped with computers system that provides information on the Subscriber's medical past (which was provided by the Subscriber) and staffed with a skilled medical team.

6.2. Service Provider services Subscribers as aforementioned will be provided 24 hours a day throughout the year including weekends and holidays, except during an emergency and / or in the case of a mass attack and / or substantial paralysis of communication systems.

6.3. A message sent by the Service Provider through registered mail to the Subscriber's address will be considered as if it reached its destination within 7 days from the day of its delivery.

Harel P.M.S. Program PREFERRED PLATINUM (In Accordance with the Proper Disclosure Regulations)

Subject	Article	Conditions
General	Program Name	Harel P.M.S. PREFERRED PLATINUM
	Annex Covers	Extended surgery coverage, private surgeries abroad, transplants in Israel and abroad and special treatments abroad, special medical consultation, special medications, unique medical services, living healthy, subscription for "heart event", escort by a personal physician.
	Duration of Insurance	For the life of the Insured except as described below: In the TOS - unique medical services - automatic annual renewal. In the TOS - living healthy - an annual automatic renewal. In the TOS – subscription for "heart event" - 3 years renewable automatically. In the TOS - escort by a personal physician - renewable.
	Qualifying Period	90 days for each cover, except in TOS unique medical services, in TOS living healthy, in TOS subscription for "heart event", in Extended Surgery Coverage, in the case of abortion or cesarean section the qualifying period will be of 365days.
	Stand By Period	**Non** except in expanded coverage for surgeries Article 4 (lose of work ability due to surgery) stand by period will be of 90 days.
	Deductible Amount	Transplants abroad and special treatments abroad - 15,000$ per special treatment not coordinated by the Company. Special medications – as par Insurance Details Page. Unique medical services - deductible depending on the service provided. Living healthy - deductible depending on the service provided. subscription for "heart event" - 70% of the price of cardiac transmitter at the time.
Changing Terms	Change in the Annex Terms During the Period of Insurance	The changes require the approval of the Commissioner of Insurance, and will become effective 60 days after approval.
Premium	Premium Level and Structure	Premium changes every 5 years, a fixed premium from age 65. For Joiners over the age of 65, fixed premium according to an entry premium. Attached is a premium table according to joining age and changes.
	Changes in Premium	The changes require the approval of the Commissioner of Insurance, and will become effective 60 days after

	During Insurance Period	Approval.
Cancellation Conditions	Annex Cancellation Conditions By the Insured	Written notice to the Company at any time (eliminating all Insured persons listed on the Insurance Information Page).
	Annex Cancellation Conditions By the Company	1. If the Insured and / or the Policy owner does not pay or did not pay the premium regularly (according to the Insurance Law). 2. If the Insured withheld a material fact from the Company, with the knowledge it would cause the Company not to admit him into the insurance (according to the Insurance Contracts Law 1981).
Exceptions	Exclusion Due to Existing Medical Condition	General Insurance Terms (896) - Article 4.3 of the general exceptions.
	Restrictions on the Company's Liability	General Insurance Terms (896) - Article 4 Extended Surgery Coverage (804) - Article 5 Cover surgery abroad (851) - Article 5 Special Medical Consultation (805 A) – Articles 2.1.2, 2.3.1, 2.3.2 Special Medications (904) - Articles 2, 5 Unique Medical Services (907) - Articles 3.2.4, 5.3 Escort by a Personal Physician (934) Article 2.

Harel P.M.S. Preferred Platinum
(Details About the Insurance Coverage – According to the Regulations of "Proper Disclosure" to the Insured (No. 877)

A	B	C	D	E	F
Details of Plan Coverage	**Coverage Description**	**Indemnity / Compensation**	**Requiring Company's Approval in Advance**	**Interface with basket Base And / or Additional Health Services**	**Offset of Benefits With Other Insurance**
Surgeries				Replacement Insurance	
Covered Surgeries	All surgeries	Indemnification	Yes	↓	Yes
Private Surgeries Coverage In Israel and / or Abroad	In Israel and / or abroad	Indemnification	Yes		Yes
Coverage for Not-in-Agreement Surgeon	Exists up to a limit. the amount is prescribed on the Company's website	Indemnification	Yes		Yes
Compensation for Public Hospital Surgery	Exists as prescribed on The Company's Website	Compensation	Yes		No
Alternative to Surgery Treatments					
Alternative to Surgery Treatment Abroad	Coverage for Alternative to Surgery Treatment, which is designed to prevent the Surgery it is a replacement for and achieved a goal similar for surgery it is replacing, and up to the amount specified in the Insurance Details Page	Indemnification	--	Supplement Insurance	Yes
Surgeries Abroad				Supplement Insurance	
Coverage for Private Surgery Performed Abroad	Surgeon fees coverage, hospitalization up to 30 days, cost of operation room, pathological examination implanted accessory	Indemnification	Yes	↓	Yes
Accompanying Coverage for Surgeries	Medical flight, corpse airlift, bringing a specialist to perform expertise in Israel, guidance and providing information, advice and assistance to escort in stay arrangements, discount on traveler insurance for the escort, transfers for insured and escort, flight costs to escort in case the insured was flown by medical flight	Indemnification	Yes	↓	Yes
Accompanying Coverage for Surgeries Due to Which the Insured Was Hospitalized for More Than 10 Days.	Stay expanses, private nurse, recovery costs, ongoing medical monitoring abroad, rehabilitation expanses.	Indemnification	Yes		Yes

A	B	C	D	E	F
Details of Plan Coverage	**Coverage Description**	**Indemnity / Compensation**	**Requiring Company's Approval in Advance**	**Interface with basket Base And / or Additional Health Services**	**Offset of Benefits With Other Insurance**
Transplants				Replacement Insurance	
Insurance Benefits	**Service Provider in the agreement** – full coverage (no limit) **Service Provider not in the agreement** – up to a limit amount of 1,000,000 $	Indemnification	Need determined by two specialist doctors		Yes
	Or 50,000$	Compensation			No
	Transplant of an organ from an animal – up to a limit of 600,000$	Indemnification			Yes
	Transplant of bowels or ovaries – up to a limit of 400,000$	Indemnification			Yes
Monthly Allowance after Performance of Transplant	As high as 2,500 ILS or 3,500 ILS or 6,000 ILS as stated in the Insurance Details Page	Compensation	Yes		No
Monthly Allowance after Performance of Special Treatment Abroad	As high as 10,000 ILS	Compensation	Yes		No

Clarification: Recently the Organ Transplant Law, 5768 - 2008 was enacted. Your Insurance Policy is subject to the provisions of laws and regulations. For avoidance of doubt, it is clarified that before granting an indemnification or compensation for funding the performance of a transplant, the Insurer will review if the transplant was performed in accordance with the law, including if the following condition were met:

1) Taking organ for transplantation was done under the law applicable in that State;

2) Legal provisions on the prohibition of trade in organs are met.

Also, it is clarified that the foregoing will apply even if your Insurance Policy includes a provision that contradicts the law and therefore, the Insurer will not act by it - such as, a provision according to which a person shall be given consideration for an organ taken from his body or from another person's body, or destined for taking, all whether the taking is done while the person is alive or done after his death.

A	B	C	D	E	F
Details of Plan Coverage	**Coverage Description**	**Indemnity / Compensation**	**Requiring Company's Approval in Advance**	**Interface with basket Base And / or Additional Health Services**	**Offset of Benefits With Other Insurance**
Special Medical Counseling (discovery of a serious illness)				Replacement Insurance	
Number of consultations / Payment limit	Two consultations, up to the "HADASA" PMS tariff for head of department	Indemnification	Yes	↓	Yes
Special Medications				Supplement Insurance	
Medications Included in Coverage	Medications excluded from the basket of health services or not covered in the basket for the insured due to the indication, and approved for the required use, in Israel or in one of the recognized countries or that have not been approved for the required use, but are known to be effective treatment for the insured's condition under the terms of the policy or an orphan medication as defined in the policy			↓	
Maximum Insurance Amount for the Entire Insurance Period	Up to 1,000,000 ILS. The maximum insurance amount will be renewed once every 3 years.	Indemnification	Yes		Yes
Deductible amount per prescription for medications of monthly cost up to 10,000 ILS	As stated in the Insurance Details Page				
Coverage for the Service or medical treatment Involved in Giving the Medication	As stated in the Insurance Details Page	Indemnification			Yes
Coverage for UPGRADE Medications	A complementary coverage for medications covered by the AHS ("SHABAN") program, which includes refund of deductible amount paid or monthly compensation, according to the terms of the policy.	Indemnification / Compensation			Yes (in indemnific-tion)

Up-to-date for index 10552

Refers to Column E

Alternative Insurance - private insurance which is a substitute for the health services provided in the Public health basket and / or the AHS ("SHABAN"" - Additional Health Services in HMO's). In this Insurance the Insurance benefits will be paid regardless of the basic rights that come on basic levels (from the first ILS).

Complementary insurance - private insurance – by which insurance benefits are paid above and beyond the basic basket and / or the AHS ("SHABAN"). That is, the benefits which will be paid are the difference between the actual expenses and the expenses covered by the basic basket e and / or the AHS ("SHABAN").

Supplement Insurance - Private insurance which includes services that are not included in the basket base and / or AHS ("SHABAN").

Insurance benefits are paid from the first ILS.
Definitions are valid for the day they were published.

Clarification Regarding Period of Military Service

Note that the use of your health Insurance Policy during the military service is subject to the army's orders as they will be changed from time to time.

Maximum Insurance Benefits Which are not of Specified Value

It is clarified that the maximum Insurance benefits that are not of specified value, if such exist in your policy, are based on the agreement prices updated from time to time as specified on the Company's website.
To find out the amount of such insurance benefits included in your insurance plan, please contact the Harel center, on the phone *Harel or on the Company's Website
https: / / www.harel-group.co.il/wps/portal

Harel P.M.S.
Preferred Platinum
Monthly Premium In ILS
Index 11404 (January 15th 2010)

Age	Premium
child *	35.11
21-29	94.15
30-34	106.89
35-39	124.53
40-44	142.63
45-49	170.03
50-54	209.59
55-59	296.38
60-64	383.00
65	448.96

Premium changes every 5 years
Fixed premium from the age of 65
For new joiners over the age of 65 the premium is fixed according to the entry premium.
* Fourth child onwards in the same product free (Child - up to the age of 21)

Full and Binding Conditions are the Conditions in the Insurance Policy