



Harel SAFE STAY+

Extended Health Insurance for a foreign worker in Israel

June 2016

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SAFE STAY + **Extensive Medical Insurance for the Foreign Worker**

If this Policy was purchased and this is noted on the Insurance Details Page, as said below, the Insurer will indemnify the Insured for expenses for medical services and/or will directly pay the service providers and/or medical institution that provides the health services for an insurance event and/or will compensate the Insured, all as defined and set forth in detail in the Policy, during the insurance period, within the limits of the liability of the Insurer, according to the terms, exclusions, and exceptions set forth in this Policy.

Chapter A: Definitions and General Terms

1. Definitions

- 1.1. **The Insurer:** Harel Insurance Company, Ltd.
- 1.2. **The Insured:** A person staying in the State of Israel as a foreign worker who is employed by the Policyholder and whose name is specified on the Insurance Details Page.
- 1.3. **Foreign worker:** A person working in Israel who is not an Israeli citizen or resident of Israel.
- 1.4. **The Policyholder:** An employer or corporation who entered into the insurance contract with the Insurer and whose name is specified on the Policy as the owner of the policy, who requests to insure the foreign worker whose name is specified on the Insurance Details Page of this Policy.
- 1.5. **The Policy:** The insurance contract, including the proposal, the Insurance Details Page and any rider or appendix attached to it.
- 1.6. **The Insurance Proposal:** A proposal form in the version determined by the Insurer that has been fully completed with all details, a statement regarding the date of entry to Israel and a waiver of medical confidentiality, signed by the Policyholder in the place where his/her signature is required.
- 1.7. **Health Condition Statement:** The Health Condition Statement form and waiver of medical confidentiality of the Insurer, signed by the Insured.
- 1.8. **Insurance Details Page:** A page attached to the Policy, which constitutes an integral part thereof, which includes, among other things, the personal details of the Insured and the conditions required in order to adapt the insurance policy to the terms of the Insurance contract with the Insured. In the case of a conflict between the terms of the Policy and the terms specified on the Insurance Details Page, the terms on the Insurance Details Page shall prevail.
- 1.9. **Foreign country/outside of Israel:** Any place or country outside of Israel, including any means of transportation traveling to or from Israel.
- 1.10. **Israel:** The territory of the State of Israel, with the exception of any means of transportation traveling to or from Israel, including territories controlled by the IDF, but excluding the territories held by the Palestinian Authority.
- 1.11. **Insurance period:** The period specified on the Insurance Details Page attached to the policy, which shall not be more than 12 months from the date of commencement of the Insurance.
- 1.12. **One employment period:** The entire period of work of the Insured, even if it is not continuous, in which there existed employer-employee relations between a given employer and a given foreign worker.
- 1.13. **Insurance event:** A case in which the Insured has need, during the insurance period, of medical treatment in Israel that is included under this Policy and that is provided during the insurance period and/or at the latest within 90 days of the date of the end of the insurance period, all this according to the terms, exclusions and exceptions as set forth in this Policy.
- 1.14. **Medical institution:** A hospital or clinic, including a medical institute, laboratory, diagnostic centers, pharmacy.
- 1.15. **General-government hospital:** An institution in Israel that is recognized by the qualified authorities as a general-government hospital and that serves as a hospital only, with the exception of an institution that is also a sanitarium and/or a rehabilitation institution.

- 1.16. **Physician:** A person who holds a legal certificate of qualification to work as a physician in Israel.
- 1.17. **Attending physician:** A general physician who is not a specialist, as well as a specialist physician in family medicine and/or internal medicine and/or gynecology.
- 1.18. **Health/medical services:** All the medical services to which the foreign worker is entitled according to the terms of this Policy.
- 1.19. **Primary health services:** Services provided by an attending physician according to the terms of this Policy.
- 1.20. **Medical emergency:** Circumstances in which there is an immediate threat to a person's life or in which there exists an immediate risk that severe irreversible disability will be caused to a person if not provided with urgent medical treatment.
- 1.21. **Preexisting condition:** A defect, congenital disease, including hereditary diseases and/or a health condition and/or a medical phenomenon, and/or a disease, whether treated or not, and/or their consequences, whether direct or indirect, that were caused and/or worsened due to a health condition that existed prior to the date of commencement of the Insurance, subject to the Insured's Health Condition Statement and/or to the confirmation of a physician, all subject to the said in Section 5.1.4 below.
- 1.22. **Service providers:** A general-government hospital and in addition, physicians and/or a medical institution connected by agreement with the Insurer, **from which and solely from which the Insured will be entitled to receive the health services specified in this Policy, all this subject to the terms of the Policy.**
- 1.23. **Insurance fees:** The amounts that the Policyholder must pay the Insurer, according to the terms of the policy, for insurance coverage according to this Policy.
- 1.24. **The customary payment:** A payment, including a guarantee or deposit, that applies to the Insured, in return for the actual provision of the medical service, and that was determined in the Second or Third Schedule to the Health Insurance Law at the beginning of the insurance period or by notice regarding terms and payments that the state issued to the individual on the determining date according to the Health Insurance Law or in the proposal of the health fund according to Section 8(1a) of the Health Insurance Law, which was approved according to Section 8 (2a) of that law, and if the different instructions included different payments for the same medical service - the highest among them.
- 1.25. **Insured card:** A card to be issued by the Insurer in addition to the Policy, on which the personal details of the Insured will be specified, which the Insured will present to any medical institution in order to obtain medical services.
- 1.26. **Health Insurance Law:** The National Health Insurance Law, 1994 - 5754.
- 1.27. **Foreign Workers Law:** The Foreign Workers Law (Illegal Employment and Assurance of Fair Conditions), 1991-5751.
- 1.28. **Health basket:** As defined in the Health Insurance Law.
- 1.29. **Foreign Workers Ordinance:** The Foreign Workers Ordinance (Prohibition of Illegal Employment and Assurance of Fair Conditions) (Worker's Basket of Health Services), 2001-5761.
- 1.30. **Regulations on Health Services at Work:** Parallel Tax Regulations (Health Services at Work), 1973-5733.
- 1.31. **Service call center:** A call center on behalf of the Insurer that provides a response to the Insured with regard to service providers, and operates 24 hours a day.

2. General Terms

- 2.1. **Duty of Disclosure:** If, prior to entering into the contract, the Insurer presented to the Insured, whether on the Insurance Proposal form or by any other means in writing, a question regarding a matter that could affect the willingness of a reasonable insurer to enter into a contract, in general, or to enter into the terms included in it (herein: an essential matter), the Insured must answer it in writing with a complete and honest answer. A general question that incorporates different matters, without differentiating among them, does not require an answer as said, unless it was reasonable at the time of entering into the contract.
- 2.1.1. Deliberate deceptive concealment on the part of the Insured of a matter that he/she knew was an essential matter, shall be legally equivalent to providing an answer that is incomplete and dishonest.
 - 2.1.2. If an essential matter is answered incompletely and dishonestly, the Insured is entitled, within thirty days of the date on which this became known to it and as long as no insurance event has occurred, to cancel the Policy by written notification of the Insured.
 - 2.1.3. If the Insurer cancels the Policy by force of this section, the Insured is entitled to a refund of the insurance fees that he/she paid for the period after the cancellation, after deduction of the Insurer's expenses, unless the Insured acted with the intention of fraud.
 - 2.1.4. If the insurance event occurred before the Policy was cancelled by force of this section, the Insurer is not liable, with the exception of reduced insurance benefits at a proportional rate, which is the ratio between the insurance fees that would have been paid as customary in the company according to the true condition and the agreed insurance benefits, and the Insurer is completely exempt in any of the following:
 - 2.1.4.1. The answer was provided with the intention of fraud.
 - 2.1.4.2. The Insurer believes that it would not have entered into the contract, even for higher insurance fees, if it had known the true situation; in this case, the Insured is entitled to a refund of the insurance fees he/she paid for the period after the occurrence of the insurance event with the deduction of the Insurer's costs.
 - 2.1.5. The Insurer is not entitled to the above-said remedies in each of these, unless the incomplete and dishonest answer was provided with the intention of fraud:
 - 2.1.5.1. It knew or should have known the true situation at the time of entering into the contract or it caused the answer to be incomplete and dishonest.
 - 2.1.5.2. The fact about which the answer provided was incomplete and dishonest ceased to exist prior to the insurance event, or did not affect its case, the liability of the Insurer or its scope.
- 2.2. **Validity of the Policy:** The entry of this Policy into effect is contingent upon actual payment of the first premium. This term shall not apply if the Insured provided a means of payment from which it is possible to collect the insurance premium. If insurance fees were paid to the Insurer before the Insurer gave its agreement draw up the insurance, the payment shall not be construed as agreement to of the Insurer to draw up the insurance. In this case, the Insurer will, within 90 days from the date of first receipt of insurance fees, send a decision regarding the acceptance or non-acceptance of the applicant for the insurance, and will send

him/her, according to the case at hand, an insurance policy including an Insurance Details Page, or a rejection notice stating that the Insured was not accepted for the insurance and is not covered by valid insurance, or a request for completion of data or a counterproposal for insurance. If the Insurer does not, within 90 days from the date of receipt of the insurance fees for the first time, send a rejection notice as said above or a request for completion of data or a counterproposal for insurance, the Insured will be considered to have been accepted for the insurance under the terms specified in the insurance proposal. If the candidate for insurance has an insurance event during the period between receipt of the insurance fees for the first time and the Insurer's decision regarding his/her acceptance or non-acceptance to the insurance, and if, according to the instructions of the Insurer's medical underwriting regarding insurance candidates with similar characteristics, the Insurer would have notified the insurance candidate at the end of the underwriting process of his/her acceptance for insurance (were it not for the occurrence of the insurance event), the insurance candidate shall be entitled to coverage under the Policy for the insurance event, subject to all the other instructions and terms of the Policy.

2.3. Health Condition Statement:

- 2.3.1. The Policyholder shall provide the Insurer with a Health Condition Statement and Waiver Of Medical Confidentiality, signed by the Insured, which instructs his/her physicians and/or any other entity or medical institution, in Israel or abroad and/or the National Insurance Institute and/or the Ministry of Defense and/or another government ministry and/or insurance company and/or health fund to provide the Insurer with reasonable medical information regarding the Insured that it has in its possession.
- 2.3.2. The Policyholder will obtain the signature of the Insured on the Health Condition Statement and Waiver of Medical Confidentiality form issued by the Insurer in a language understood by the Insured, and will send the Insurer the form in a language understood by the Insured that is signed by the Insured, together with a statement of the Policyholder that the form was signed by the Insured after its contents were explained to him/her in a language he/she understands and/or that the Insured signed the Health Condition Statement form after he/she read its content in a language that he/she understands.

2.4. Claims:

- 2.4.1. A notice of any insurance event shall be delivered to the Insurer within a reasonable amount of time, as quickly and as early as possible by sending a letter or sending a fax. The notice shall be accompanied by the details of the insurance event, which will be sent to the Insurer in order to obtain all the facts it requires.
- 2.4.2. The Policyholder and/or the Insured shall attach to the form for notice of an insurance event all the relevant medical documents regarding the insurance event, including diagnoses, a history of the event (anamnesis) and, if payments were made by the Policyholder and/or by the Insured - original receipts of payment or, in the absence of an original receipt, a copy along with an explanation to whom the original receipt was sent and confirmation by that entity regarding the amount it paid the Insured regarding those documents or along with an explanation to whom the original documents were sent and details of the reason for his/her inability to provide them.

- 2.4.3. The Insured will cooperate with the Insurer before and after submission of the claim and will do all required in order to enable the Insurer to clarify its liability for payment according to the Policy and its scope.
- 2.5. **Medical examination:** The Insurer shall be entitled to reasonably demand of the Insured to undergo medical examinations by a physician on behalf of the Insurer and at the expense of the Insurer or by a physician on behalf of the Insured.
- 2.6. **Extension of the insurance period:**
- 2.6.1. The Insurer undertakes to extend the insurance period, continuously, at the end of the insurance period, in response to a request from the Policyholder or the Insured that is received by the Insurer and solely if insurance fees have also been paid for the interim period between the end of the original insurance period and the extension of the insurance, provided that the Insured continues to work for an employer as a foreign worker in Israel.
- 2.6.2. The Insured or the Policyholder are entitled to renew the insurance without renewed underwriting, within 90 days.
- 2.6.3. An Insured who is not entitled to an extension without underwriting as said in Section 2.6.2 shall be subject to the instructions of Sections 2.6.4-2.6.5 below.
- 2.6.4. In any other case that is not included under the cases listed in Sections 2.6.1 to 2.6.2. - the Policyholder is entitled to ask the Insurer to extend the insurance period for an additional period of time. Extension of the insurance period shall be subject to a process of underwriting as customary for the Insurer and subject to the prior written approval of the Insurer. It is hereby clarified that at the end of the insurance period, as defined in the Policy, the insurance will not be extended automatically except by its agreement as said in this section, within the period of time specified in Section 2.6.4.2 below, even if the Policyholder and the Insured proposed its extension to the Insurer in any form and at any time.
- 2.6.4.1. The Policyholder is entitled to request extension of the insurance period (herein: "request for extension"). The request for extension shall be sent to the Insurer by post at least 30 days before the end of the insurance period.
- 2.6.4.2. If the Insurer agrees to extend the insurance period - the Insurer will notify the Policyholder in writing of its consent. The letter will be sent to the Policyholder within 20 days of receipt of the request for an extension. If the Insurer agrees to extend the insurance period, the insurance continuity of the Insured shall be maintained, including the first date as defined below regarding a preexisting condition.
- 2.6.5. The insurance fees for the additional period shall be calculated according to the number of days of extension at the rate of insurance fees in effect with the Insurer on the day that the extension begins.
- 2.6.6. The Insurer shall be entitled to change the insurance fees at the beginning of any extension of this Policy.
- 2.7. **Cancellation of insurance:**
- 2.7.1. In the case that the Insured and/or the Policyholder does/do not pay or did not pay the insurance fees as arranged, the Insurer is entitled to cancel the Policy according to the instructions of the Insurance Contract Law 5741-1981.

- 2.7.2. In the case that the Policyholder cancels the policy before the end of the insurance period due to termination of the employment period of the Insured by the Policyholder, the Insurer will refund the Policyholder part of the insurance fees for the period in which the Insured is no longer insured, subject to its duty according to the instructions of the Insurance Contract Law.
- 2.7.3. In the matter of Section 2.7.2: the proportionate insurance fees shall be returned to the Policyholder for the period after return of the Insured card to the Insurer **and in the case of cancellation within less than two months from the date of commencement of the insurance period, handling charges in the amount of insurance fees for two months for this policy shall be deducted from the proportionate insurance fees to be refunded.**
- 2.7.4. In the case that the Insured concealed from the Insurer an essential matter as said in Section 2.1 above, as set forth in the Insurance Law.
- 2.7.5. In the case that the Insured deliberately did something that could prevent the Insurer from clarifying its duty or encumber it, the Insurer shall not be required to pay insurance benefits except insofar as it was required to do so had this not happened.
- 2.7.6. The Policyholder and/or the Insured are entitled to cancel the policy by written notice to the Insurer at any time.
- 2.8. **Absence of Insurer liability for acts and/or failures of service providers - The Insurer shall not have any responsibility** for the quality of medical and/or other services provided to the Insured under this insurance. The Insurer is not responsible for any damage caused the Insured and/or any other person directly or indirectly due to the choice by the Insured and/or his referral by the Insurer to medical and/or other medical services and/or for professional negligence of the service providers.
- 2.9. **Limitations:** The period of limitations of a claim for payment of insurance benefits for an insurance event according to this policy is 3 years from the date of incidence of the insurance event. If the basis for the claim is disability caused to the Insured in an accident as said in Chapter D below, the period of limitation shall be counted from the day that the Insured had the right to claim insurance benefits according to the conditions of the insurance contract.
- 2.10. **The Insurance Contract Law:** The instructions of the Insurance Contract Law, 5741-1981 shall apply to this policy.
- 2.11. **Changes in insurance services:**
 - 2.11.1. **The Insured shall be entitled to the services included in the health basket, in the medications basket and in the services at work basket, as defined below, and as they are changed from time to time.**
 - 2.11.2. Insofar as changes occur in the health basket and/or the medications basket and/or the services at work basket and/or in the Health Law and/or in any ordinance or instruction after the commencement of the insurance period (herein: "the new health basket"), the Insurer shall notify the Policyholder and/or the Insured parties regarding the changes that were made in the health basket and/or the medications basket and/or the services at work basket and/or the Health Law and/or in any ordinance and/or instruction after the commencement of the insurance period, and shall be entitled to make changes in the Policy and in the insurance fees, including payment of an addition for the insurance fees demanded because of the said change.

- 2.12. **Notices:** The Policyholder must notify the Insurer of any change of its address in a letter.
- 2.13. **Payment of insurance fees, taxes and charges:** The Policyholder must pay the Insured the insurance fees and government and other taxes that apply to this Policy or that are charged on insurance fees, and on all other payments that the Insured is required to pay according to the policy, whether these taxes existed at the time of preparation of the policy or if they were instituted on a later date.
- 2.14. **Place of jurisdiction:** The sole and exclusive place of jurisdiction in all matters related to and arising from this policy shall be the authorized courts in Israel according to the law in Israel, and no other court whatsoever shall have any authority to judge. The law that applies to claims that stem from and/or are related to this policy is Israeli law.

Chapter B: The Health Services

3. The health services that will be provided to the Insured
 - 3.1. Subject to the said in this Policy, the Insured shall be entitled to health services, all as set forth in the following:
 - 3.1.1. **The treatment basket -**
 - 3.1.1.1. All the services listed in the Second Schedule to the National Health Insurance Law on the date of commencement of the insurance period, as changed from time to time.
 - 3.1.1.2. Hospitalization services in a psychiatric hospital or in a psychiatric ward in a general hospital, in a medical emergency, for a period that shall not exceed 60 days for one period of employment.
 - 3.1.1.3. The services set forth in the following -
 - 3.1.1.3.1. Amniocentesis for women of the age 35 and older at the beginning of the pregnancy.
 - 3.1.1.3.2. Vaccination against tetanus, rabies and diphtheria.
 - 3.1.1.3.3. Mantous tests and chest X-rays.
 - 3.1.1.3.4. Wheelchairs and walkers.
 - 3.1.2. **Medications basket:** All the services listed in the National Health Insurance Ordinance (Medications in the Health Services Basket), 5755-1995 on the date of commencement of the insurance period.
 - 3.1.3. **Services at work basket:** All the services listed in Regulations 2 and 5 of the Health Services at Work Regulations, mutatis mutandis on the date of commencement of the insurance period.
4. **Additional Undertakings of the Insurer**
 - 4.1. Subject to the instructions of this Policy, the Insurer shall bear the expenses specified below, all subject to the terms, exclusions, and exceptions specified in this Policy and below -
 - 4.1.1. **Customary payment:** The Insurer shall bear the customary payment for medical services that are covered according to this Policy, which the Insurer is required to pay against their receipt. **The Insurer shall not bear a customary payment if the medical service for which a customary payment was made is not covered under this Policy.**
 - 4.1.2. Provision of coverage for expenses related to the flight of the Insured from Israel back to the Insured's country of origin in any case in which the Insured's medical condition requires accompaniment or other special arrangements during the flight.
 - 4.1.3. **Expenses of transporting the corpse of the Insured:**
 - 4.1.3.1. In the case of the death of the Insured, under circumstances that entitle him/her to medical service according to the terms of this Policy, the Insurer shall bear the expense of transporting his/her corpse from Israel to his/her country of origin.
 - 4.1.3.2. The said in Section 4.1.3.1 above notwithstanding, in the case of the death of the Insured as the result of injury at work, as defined in Section 5.1.7 below, the Insurer shall bear the expense of transporting the corpse of the Insured from Israel to the country of origin of the Insured.

- 4.1.3.3. **The liability of the Insurer according to sections 4.1.3.1 and 4.1.3.2 above are conditional upon prior receipt of approval from the Insurer and upon the performance of the above air transport solely through the Insurer.** If the Insured or someone on his/her behalf did not apply to the Insurer for the purpose of obtaining its approval, prior to air transport of the Insured from Israel back to his/her country of origin, as said above, the Insurer shall be entitled to reduce the amount of the insurance benefit to which the Insured is entitled to the amount that the Insurer would have paid if the Insured had applied to the Insurer with a request for approval as said prior to performance of the air transport.
- 4.1.4. Emergency flight of a close relative to Israel:
- 4.1.4.1. In this section, “**close relative**”: wife, husband, son, daughter, brother, sister.
- 4.1.4.2. If the Insured was hospitalized **under circumstances that entitle him/her to receive health services according to this Policy** for the purpose of an invasive surgical procedure involving hospitalization of over 10 days or that the attending physician determines that the life of the Insured is in danger, the Insurer will pay a close relative the cost of airfare and travel to the place of hospitalization of the Insured in Israel up to the amount of \$1,500 and the cost of a stay of up to 10 days in a hotel up to the maximum amount of \$40 a day.
- The undertaking of the Insurer according to this section is conditional upon the airline ticket and arrangements for the hotel stay being purchased through the Insurer and approved by the Insurer in writing and in advance. If the Insured did not apply to the Insurer for the purpose of obtaining its approval for the expenses as said above, the Insurer shall be entitled to reduce the amount of insurance benefits to which the Insured is entitled to the amount that the Insurer would have paid if the Insured had applied to the Insurer in advance and asked to receive the said approval.
- 4.1.5. **Flight expenses in the case of incapacity to work:** If a specialist in occupational medicine determines that the Insured is not fit to perform the work for which he/she was accepted for work by the Policyholder, and that he/she will not be fit to perform it within a period of 90 days from the date at which the physician performed the examination, even if provided the medical treatment that he/she needs (herein: “incapacity to work”), all this within the insurance period, the Insurer shall bear the cost of airfare to the country of origin of the Insured up to a maximum amount of \$2,000. **The Insurer shall not bear the cost of airfare as said in Section 4.1.5 above if the incapacity to work derived from circumstances that do not entitle the Insured to health services according to this Policy, with the exception of circumstances as said in Sections 4.1.5 above and 5.1.5 below.**

4.1.6. First aid dental care

- 4.1.6.1. The Insured shall be entitled to receive the dental emergency services and first aid specified below and these services only, through dental clinics throughout Israel, to be determined from time to time by the Insurer, the details of which can be obtained from the Insurer's service call center.
 - 4.1.6.1.1. Extensive caries, temporary filling.
 - 4.1.6.1.2. Open space in a tooth, temporary filling.
 - 4.1.6.1.3. Exposed neck of tooth, material to prevent sensitivity.
 - 4.1.6.1.4. Acute inflammation, extraction of nerve or embalming material.
 - 4.1.6.1.5. Abscess originating in a tooth, drainage of abscess and/or treatment by closure.
 - 4.1.6.1.6. Compacted food, treatment of gums.
 - 4.1.6.1.7. Inflammation under the crown, rinsing and/or drug treatment.
 - 4.1.6.1.8. Pain following extraction, pain relief.
 - 4.1.6.1.9. Pressure sores under an existing prosthesis, release of pressure sores.
 - 4.1.6.1.10. Any additional treatment due to toothache, which will be provided to ease or end the pain.
 - 4.1.6.1.11. Examination and X-ray of the painful teeth.
 - 4.1.6.1.12. Provision of an appropriate prescription for pain relief in the case that treatment is not possible at the time.
- 4.1.6.2. The said in Section 5.1.4 below notwithstanding, the Insured shall be entitled to the dental emergency treatment and first aid specified in Section 4.1.6.1 above even if they are required due to a preexisting condition.

5. Exclusions to Chapter B

- 5.1. The said in Sections 3 and 4 above notwithstanding, the Insurer shall not bear the expenses and/or the medical expenses in regard to the services listed below and the Insured shall not be entitled to expenses and/or these services under this Policy -
 - 5.1.1. In the healthcare basket -
 - 5.1.1.1. Psychological services.
 - 5.1.1.2. Treatments at the Dead Seas for psoriasis patients.
 - 5.1.1.3. Genetic testing.
 - 5.1.1.4. Hospitalization in a nursing ward or other nursing services.
 - 5.1.1.5. Services to treat problems of impotence, sexual dysfunction, male or female fertility, and artificial fertilization or artificial insemination treatments.
 - 5.1.1.6. Services provided outside of Israel.
 - 5.1.1.7. An insurance event that occurred after the end of the insurance period and/or consecutive insurance periods as said in Section 2.6 above.

- 5.1.2. In the medications basket -
 - 5.1.2.1. Medications for treatment of Alzheimer's disease.
 - 5.1.2.2. Medications designed to treat problems of impotence, sexual dysfunction, male or female fertility, or medications provided as part of artificial fertilization or artificial insemination treatments.
- 5.1.3. Pregnancy - Health services related to pregnancy for a period of the first 9 months, cumulative, in which there were employer-employee relations between the employee and one or more employers in Israel, with the exception of a medical emergency.
- 5.1.4. Preexisting condition: Medical services that the Insured requires due to a medical problem deriving from a medical condition that preceded the first date on which any employer in Israel arranged medical insurance, this for the first 3 years from the date of effect of the Foreign Workers Ordinance - the date 12 October 2001 or from the first date on which medical insurance was arranged for the Insured, whichever comes later (herein: "the first date") if one of the following applies:
 - 5.1.4.1. The Insured himself/herself confirmed that the medical problem for which service is required derived from a preexisting condition.
 - 5.1.4.2. A physician confirmed, according to the findings available to him/her, that the medical problem for which the employee required service derived from a preexisting condition.
 - 5.1.4.3. The Insured was overseas after the first date for a period or periods exceeding 90 consecutive days with several employers, or for a period exceeding 120 consecutive days if the stay was between periods of employment with the same employer - the first date for the purpose of Section 5.1.4 shall be considered the first date after the stay in which the employee was insured under medical insurance.
 - 5.1.4.4. Health services in a medical emergency due to a preexisting condition: The said in Section 5.1.4 above notwithstanding, the Insurer shall bear medical expenses for health services that the Insured requires during a medical emergency due to a preexisting condition, for the purpose of stabilizing the Insured's medical condition to a condition that enables further treatment of the Insured outside of Israel and the expenses for other medical services that the Insured requires due to the same preexisting condition, for a period of 30 days from said determination by a physician or determination regarding stabilization of the medical condition as said.
- 5.1.5. Incapacity to work -
 - 5.1.5.1. Medical services that the Insured requires after a specialist in occupational medicine has determined that the Insured is unfit to perform the work for which he/she was accepted to work by the Policyholder, and that he/she will not be fit to perform it within a period of 90 days from the date that the physical examined him/her, even if he/she is given the medical treatment that he/she requires.

- 5.1.5.2. The said in Section 5.1.5.1 above notwithstanding, the Insured shall be entitled to medical services that he/she requires in an emergency situation in order to stabilize his/her medical condition, to a condition that enables treatment outside of Israel, as well as other medical services that he/she requires for a period of 30 days from said determination by the physician or determination regarding stabilization of his/her medical condition as said.
 - 5.1.6. Road accidents and acts of hostility - medical services required by the Insured due to:
 - 5.1.6.1. A road accident, as defined in the Road Accident Victims Compensation Law 1975 - 5735.
 - 5.1.6.2. Acts of hostility, as defined in the Benefits for Victims of Hostile Acts Law, 1970 - 5730, if he/she was injured as defined in that law.
 - 5.1.7. Health services due to injury at work
 - 5.1.7.1. The Insurer shall not bear the expenses for health services of the Insured if the Insured requires them due to injury at work, according to its meaning in the National Insurance Law [Consolidated Version], 1995 - 5755 (herein: "injury at work"), provided that the employer confirmed, in a form determined by the National Insurance Institute and designed for this purpose (herein: "injury form"), that the said injury is an injury at work.
 - 5.1.7.2. If the employer provided the injury form and the National Insurance Institute did not determine, within three months from the date of the injury at work, that it is an injury at work, the Insurer shall bear the expenses of the health services provided to the Insured due to that injury at work, within the three months, even if they were provided by other than the service providers, and after three months, if they were provided by the service providers of the Insurer.
 - 5.1.7.3. If the injury derived from an injury at work, the Policyholder undertakes to confirm the injury as said in Section 5.1.7.1 above, on the injury form to the National Insurance Institute with a copy to the Insurer within 7 days from the date of the injury at work. In the case that the Policyholder has not confirmed as said and it is found that the injury was an injury at work as defined above, the Policyholder shall bear all expenses that the Insurer paid and shall pay them in addition to linkage differences and interest on interest according to law, within 7 days of the date this is demanded by the Insurer.
 - 5.1.8. Receipt of services from a service provider that is not under agreement with the Insurer.
6. Rules for approval or determination of a specialist physician - preexisting condition and incapacity to work
 - 6.1. A physician's confirmation that the medical problem for which the Insured requires medical service derives from a preexisting condition and a physician's determination that the Insured has reached stabilization of his/her medical condition - shall be made by a specialist physician.

- 6.2. The 30 days mentioned in sections 5.1.4 and 5.1.5 shall be counted only from the date of a final confirmation or a final determination as said in Section 6.3 below, but will not be considered a final determination as said regarding the stabilization of the medical condition of an employee if the director of the hospital ward in which the Insured is hospitalized or the deputy director of the ward - in the absence of the director - has determined that the date on which the entitlement of the Insured to health services according to the instructions of this policy was meant to end, the medical condition of the Insured had not yet been stabilized. This determination shall be decisive unless determined otherwise by the director or deputy director, of the ward, as said.
- 6.3. The rules for confirmation or determination as said in Section 6.2 shall be as specified below:
- 6.3.1. The Insurer shall have the right to demand of the Insured to undergo examination by a specialist physician on its behalf, at the expense of the Insurer. The opinion of the physician will be presented to the Insured together with a notice regarding the entitlement of the Insured to a counter-opinion as said in Section 6.3.2 below and together with the details of entities or organizations that are likely to assist the Insurer in realizing this right, which have given their agreement to this.
- 6.3.2. The Insured is entitled to a counter-opinion from a specialist physician of his/her choice, which will be presented to the Insurer within 21 days of the insured's receipt of the opinion on behalf of the Insurer. The Insurer will bear the expenses of the counter-opinion up to a ceiling amount to be determined by the director-general of the Ministry of Health and the director of the Insurance and the Capital Market Department of the Ministry of Finance (herein: **"the determining wage"**).
- 6.3.3. If the two said specialist physicians have different opinions, the parties will appoint a physician acceptable to them, financed by the Insurer, and his/her opinion shall be decisive. If the parties do not agree on the said physician, a specialist physician will be appointed by the head of the Israel Medical Association (herein: "the Association") that is engaged in the medical field related to the illness of the Insured, and for the matter of determining incapacity to work even if given medical treatment - by the head of the union of occupational medicine of the Association (herein: **"the deciding physician"**) and his/her opinion shall be decisive. If the head of the Association has not appointed a deciding physician as said within 15 days of the day the Insurer requested he/she do so, the deciding physician will be appointed by the director general of the Ministry of Health or someone authorized for this purpose. The wages of the deciding physician will be the fixed wages and they will be paid by the Insurer.

Chapter C: The Service Providers and the Medical Services

7. The Service Providers

- 7.1. The medical services included in this Policy shall be provided solely by the service providers, subject to any change of which the Insured notifies the Policyholder in writing. If the service provider ceased to work with the Insurer, the Insured will contact the call center of the Insurer to obtain a referral to another service provider.
- 7.2. The medical services included in this Policy shall be provided to the Insured according to medical judgement, at a reasonable quality, within a reasonable amount of time and within a reasonable distance from the place of residence of the Insured.
- 7.3. The said in Section 7.1 above notwithstanding, the Insured shall be entitled to receive, at the funding of the Insurer, the medical services listed below under the circumstances listed below:
 - 7.3.1. Emergency services in any of the general hospitals in Israel, in any of the following cases:
 - 7.3.1.1. Any new fracture.
 - 7.3.1.2. Severe dislocation of a shoulder or elbow.
 - 7.3.1.3. An injury requiring stitching by means of sutures or other means of stitching.
 - 7.3.1.4. Aspiration of a foreign object into the respiratory tract.
 - 7.3.1.5. Penetration of a foreign object into an eye.
 - 7.3.1.6. Cancer treatment.
 - 7.3.1.7. Treatment of hemophilia.
 - 7.3.1.8. Treatment of cystic fibrosis.
 - 7.3.1.9. Transportation by ambulance to an emergency room from the street or another public space due to a sudden event.
 - 7.3.1.10. A referral that ends in non-elective hospitalization
 - 7.3.1.11. A medical emergency.
 - 7.3.2. Hospitalization services provided to the Insured soon after referral to an emergency room, in the cases listed in Section 7.3.1 above.

8. Obtaining Medical Services

- 8.1. Access to the different medical services shall be contingent upon the prior approval of the Insurer and/or the approval of the attending physician and/or it shall be free, all as specified below:
 - 8.1.1. Access to the primary medical services included in this Policy shall be free, and the Insured will not be required to obtain prior approval of the Insurer before obtaining a medical service of this type.
 - 8.1.2. Access to non-primary medical services, except in the cases listed in Section 7.3 above, shall be dependent upon obtaining prior approval of the attending physician in the primary medical services. If the Insured did not contact the Insurer in order to obtain its approval for expenses as said above, the Insurer shall be entitled to reduce the amount of the insurance benefits to which the Insured is entitled to the amount that the Insurer would pay the Insured if he/she had contacted the Insurer in advance with a request to obtain said approval.

- 8.1.3.** Access to tests at imaging institutes, diagnostic institutes, gastroenterological institutes, laboratories and elective hospitalization services shall be dependent upon the prior written consent of the Insurer.

The Insured must submit a written request to the Insurer for approval of the services listed in this subsection, together with the confirmation of the attending physician that the Insured requires this medical service.

The requested approval or a notice of refusal to provide it shall be provided within 7 days of the date of determination by the attending physician regarding the need for the test or hospitalization, according to the matter at hand and/or from the date on which the Insurer received the request of the Insured, and in any case, shall not be postponed to a date that could endanger the Insured or reasonably impair the treatment to which he/she is entitled under this Policy.

If the Insured does not contact the Insurer for the purpose of obtaining its approval of expenses as said above, the Insurer shall have the right to reduce the amount of insurance benefits to which the Insured is entitled to the amount that the Insurer would have paid if the Insured had contacted the Insurer in advance with a request to obtain the said approval.

- 8.1.4.** With the exception of the cases listed in Section 7.3 above, the Insurer shall not bear the expenses of medical services of the Insured in an emergency room, except if the Insured received the prior approval of the attending physician.

Chapter D: Compensation for Death and Disability

as the Result of an Accident

9. For Insured who have not yet reached the age of 18 years and/or have reached the age of 65, there shall be no insurance coverage according to this chapter. The total undertaking of the Insurer according to this chapter shall not exceed the maximum amount of \$10,000 per Insured, to which the Insured will be entitled once only.
- 9.1. In this chapter -
- 9.1.1. **"The Insured"**: A person staying in the State of Israel as a foreign worker and only if his/her age is over 18 years and less than 65 years.
 - 9.1.2. **"Accident"**: Unexpected physical injury caused during the insurance period by external, visible, violent means that is the only direct and immediate cause of the death or disability of the Insured, with the exception of damage caused as the result of verbal violence and/or emotional pressure **and/or the accumulation of small repeated injuries over a period of time that lead to disability, which shall not be considered an "accident," and except if the damage was caused as the result of a hostile act as defined in the Benefits for Victims of Hostile Acts Law, 1970-5730.**
 - 9.1.3. **"Disability"**: A permanent medical disability caused as the direct and decisive result of an accident (an accident that occurred during the insurance period).
 - 9.1.4. **"Total disability"**: Total loss of an organ or limb due to its separation from the body or total loss of functional ability of a body organ or limb.
 - 9.1.5. **"Death of the Insured"**: Death of the Insured due to an accident.
- 9.2. If the Insured suffers, within the insurance period, bodily injury the direct reason for which is an accident, insurance benefits shall be paid as follows:
- 9.2.1. In the case of **the death of the Insured**, whose age at the time of death was 18 and less than 65, the beneficiary specified in the proposal, or in the absence of a beneficiary, the legal heirs of the Insured or the managers of his/her estate or the executors of his/her will, the amount of \$10,000.
 - 9.2.2. In the case of **total disability**: In the case of total disability caused after the date of the accident that occurred after the date of the beginning of the insurance, the Insurer shall pay an insurance amount according to the rates specified below: (the amount to be paid shall be calculated as a percentage of the the total insurance amount specified in Section 9.2.1 above). For example, if it is determined that the Insured has total disability of the leg and the maximum insurance amount specified is \$10,000, the Insured will receive: $40\% \times \$10,000 = \$4,000$.

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

*Regarding a left-handed person: The left hand will be treated according to the same percentages specified for the right hand and injury to the right hand, according to the percentages for the left hand.

- 9.2.3. **A disability that existed prior to the commencement of the insurance and/or disability determined according to this appendix shall be deducted from the percentage of disability that entitles payment according to this appendix.**
- 9.2.4. **Organs or limbs that are not specified in the list -** in any case in which disability is caused to an organ or limb that does not appear in the list in Section 9.2.2 above, the percentages of disability shall be determined according to the determination of a medical specialist in the field of the said disability and shall be paid as a percentage of the full insurance amount. For example: If it is determined that the Insured has total disability of the back and a specialist physician determined that it is a case of 70% disability, where the maximum insurance amount on the Insurance Details Page is \$10,000, the Insured will receive: $70\% \times \$10,000 = \$7,000$.
- 9.2.5. **Disability that is not total (in cases in which the nature of the disability is included in the list) -** In any case of partial disability organs or limbs specified in the list, the adjusted percentage of disability shall be as defined in Section 9.2.6 below.
- 9.2.6. **Adjusted percentage of disability -** Shall be equal to the percentage of disability from an accident, multiplied by the percentage of total disability in the list regarding the same organ or limb, and multiplied by the full insurance amount. For example, the percentage of partial disability of a leg is determined as 20% and the maximum insurance amount specified on the Insurance Details Page is \$10,000. The percentage of the total disability of a leg on the list according to the table above is 40%. In this case, the Insured will receive $20\% \times 40\% \times \$10,000 = \$800$.

9.2.7. It is clarified that plastic disability (disfigurement) shall not be covered under this Policy.

Special Exclusions to Chapter D: Compensation for Death and Disability as the Result of an Accident

10. The Insurer shall not pay insurance benefits according to this Policy if the death or disability were caused directly or indirectly by or due to:
- 10.1. Earthquake, volcanic eruption, nuclear fission, nuclear fusion, radioactive contamination.
 - 10.2. Active participation of the Insured in military activity, police activity, underground activity, revolution, rebellion, riots, disturbances, sabotage, terrorism, strike, illegal activity.
 - 10.3. Participation of the Insured in an act of sabotage or terrorism of any type and/or in war and/or in war-like activity of hostile forces, organized or non-organized.
 - 10.4. Flight of the Insured in an aircraft, with the exception of flight of the Insured as a passenger in a civil aircraft with a certificate of fitness for transporting passengers, subject to the undertaking of the Insurer, in Israel only.
 - 10.5. Deliberate self-inflicted injury or suicide or attempted suicide, whether the Insured is of sane mind or not.
 - 10.6. Sports activity in the framework of a sports association registered according to the Sports Law 1988 - 5748 and/or competitive sports activity and/or professional sports activity (that constitutes his/her primary occupation or that involves monetary payment).
 - 10.7. Participation of the Insured in extreme sports according to the list that appears on the Company website. For this matter, "extreme sport" refers to fields of sport considered to be dangerous and that include/require of those that engage in them, among other things, high levels of difficulty and/or physical effort. The list of the fields of extreme sports shall be updated from time to time according to the list that appears on the Company website, www.harel-group.co.il (Tourist Insurance tab).
 - 10.8. Use of explosives.
 - 10.9. Mental illnesses, deliberate self-endangerment, with the exception of self-defense and rescue of lives.
 - 10.10. Alcoholism or drug use by the Insured.
 - 10.11. Death or disability as the result of medical or surgical treatment.
 - 10.12. A work accident as defined in the National Insurance Institute Law.
 - 10.13. A road accident, as defined in the Road Accident Victims Compensation Law, 1975-5735.
 - 10.14. Plastic disability (disfigurement).

Table of Limits of Liability for the Policy

Main Areas of Coverage	Limits of Liability
Medical expenses during hospitalization	Full coverage
Medical expenses during hospitalization in a psychiatric hospital	Up to 60 days of hospitalization
Medical expenses not during hospitalization - including a family doctor, a specialist physician, diagnostic tests, imaging services, medications	Full coverage
Emergency room - subject to the criteria determined in the Ordinance	Full coverage
Medical flight - accompaniment of medical staff and equipment required by the medical condition of the Insured insofar as he/she has lost the capacity to work	Full coverage
Riders (without additional charge)	
Emergency dental treatment	Full coverage
Transportation of a corpse	Full coverage
Personal accident - death/disability	\$10,000
Emergency flight for a close relative and expenses of stay in Israel of up to 10 days	\$1,500
	\$40 per day in a hotel
Air ticket back to country of origin in the case of loss of capacity to work	\$2,000

The Insurer is bound solely by the full terms and exclusions of the Policy.

Contact details

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For details contact customer call
center

☎ *2735

Or to your insurance agent