Harel SAFE STAY+

Extended Health Insurance for a foreign worker in Israel

HAREL
Insurance & Finance

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SAFE STAY+
Extended Health Insurance Policy for the Foreign Worker

Edition December 2014

If this Policy was purchased and this is indicated in the Schedule as specified hereunder, the Insurer shall indemnify the Insured in respect of expenses for medical services and/or shall pay directly to the service providers and/or to the medical institution that provided the health services in respect of an Insurance Event and/or shall compensate the Insured, as specified and defined in the Policy, during the Insurance Period, in the liability limit of the Insurer, and under the terms and exclusions set forth in this Policy.

Chapter A: Definitions and General Terms

In this Insurance Policy Appendixes thereof the following terms shall have the respective meanings set forth beside them below:

1. **Definitions**

1.1. **Insurance Event:** an event where during the Insurance Period, the Insured requires medical treatment in Israel as specified in this Insurance Policy, and the medical treatment in respect of that event was provided during the Insurance Period and or within 90 days as of expiration of the Insurance Period at the latest, and all under the conditions, restrictions and exceptions as specified in this Insurance Policy.

1.2. **General Hospital:** an institution in Israel that is recognized by the competent authorities as General Hospital and which serves solely as a Hospital, excluding an institution that is also a sanatorium and/or rehabilitation institution.

1.3. **Public General Hospital in Israel:** a medical institution recognized by the competent authorities in Israel solely as a general hospital and that is defined as a public hospital in the information database of the Israeli Ministry of Health.

1.4. **Policyholder:** an employer, whether a person, a body of persons or a corporation, that enters into contract with Insurer, and who/which is named in the Insurance Policy as the Insurance Policyholder who/which wishes to insure the foreign worker through this Insurance Policy.

1.5. **Insurance Premiums:** the amounts that the Insurance Policyholder has to pay to the Insurer for the insurance coverage under this Insurance Policy, in accordance with the Insurance Policy terms and conditions.

1.6. **Insurer:** Harel Insurance Company Ltd.

1.7. **Insured:** a person who is staying in the state Israel as a foreign worker, or who will stay in the state Israel in the future as a foreign worker, employed by the Insurance Policyholder, and whose name is listed in the Schedule enclosed with this Policy.

1.8. **The Insurance Policy:** this insurance contract including the Proposal, the Policy Schedule and any appendix or addendum enclosed therewith.

1.9. **Insurance Proposal:** A proposal form as determined by the Insurer, when all its details are filled, including a health statement, statement on the date of entering Israel and medical confidentiality waiver signed by the Insured and by the Policyholder where his signature is required.

1.10. **Health statement:** A health statement and medical confidentiality waiver of the Insurer, signed by the Insured.

1.11. **Policy Schedule:** a document enclosed with the Policy, constituting an inseparable part thereof, that includes the details and conditions required for the purpose of adjusting the insurance policy to by terms set forth in the insurance contract of the Insured.

1.12. **Customary Payment:** charge, including guarantee or deposit, applicable to an Insured, in return for rendering of the medical service in practice, and which was set forth in the second or third Addendum of the Health Insurance Law at the commencement date of the Insurance Period or in the Notice Concerning Terms, Conditions and Payments Issued by the State to the individual at the effective date under the Health Insurance Law or in the proposal made by the health fund under Section 8(A1) of the

Health Insurance Law, which was approved in accordance with Section 8 (A2) of that same Law, and if the various provisions contained different payments for the same medical service - upon the higher.

1.13. **Abroad/Outside Israel:** Any place outside of Israel, including means of transport on their way from Israel or to it.

1.14. **Israel:** Israel territories, excluding any means of transport on their way to Israel or from it, including territories controlled by the IDF, but excluding territories held by the Palestinian Authority.

1.15. **Health Insurance Law:** the National Health Insurance Law, 1994.

1.16. **Foreign Workers Law:** Foreign workers Law (Unlawful Employment and Assurance of Fair Terms and Conditions), 1991.

1.17. **Insured's Card:** card to be issued by the Insurer in addition to the Insurance Policy, wherein the Insured's personal information will be specified, including his / her picture for identification purposes, and which will be presented by the Insured to every Medical Institution in order to receive medical service.

1.18. **Medical Institution:** including clinic, medical institute, laboratory, diagnosis centers, pharmacies etc.

1.19. **Call Center:** telephone Service Center on behalf of the Insurer, providing response to the Insureds in everything relating to the Service Providers, operating 24 hours a day.

1.20. **Emergency Medical Condition:** circumstances in which a person is in immediate danger to his life or there is an immediate danger that the person will sustain a severe, non - reversible, disability, if urgent medical treatment is not provided to him.

1.21. **Existing Condition:** defect, congenital illness, including heredity diseases and/or health condition and/or medical phenomenon and/or illness, whether treated or not, and/or the results thereof, whether caused directly or indirectly, caused and/or worsened because of a health condition which existed before the commencement date of the Insurance Period, subject to the Insured's statement and/or a physician's certification all subject to the provisions of section 5.1.4 hereinafter.

1.22. **Service Providers:** a Public Hospital and/or a Private Hospital that contracted with the Insurer that are named in the list enclosed with this Insurance Policy, from which the Insured shall be solely entitled to receive the Health Services listed in this Insurance Policy, all subject to the Insurance Policy terms and conditions.

1.23. **The National Minimal Standard of Health Services (commonly known as the "Health Basket"):** as defined in the Health Insurance Law.

1.24. **Foreign worker:** a person employed in Israel, who is neither an Israeli citizen nor an Israeli resident.

1.25. **Foreign workers Order:** Foreign workers Order (Prohibition of Unlawful Employment and Assurance of Fair Terms and Conditions) (Minimal Standard of Health Services for an Employee), 2001.

1.26. **Physician:** a person who was certified and licensed to practice medicine, who is legally authorized to work as a Physician in Israel.

1.27. **Attending Physician:** a general practitioner, who is not a specialist and also a Physician who is a specialist in family medicine and/or internal medicine and/or gynecology.

1.28. **Health/Medical Services:** all Medical Services to which the foreign worker is entitled to under the terms and conditions of this Insurance Policy.

1.29. **Primary Medical Services:** services provided by an attending physician within its meaning hereinabove.

1.30. **Insurance Period:** a period of 12 months as of the insurance commencement date as specified in the Schedule enclosed with the Policy or any shorter period that was shortened in accordance with the terms and provisions set forth in the Policy.

1.31. **Single Employment Term:** the full employment period of an Insured, even if it was not continuous, during which the labor relations were maintained between a certain employer and an individual foreign worker.

1.32. **Health Services at Work Regulations:** Parallel Tax Regulations (Health Services at Work), 1973.

2. General Terms

2.1. Duty of disclosure: In the event that prior to concluding the contract the Insurer presented to the Insured, whether in the insurance proposal form and whether in any other manner in writing, a question on an issue that may affect the willingness of a reasonable insurer to conclude the contract in general or conclude the contract in accordance with the terms set forth thereat (hereinafter: "Material Matter") the Insured shall provide a full and correct reply to the said question. A general question that involves different matters without making a distinction between these matters shall not require a reply as said unless it was reasonable at the time of concluding the contract.

2.1.1. Concealment with fraudulent intent by the Insured of a matter which the Insured knew was a Material Matter shall be deemed as providing a partial and dishonest answer.

2.1.2. In the event a partial and dishonest answer was provided to a question on a Material Matter, the Company shall be entitled to terminate the Policy upon delivery of a written notice to the Insured within thirty days as of the date it became aware of the same and as long as the Insurance Event did not occur.

2.1.3. In the event the Company terminated the Policy by virtue of this section, the Insured shall be entitled to reimbursement of Insurance Premiums he paid for the period following the termination, with deduction of the Company's costs, unless the Insured acted with fraudulent intent.

2.1.4. In the event the Insurance Event occurred before the Policy was terminated by virtue of this section, the Company shall be obligated solely to pay reduced Insurance Premiums in a relative rate, which shall comply with the rate between the Insurance Premiums that would have been regularly paid by the Company according to normal circumstances and the agreed Insurance Premiums, and the Company shall be exempt in any of the following:

2.1.4.1. The answer was given with fraudulent intent.

2.1.4.2. A reasonable insurer would not have engaged in the same contract, even for higher Insurance Premiums if it had known the actual circumstances; in such circumstances the insured is entitled to a reimbursement of Insurance Premiums which he paid for the

period after the occurrence of the Insurance Event with deduction of the Company's costs.

2.1.5. The Insurer shall not be entitled to recover the remedies specified hereinabove in any of the circumstances specified hereunder unless the answer that was partial was given with fraudulent intent:

2.1.5.1. The Insurer knew or should have known about the actual circumstances at the time of concluding the contract or caused that the answer that was provided was deficient and honest.

2.1.5.2. The fact subject matter of the partial and dishonest answer no longer existed prior to the occurrence of the Insurance Event or did not affect the Insurance Event or the liability of the Insurer or its scope.

2.2. Effect of the Policy: the coming into force of this Policy is conditional on payment of first premium. This term shall not apply if the Insured received means of payment from which payment of premium can be charged. If the Company received payment of Insurance Premiums before the Company granted its consent to arrange the se, payment shall not be deemed as approval of the Company to arrange the insurance. In such circumstances the Company shall deliver, what 90 days as of the date of first receiving the Insurance Premiums, a decision about the acceptance or rejection of the prospective insured and shall deliver to him, as the case may be, an insurance policy, including a Policy Schedule, or a rejection notice according to which the Insured is not accepted to the insurance and lacks insurance coverage in effect or a query to complete data or a counter insurance proposal. If within 90 days as of the date of first receiving the Insurance Premiums the Company did not deliver a rejection notice as said or a query for completion of data or a counter insurance proposal, the Insured shall be deemed to have been added to the Policy under the terms set forth in the insurance proposal. In the event the Insured experienced an Insurance Event during the period between first receiving Insurance Premiums and the decision of the Company about his acceptance or rejection from the Policy and in accordance with the medical underwriting instructions existing in the Company at the time in respect of prospective insureds with similar characteristics, the Company would have delivered notice to the prospective insured, upon completion of the underwriting process, about his acceptance to the insurance (if the Insurance Event had not occurred) the prospective insured shall be entitled to coverage under the Policy for the Insurance Event subject to all other terms and provisions set forth in the Policy.

2.3. **Health statement**:

2.3.1. The Policyholder shall deliver to the Insurer a health statement and waiver of medical confidentiality signed by the Insured and instructing the physicians of the Insureds and/or any medical institution whether in Israel and whether abroad and/or the National Insurance Institute and/or the Ministry of Defense and/or any other government office and/or an insurance company and/or the health fund to deliver to the Insurer any reasonable medical information pertaining to the Insured and that is in tr possession.

2.3.2. The Policyholder shall sign the Insured on a medical confidentiality waiver form furnished to him by the Insured in a language that the Insured understands and shall deliver to the Insurer the form in a language that the Insured

understands and signed by the Insured, together with the declaration of the Policyholder stating that the form was signed by the Insured after the Insured received an explanation about its content in a language that he understands and/or that the Insured signed the health statement after he read its content in a language he understands.

2.4. **Claims:**

2.4.1. A notice on an Insurance Event shall be delivered to the Insurer within a reasonable time at the earliest opportunity whether by delivery of a letter or whether by fax. The notice shall include all details about the Insurance Event that shall be delivered to the Insurer so as to receive all information the Insurer requires.

2.4.2. The Policyholder and/or the Insured shall enclose with the notice on the Insurance Event all relevant medical documents pertaining to the Insurance Event including diagnoses, anamnesis, and if the Policyholder and/or the Insured made any payments - original receipts attesting to payments or, in the absence of original receipts, against a copy with an explanation about its recipient and approval of the said entity for the amount that the subscriber paid in respect of these documents or with an explanation about the recipient of the original documents and explanation of the reason why he is unable to furnish them.

2.4.3. The Policyholder and the Insured shall cooperate with the Insured before and after the submission of the claim and shall make every possible effort to allow the Insurer to inquire his liability for payment in accordance with the Policy and scope thereof.

2.5. **Medical examination:** the Insurer shall be entitled to demand from the Insured to reasonably undergo medical examination/examinations with a physician on behalf of the Insurer and at the expense of the Insurer.

2.6. **Extension of the Insurance Period:**

2.6.1. The Insurer undertakes to extend the policy to the Insured under insurance continuity if the Policyholder or the Insured requested the same and as long as the Insured continues to be employed as a foreign worker in Israel, for a period that shall not exceed 5 years as of the insurance commencement date with the Insurer, without renewal of underwriting (hereinafter: "Extension without Underwriting").

"Continuity" in this section shall mean extension and/or renewal of the Policy no later than 30 days prior to expiration of the previous Insurance Period. **An Insured who contacts the Insurer on any date after the said date shall not be entitled to Extension without Underwriting and all the provisions applicable to a new insured shall apply to the said Insured.**

2.6.2. The transition of an Insured between Policyholders (hereinafter: **"Interim Period"**) shall not derogate from the right of the Insured to extend the Policy, provided that Insurance Premiums **are paid** also in the Interim Period in accordance with the terms set forth in the Policy and that the employment of the Insured with the Policyholder was renewed within 60 days as of the date his employment by the previous policyholder was terminated.

2.6.3. Notwithstanding the said in section 2.6.1 hereinabove, the Insurer undertakes to extend the term of the policy of the Insured for a period longer than the period specified in section 2.6.1 hereinabove solely under continuity if the staying visa of the Insured in Israel as a foreign worker was extended, and solely for the extended staying period as specified in the visa.

2.6.4. To dispel any doubt, an extension and/or renewal of the Policy in accordance with the provisions set forth in this section shall not change the insurance commencement date with the Insurer.

2.6.5. The provisions set forth in sections 2.6.6 - 2.6.7 hereunder shall apply to an Insured who is not entitled to an Extension without Underwriting. The provisions set forth in sections 2.6.8-2.6.9 hereunder shall apply to any kind of extension.

2.6.6. In any other event that is not included in the events specified in sections 2.6.1 to 2.6.3 - the Policyholder shall be entitled to approach the Insurer with a request to extend the Insurance Period. The extension of the insurance shall be subject to an underwriting process as customary in Harel and subject to the prior and written approval of the Insurer. It is hereby clarified that upon expiration of the Insurance Period, as defined in the Policy, the insurance shall not be automatically extended except for approval as provided in this section as said within the period of time specified in section 2.6.6.2 hereunder, even if the Policyholder and the Insured proposed to the Insurer to extend them in any form and on any date.

2.6.6.1. The Policyholder shall be entitled to request to extend the Insurance Period (hereinafter: **"Request for Extension"**). The Request for Extension shall be delivered to the Insurer in registered mail at least 30 days prior to expiration of the Insurance Period.

2.6.6.2. In the event the Insurer agrees to extend the Insurance Period - the Insurer shall deliver written notice to the Policyholder stating its approval. The notice shall be delivered to the Policyholder within 20 days as of the date of receiving the Request for Extension. In the event the Insurer agreed to extend the Insurance Period the insurance continuity of the Insured shall be maintained including the first date within its meaning hereunder as part of an existing condition.

2.6.7. Calculation of the Insurance Premiums for the Insured for the additional period shall be done according to the number of days of extension according to the Insurance Premiums rate that shall be in effect with the Insurer on the commencement date of the extension.

2.6.8. The Insurer shall be entitled to change the Insurance Premiums on the commencement date of each extension of this Policy.

2.7. **Termination of the insurance:**

2.7.1. In the event the Insurance Premiums were not paid regularly and as set forth in the Policy and were not paid also within 15 days after the Insurer delivered notice and demanded from the Policyholder to make the said payment, the Insurer shall be entitled to deliver written notice to the Policyholder stating

that the Policy will be canceled within 21 additional days if the amount in default is not paid beforehand.

2.7.2. In the event the Policyholder canceled the Policy prior to expiration of the Insurance Period due to termination of the employment of the Insured with the Policyholder, the Insurer shall return to the Policyholder part of the Insurance Premiums for the period in which the Insured is no longer insured, subject to his obligation in accordance with the provisions set forth in the Insurance Contract Law, 1981.

2.7.3. Regarding section 2.7.2: the relative Insurance Premiums shall be returned to the Policyholder in respect of the period following returning of the Insured's Card to the Insured and with deduction of processing fees. For the purpose of this section **"processing fees"** - the expenses incurred by the Insurer in the issuance of the insurance policy, the expenses related to the issuance of the Insured's Card, stamps and any other expense in connection with the process of issuing the Policy that shall not fall below the amount of Insurance Premiums for two months in respect of this Policy.

2.7.4. The said in this shall not derogate from the right of the Insurer to terminate the Policy if the Insurance Premiums were not paid regularly as specified in section 2.7.1 hereinabove or in the event the Insured concealed from the Company a material fact as specified in section 2.1 hereinabove, as set forth in the Insurance Contract Law, 1981.

2.7.5. In the event the Insured committed an act deliberately that could have prevented from the Company from inquiring its liability or impede the Company, the Company shall not be obligated to pay Insurance Benefits however solely to the extent that it owed the Insurance Benefits if the said action had not been committed.

2.7.6. The Policyholder and/or the Insured may terminate the Policy upon delivery of notice to the Company at all times.

2.8. **Lack of liability of the Insurer for the acts and/or omissions of service providers - the Insurer shall not be held liable for the acts and/or omissions of service providers in connection with the health services and/or consequences thereof.**

2.9. **Limitation:** the period of limitation of a claim for Insurance Benefits for an Insurance Event in accordance with this Policy shall be 3 years as of the date of the occurrence of the Insurance Event. In the event the cause of action is disability that was caused to the Insured as a result of an accident as specified in Chapter D hereunder, the period of limitation shall be counted as of the date the Insured was entitled to claim Insurance Benefits in accordance with the terms set forth in the insurance contract.

2.10. **Insurance Contract Law:** this Policy shall be governed by the Insurance Contract Law, 1981.

2.11. **Changes in health services:**

2.11.1. **The Insured shall be entitled to the services included in the health basket, the medications basket and the services at work basket within their meaning hereunder and as changed from time to time.**

2.11.2. **In the event that changes in the health basket and/or the medications basket and/or the services at work basket and/or the National Health**

Insurance Law are implemented and/or in any order and/or directive after the insurance commencement date (hereinafter: "New Health Basket") the Insurer shall notify the Policyholder and/or the insureds about the changes in health basket and/or the medications basket and/or the services at work basket and/or the National Health Insurance Law and/or any order and/or directive after the insurance commencement date and shall be entitled to change the Policy and the Insurance Premiums, including payment of addition to the Insurance Premiums as required following the said change.

2.12. **Notices:** the Policyholder shall notify the Insurer about any change of its address by delivery of notice in registered mail. A notice delivered by the Insurer to the last known address of the Policyholder shall be deemed as a notice duly delivered.

2.13. **Payment of Insurance Premiums, taxes and charges:** the Policyholder shall be obligated to pay the Insurance Premiums and the government and other taxes applicable to this Policy or that are imposed on the Insurance Premiums to the Insurer and all other payments that the Insurer is obligated to pay in accordance with the Policy, whether these taxes exist on the date of issuing the Policy and whether imposed on any date thereafter.

2.14. **Jurisdiction:** the competent courts in Israel shall be vested with exclusive and sole jurisdiction in anything relating to and arising out of this Policy and in accordance with Israeli law and no other court in any other jurisdiction shall be vested with jurisdiction over this Policy. Any claims deriving from and/or related to this Policy shall be governed by Israeli law.

Chapter B: Health services

3. Health services provided to the Insured

3.1. Subject to the provisions set forth in this Policy, the Insured shall be entitled to the health services as specified hereunder:

3.1.1. Basket of treatments -

3.1.1.1. All services enumerated in the Second Schedule of the National Health Insurance Law at the time 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 condition for a period that shall not exceed 60 days for one term of employment.

3.1.1.3. The services specified hereunder -

3.1.1.3.1. Amniocentesis for women over 35 years of age in at the onset of pregnancy.

3.1.1.3.2. Vaccines against tetanus, rabies and diphtheria.

3.1.1.3.3. Mantoux test and chest X-Ray.

3.1.1.3.4. Wheelchairs and walkers.

3.1.2. **Medications basket:** all services enumerated in the National Health Insurance Order (Medications in the Healthcare Services Basket) 1995 at the time of commencement of the Insurance Period.

3.1.3. **The services at work basket:** all services enumerated in Regulations 2 and 5 of the Health at Work Regulations in the manner set forth in the said Regulations, mutatis mutandis on the insurance commencement date.

4. Additional undertakings of the Insurer

4.1. Subject to the provisions set forth in this Policy, the Insurer shall incur the costs specified hereunder, subject to the terms and exclusions as specified in this Policy hereunder:

4.1.1. **Customary payment:** the Insurer shall incur the customary payment in respect of medical services that are covered under this Policy and that the Insured is required to incur against their receipt in customary payment. **The Insurer shall not incur the customary payment in the event the medical service in respect of which customary payment was made is not covered in accordance with this Policy.**

4.1.2. All expenses in connection with the flight of the Insured from Israel back to his country of origin in any event that his medical condition necessitates a companion or other special arrangements at the time of flight.

4.1.3. **Costs incurred for transfer of the body of the Insured:**

4.1.3.1. In the event of the death of the Insured under circumstances entitling him to medical service in accordance with the provisions set forth in this Policy, the Insurer shall incur the costs of transferring his body from Israel to his country of origin.

4.1.3.2. Notwithstanding the said in section 4.1.3.1 hereinabove and in section 5.1.7 hereunder, in the event the Insured died as a result of Occupational Injury, within its meaning in section 5.1.7 hereunder, the Insurer shall incur the costs of transferring the body of the Insured from Israel to the country of origin of the Insured.

4.1.3.3. **The liability of the Insurer under sections 4.1.3.1 and 4.1.3.2 is conditional on receiving the advance confirmation of the Insurer and in making the said flight solely by the Insurer.** In the event the Insured did not contact the Insurer for the purpose of obtaining his approval prior to flying the Insured from Israel back to his country of origin as specified hereinabove, the Insurer shall be entitled to lower the Insurance Benefits that the Insured would have been entitled to receive up to the amount that the Insurer would have paid if the Insured had contacted the Insurer with a request to obtain approval as said prior to the flight.

4.1.4. **Emergency flight to a close relative to Israel**

4.1.4.1. In this section "close relative": wife, husband, son, daughter, sibling.

4.1.4.2. In the event the Insured was hospitalized **under circumstances entitling him with medical services in accordance with this Policy** for the purpose of performing an invasive surgical procedure that involves hospitalization longer than 10 days or that the attending physician stated that the Insured's life is at risk, the Insurer shall pay to the close relative the costs of purchasing a flight ticket and travel to the place where the Insured is hospitalized in Israel up to $1,500 and accommodation costs of up to 10 days in a hotel up to a maximum amount of $40 per day.

The undertaking of the Insurer in accordance with this section shall be granted on the condition that the flight ticket and the accommodation arrangements at the hotel were purchased by the Insurer and were approved in writing and in advance by the Insurer. In the event the Insured did not contact the Insurer for the purpose of obtaining its approval for such expenses as specified hereinabove, the Insurer shall be entitled to lower the amount of Insurance Benefits the Insured is entitled to receive up to the amount that the Insurer had paid if the Insured had contacted the Insurer in advance with a request for obtaining such approval as said.

4.1.5. **Flight costs in the event of Occupational Incapacity:** in the event a physician specializing in occupational medicine determined that the Insured is not competent to perform the work for which he was hired by the Policyholder, and that he is not competent to perform the work within 90 days as of the date he was examined by him, even if he receives the medical care which he needs (hereinafter: **"Occupational Incapacity"**), and during the Insurance Period, the Insurer shall incur the costs of the flight ticket to the country of origin of the Insured up to a maximum amount of $2,000.

The Insurer shall not incur the costs of the flight ticket as specified in

section 4.1.5 hereinabove, where the Occupational Incapacity derived from circumstances that do not entitle the Insured with medical services under this Policy, except for circumstances as specified in section 4.1.5 hereinabove and 5.1.5 hereunder.

4.1.6. **First aid dental care services:**

4.1.6.1. The Insured shall be entitled to receive solely the dental emergency care and first aid services specified hereunder by nationwide dental clinics, as set forth by the Insured from time to time and whose details 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 tooth cavity - temporary filling.

4.1.6.1.3. Exposed tooth neck - desensitizing medication.

4.1.6.1.4. Acute infection in tooth pulp - extracting nerve or embalming substance.

4.1.6.1.5. Abscess originating in the tooth - cleansing abscess and/or treatment with occlusion.

4.1.6.1.6. Food impaction - gum treatment.

4.1.6.1.7. Pericoronitis - rinsing and/or medical treatment.

4.1.6.1.8. Pains following extraction - analgesics.

4.1.6.1.9. Pressure ulcers under existing prosthetics - releasing pressure ulcers.

4.1.6.1.10. Any other treatment deriving from toothache - a treatment for relieving or stopping the pain will be provided.

4.1.6.1.11. Examination and X-Ray of aching teeth.

4.1.6.1.12. Providing a suitable prescription to relieve the pain in the event no treatment can be provided to the tooth at the time.

4.1.6.2. Notwithstanding the said in section 5.1.4 hereunder, the Insured shall be entitled to the emergency and first aid services specified in section 4.1.6.1 hereinabove even if required due to an existing condition.

5. **Exclusions to Chapter B**

5.1. **Notwithstanding the said in sections 3 and 4 hereinabove, the Insurer shall not incur the costs and/or the medical costs in respect of the services enumerated hereunder and the Insured shall not be entitled to the said costs and/or services under this Policy -**

5.1.1. **Within the medical healthcare basket:**

5.1.1.1. **Psychological services;**

5.1.1.2. **Treatments for psoriasis patients provided in the Dead Sea.**

5.1.1.3. **Genetic tests.**

5.1.1.4. **Long-term care hospitalization or other long-term care services.**

5.1.1.5. Services provided for treating impotence, sexual dysfunctions, male or female fertility and IVF or artificial insemination treatments.

5.1.1.6. Services provided outside Israel.

5.1.1.7. The Insurance Event occurred after expiration of the Insurance Period and/or continuous Insurance Periods as specified in section 2.6 hereinabove.

5.1.2. Within the medications basket:

5.1.2.1. Medications for the treatment of Alzheimer's disease.

5.1.2.2. Medications designated for treatment of impotence, sexual dysfunction, male or female fertility, or medications provided as part of IVF or artificial insemination treatments.

5.1.3. Pregnancy - health services in connection with pregnancy for the first 9 months, cumulatively, during which employer-employee relationship was maintained between the employee and one or more employer in Israel, save for a medical emergency.

5.1.4. Existing condition: medical services that the Insured required due to a medical problem that derived from a medical condition that preceded the first date in which any employer in Israel arranged medical insurance in the first 3 years as of the effective date of the Foreign Worker Order - on 17.10.2001 or as of the first day in which medical insurance was arranged for the Insured, upon the later (hereinafter: "First Date") upon fulfillment of one of the following:

5.1.4.1. The Insured confirmed that the medical problem in respect of which he required the service derived from an existing condition.

5.1.4.2. A physician approved, according to the findings he holds, that the medical problem in respect of which the employee requires the service derives from an existing condition.

5.1.4.3. The Insured stayed outside Israel after the First Date for a period or for periods that exceed 90 consecutive days with a number of employers or for a period that exceeds 120 consecutive days if his stay was with the same employer - the First Date for the purpose of paragraph 5.1.4 shall be deemed as the first date after the stay in which the employee is insured in medical insurance.

5.1.4.4. The health services in a medical emergency due to an existing condition: notwithstanding the said in section 5.1.4 hereinabove, the Insurer shall incur the medical costs in respect of health services that the Insured required during a medical emergency deriving from an existing condition, for the purpose of stabilizing his medical condition until the employee is in a condition that allows continuation of care also outside Israel and costs in respect of other medical services that are required to the Insured due to the said existing condition that the Insured required in the 30 days after the said determination was made by the physician or the determination about the stabilization of his medical condition as said.

5.1.5. Occupational Incapacity:

5.1.5.1. Medical services that the Insured needed after an occupational medicine specialist stated that the Insured was incapable to perform the work for the purpose of which he was hired by the Policyholder, and that he will not be competent to perform the work within 90 days as of the date he was examined by the physician even if the medical care he needs is provided to him.

5.1.5.2. Notwithstanding the said in section 5.1.5.1 hereinabove, the Insured shall be entitled to medical services he required in a medical emergency for the purpose of stabilizing his medical condition until he reaches a condition that allows his care outside Israel and for other medical services which he needs in the 30 days after the determination made by the physician as said or the determination regarding stabilization of his medical condition as said.

5.1.6. Road accident and hostilities - medical services that the Insured needs as a result of:

5.1.6.1. A road accident, within its meaning in the Road Accident Victims Compensation Law, 1975.

5.1.6.2. Hostility victims, within its meaning in the Victims of Hostilities Law, 1970 in the event he is considered a victim within the meaning in the said law.

5.1.7. Health services due to Occupational Injury

5.1.7.1. The Insurer shall not incur the health services costs of the Insured where the Insured required the said services due to Occupational Injury within its meaning in the National Insurance Institute Law [Consolidated Version] 1995 (hereinafter: "Occupational Injury") and provided that the employer confirmed, in a form designated for that purpose by the National Insurance Institute (hereinafter: "Injury Form") that the said injury is an Occupational Injury.

5.1.7.2. In the event the employer provided an Injury Form and the National Insurance Institute did not determine that the injury was an Occupational Injury within three months as of the date of the Occupational Injury, the Insurer shall incur the costs of the health services that were provided to the Insured due to the said Occupational Injury within three months, even if provided not by the service providers and after three months, if provided by the service providers on behalf of the Insurer.

5.1.7.3. Where the injury derived from the Occupational Injury, the Policyholder undertakes to confirm the injury as specified in section 5.1.7.1 hereinabove on the Injury Form of the National Insurance Institute with a copy to the Insurer within 7 days as of the date of the occurrence of the Occupational Injury. A Policyholder that did not grant such approval as said and it was found that the injury was Occupational Injury within its meaning

hereinabove, shall incur all the costs incurred by the Insurer by law within 7 days as of the date the Insurer delivered notice to that effect.

6. **Rules for the approval or determination of a specialist physician - existing condition and Occupational Incapacity**

6.1. The confirmation granted by a physician stating that medical problem due to which the Insured required medical services derives from an existing condition and the determination of a physician that the medical condition of an employee was stabilized - will be granted by a specialist physician. The determination of a physician regarding the incapacity of an insured to work, even after receiving medical care - shall be provided by a specialist of occupational medicine.

6.2. The period of 30 days specified in paragraphs 5.1.4 and 5.1.5 shall not be counted however only as of the date of the final approval or the final determination that was granted as specified in section 6.1.3 hereunder however such determination regarding the stabilization of a medical condition of an employee as said shall not be deemed as final if a department director at the hospital where the Insured is hospitalized or his deputy director - in the absence of the director - stated at the time that the entitlement of the Insured to health services in accordance with the provisions set forth in this Policy expired that the medical condition of the Insured was not stabilized yet. This determination shall be decisive unless otherwise stated whether by the department director or his deputy as said.

6.3. Rules for approval or determination as specified in section 6.1.2 shall be as follows:

6.3.1. The Insurer shall be entitled to request from the Insured to undergo an examination by a specialist physician on its behalf at the Insurer's expense. The physician's opinion shall be delivered to the Insured together with a notice on the right of the Insured to receive a counter-opinion as specified in section 6.1.3.2 hereunder and together with the details of entities or organizations that can assist it to exercise its right and that granted their consent to the said.

6.3.2. The Insured shall be entitled to receive a counter-opinion from a specialist physician at his choice and the said counter-opinion shall be delivered to the Insurer within 21 days as of the date the Insured received the counter-opinion on behalf of the Insurer. The Insurer shall incur the costs of the counter-opinion up to the limit of the amount that shall be determined by the Director General of the Ministry of Health and the Capital Markets, Insurance and Savings Division Commissioner (hereinafter: **"Fixed Fees"**).

6.3.3. In the event of differences of opinion between the two specialist physicians as said, the parties shall appoint an agreed physician whose costs shall be incurred by the Insurer, and his opinion shall be decisive. In the event the parties failed to reach agreement on the identity of the said physician, the deciding specialist physician shall be appointed by the head of the Israel Medical Association-I.M.A (hereinafter: "Association") that engages in the medical practice pertaining to the disease of the Insured, and for the purpose of determining the Occupational Incapacity also given medical care - by the head of the union of occupational medicine of the Association (hereinafter:

"Deciding Physician") and his opinion shall be decisive. In the event the head of the union failed to make such appointment as said within 15 days as of the date he was approached by the Insurer, the Deciding Physician shall be appointed by the Director General of the Ministry of Health or whoever was designated for that purpose. The fees of the Deciding Physician shall be the Fixed Fees and shall be paid by the Insurer.

Chapter C: Service providers and stipulation of the medical services on approval

7. **Service providers**

7.1. **The medical services provided under this Policy shall be provided solely by service providers subject to any change notified in writing by the Insurer to the Policyholder. In the event a service provider ceased working with the Insurer, the Insured shall contact the call center of the Insurer in order receive a referral to another service provider.**

7.2. The medical services under this Policy shall be provided to the Insured according to medical considerations in reasonable quality, within a reasonable time and within a reasonable distance from the place of residence of the Insured.

7.3. Notwithstanding the said in section 7.1 hereinabove, the Insured shall be entitled to receive the medical services enumerated hereunder under the circumstances enumerated hereunder and at the Insurer's expense:

7.3.1. ER services in each of the general hospitals throughout the country in each of the following cases:

7.3.1.1. Any new fracture.

7.3.1.2. Acute dislocation of a shoulder or elbow.

7.3.1.3. Injury that requires splicing by stitching or an alternate means of splicing.

7.3.1.4. Foreign body aspiration.

7.3.1.5. Penetration of a foreign object into the eye.

7.3.1.6. Treatment of cancer.

7.3.1.7. Treatment of hemophilia.

7.3.1.8. Treatment of Cystic Fibrosis.

7.3.1.9. Evacuation by ambulance to the ER, from the street or another public location, due to a sudden episode.

7.3.1.10. A referral that ended in non-elective hospitalization.

7.3.1.11. Medical emergency.

7.3.2. Hospitalization services that were provided to the Insured shortly after a visit to the ER if provided under the circumstances specified in section 7.3.1 hereinabove.

8. **Stipulation of the provision of medical service on obtaining advance approval**

8.1. The medical services enumerated hereunder shall be provided solely by service providers.

8.2. Access to the different medical services shall be stipulated on advance approval of the Insurer and/or the approval of the attending physician and/or shall be free as specified hereunder:

8.2.1. Access to primary medical services specified in this Policy shall be free and the Insured shall not be required to obtain the prior approval of the Insurer before receiving the said medical service.

8.2.2. Access to non-primary medical services, except for the cases enumerated in section 7.3 hereinabove, shall be stipulated on obtaining the prior approval of the attending physician in the primary medical services.

8.2.3. Access to examinations in imaging institutions, diagnostic institutions, gastroenterology institutions, laboratories and elective hospitalization services shall be stipulated on obtaining the prior and written consent of the Insurer.

The Insurer shall submit a written request to the Insurer for the approval of the services enumerated in this section together with the confirmation of the attending physician stating that the Insured needs the said medical service.

The requested confirmation or notice on refusal to provide the said service shall be delivered within 7 days as of the date the attending physician designated the need to receive the examination or the hospitalization, as the case may be, and/or as of the date the were accepted the request of the Insured, upon the later, and in any event shall not be delayed to a date that can jeopardize the Insured or impair the reasonable care the Insured is entitled to receive in accordance with this Policy.

8.2.4. Save as the circumstances specified in section 7.3 hereinabove, the Insurer shall not incur the costs of medical services of the Insured in the ER without obtaining the prior approval of the attending physician.

Chapter D: Compensation for death and disability as a result of an accident

Insurance coverage provided under this Chapter shall not be provided to Insureds who are under 18 years of age and/or who are over 65 years of age.

The total liabilities of the Insurer in accordance with this Chapter shall not exceed a maximum amount of $10,000 per insured for and the Insured shall be entitled to receive the said services for a single time.

9. 9.1. In this Chapter -

9.1.1. **"The Insured":** whoever stays in the State of Israel as a foreign worker provided that his age is over 18 years and under 65 years.

9.1.2. **"Accident":** unanticipated physical damage that was caused during the Insurance Period by an external, visible violent means which is the discrete, direct and immediate cause for the death or the disability of the Insured, except for damage that was caused as a result of verbal abuse **and unless the damage was caused as a result of a hostility within its meaning in the Victims of Hostilities Law, 1970.**

9.1.3. **"Disability":** permanent medical disability that was caused as a direct and decisive result by an Accident (an Accident that occurred during the Insurance Period).

9.1.4. **"Permanent disability":** complete loss, anatomical or functional, of an organ, or a limb or a part thereof, due to an accident that occurred and that was caused within 6 months following its occurrence.

9.1.5. **"Death of the Insured":** the death of the Insured due to the Accident caused within 6 months following its occurrence.

9.2. In the event the Insured suffered bodily damage whose direct cause is an accident during the Insurance Period, Insurance Benefits shall be paid as follows:

9.2.1. In the event of the **death of the Insured** whose age at the time of his death was 18 and less than 65, the beneficiary indicated in the Proposal or, in the absence of a beneficiary, the legal heirs of the Insured or his administrators or executors shall be paid $10,000.

9.2.2. In the event of **permanent disability**: in the event of permanent disability that was caused after the date of the Accident that occurred after the insurance commencement date, the Company shall pay an insurance amount in accordance with the rates specified hereunder (the amount for payment shall be calculated as percentage out of the full insurance amount specified in section 9.2.1 hereinabove). Example: in the event the Insured was diagnosed with permanent disability of his leg and the maximum insurance amount is $10,000, in this instance the Insured shall receive 40% X 10,000 =$4,000.

Nature of disability	Disability rate
Total and complete loss of vision in both eyes	100%
Total and complete loss of use of both hands or both legs	100%
Total and complete loss of right hand or right arm	60%
Total and complete loss of left arm or hand	50%
Total and complete loss of one leg	40%
Total and complete loss of vision in one eye	25%
Total and complete loss of thumb in one of the hands	16%
Total and complete loss of right hand digit	14%
Total and complete loss of left hand digit	12%
Total and complete loss of right hand pinky	12%
Total and complete loss of left hand pinky	10%
Total and complete loss of right forearm	8%
Total and complete loss of left forearm	6%
Total and complete loss of ring finger on one of the hands	6%
Total and complete loss of the toe	5%
Total and complete loss of any other digit in the leg	3%
Total and complete loss of hearing in both ears	40%
Total and complete loss of hearing in one ear	10%

9.2.3. **With respect to the left organ of a left-handed** - the left hand shall be considered according to the same percentage specified for the right hand and damage to the right hand according to percentage for the left hand.

9.2.4. **Disability existing prior to commencement of the insurance and/or disability that were designated in accordance with this Appendix shall be deducted from the disability rate entitling with payment in accordance with this Appendix.**

9.2.5. **Organs that are not specified in the list** - in any event in which disability was caused to an organ that is not specified in the list in section 9.2.2 hereinabove, the disability percentage shall be designated in accordance with a decision of a specialist physician of the said disability and shall be paid as percentage out of the full insurance amount. Example: in the event an Insured was diagnosed with permanent disability in his back and a specialist physician stated that this was 70% disability rate. The maximum insurance amount specified in the Schedule is $10,000. In this case the Insured will receive: 70% X 10,000 = $7,000.

9.2.6. **Partial disability (in cases in which the nature of the disability is specified in the Schedule)** - in any event of partial disability in the organs specified in the list, an adjusted disability rate shall be determined as specified in section 9.2.7 hereunder.

9.2.7. **Adjusted disability rate** - shall be equal to the disability rate from the Accident multiplied by the rate of total disability in the list in connection with the same organ and multiplied by the full insurance amount. For example: in the event partial disability rate was designated in the leg at a rate of 20% and the maximum insurance amount specified in the Policy Schedule is $10,000 the total disability rate in the Schedule in accordance with the table specified hereinabove - for a leg is 40%. In this case the Insured will receive 20% X 40% X 10,000 = $800.

Special exclusions for Chapter D: Compensation for death and disability as a result of an accident

10. The Insurer shall not pay Insurance Benefits in accordance with this Policy if the death or the disability were caused directly or indirectly by or following

10.1. An earthquake, volcanic eruption, nuclear fission, nuclear fusion, radioactive contamination.

10.2. The active participation of the Insured in a military, police, underground, revolutionary activity or an insurgence, riots, sabotage, terrorism, strike, or an illegal act.

10.3. The passive participation of the Insured in terrorist activities or hostilities of any kind and/or war and/or a belligerent action by regular or irregular hostile forces.

10.4. The flight of the Insured in any aircraft, except for the flight of the Insured as a passenger in a civilian aircraft that is certified to carry passengers subject to the sole liability of the Insurer in Israel.

10.5. Self-inflicted wound or suicide or an attempted suicide whether or not the Insured is sane.

10.6. Sports activities in a sports association and/or competitive sports activity and/or professional sports activity (that constitute his principal occupation and/or that is performed for pay).

10.7. Participation of the Insured in extreme sports in accordance with the list specified in the website of the Company. For the purpose of this matter extreme sports refer to sports that are considered to be dangerous and that include/require, inter alia, from their participants high levels of difficulty and/or physical stress. The list of extreme sports shall be updated from time to time according to a list specified in the website of the Company www.harel-ins.co.il.

10.8. The use of explosives.

10.9. Mental diseases, deliberate self-risk, except for self-defense and rescuing lives.

10.10. Alcoholism or drug abuse by the Insured.

10.11. Death or disability as a result of surgeries, including minor surgeries.

10.12. An occupational accident within its meaning in the National Insurance Institute Law.

10.13. A road accident within its meaning in the Compensation to Road Accident Victim Law, 1975.

Contact details

Head office
Harel House, 3 Abba Hillel St.
PO Box 1951
Ramat Gan 5211802

For details contact customer call center
*2735
Or to your insurance agent

06/2015 b6813/10295 StudioHarel

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Insurance & Finance