



Tour & Care - Health Policy

Medical insurance for tourist in Israel

June 2016

TOUR & CARE

Medical Insurance for Tourists in Israel

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 provider 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 temporarily who is not a resident or a citizen of the State of Israel, whose name is noted on the Insurance Details Page.
- 1.3. **The Policy:** The insurance contract, including the proposal, the Insurance Details Page and any rider or appendix attached to it.
- 1.4. **The Insurance Proposal:** The proposal form, which constitutes an application to be insured according to this Policy, that has been completed with all details and signed by the Insured or by a legal guardian. The Proposal shall also include the Health Statement completed and signed by the Insured (or the guardian) as well as details of the means of payment.
- 1.5. **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.
- 1.6. **Foreign country:** Any place or country outside of Israel, including any means of transportation traveling to or from Israel.
- 1.7. **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.
- 1.8. **Insurance period:** The period of the insurance as specified on the Insurance Details Page. The insurance period shall not exceed the maximum period, according to the following:
 - 1.8.1. **Maximum period:**

For Insured up to the age of 59: 180 days, with an option to extend for a period of up to another 180 days, but no more than 365 days in total.

For Insured between the ages of 60 and 65: 90 days, with an option to extend for additional periods of 90 days each, but no more than 365 days in total.

For Insured between the ages of 66 and 75: 45 days, with an option to extend for an additional period of 45 days, but no more than 90 days in total.
- 1.9. **Additional period:** An insurance period that has been extended, whether in the framework of the same insurance policy or as a new insurance policy, according to the instructions of Section 2.11 below.
- 1.10. **Qualification period:** A period of 48 hours from the beginning of the insurance period as defined in Section 1.8, during which the Insurer will not be liable for an insurance event that occurred, with the exception of the case of an

accident, as defined in Section 1.12 below. An insurance event that occurred during the qualification period will be treated like an insurance event that occurred before the Insurance began.

- 1.11. **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 termination of the insurance period, all this according to the terms, exclusions and exceptions as set forth in this Policy.
- 1.12. **Accident:** A physical injury caused by the application of physical force only, as the result of a sudden, singular and unexpected event, caused directly by an external and visible entity, which constitutes the sole direct and immediate cause of the occurrence of the insurance event. To eliminate any doubt, verbal violence and/or emotional pressure and/or the accumulation of small repeated injuries over a period of time that lead to disability shall not be considered an "accident."
- 1.13. **Medical institution:** A hospital or clinic, including a medical institute, laboratory, diagnostic centers, pharmacy.
- 1.14. **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 recovery hospital and/or a recuperation center and/or a rehabilitative institution.
- 1.15. **Emergency room:** a place designed to provide urgent medical care that is approved by the qualified authorities in Israel to operate as an emergency room.
- 1.16. **Expenses during hospitalization:** Medical expenses involved in hospitalization of the Insured, which were incurred during the insurance period and for a period not exceeding 90 days as specified in the Policy.
- 1.17. **Medical expenses not during hospitalization:** Payment for medical treatment, diagnostic tests and/or medications that are supplied to the Insured outside the framework of hospitalization in Israel and not exceeding that determined in the Policy.
- 1.18. **Physician:** A person who holds a legal certificate of qualification to work as a physician in Israel.
- 1.19. **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.
- 1.20. **Medical emergency:** Circumstances in which a person is in life-threatening danger or in which there exists an immediate risk that a person will be caused severe irreversible disability if not provided with urgent medical treatment.
- 1.21. **Pre-existing medical condition:** A set of medical circumstances that were diagnosed in the Insured prior to the date of joining the Insurance, including those due to a disease or accident; for these purposes, "diagnosed in the Insured" - by means of a documented medical diagnosis or in the process of a documented medical diagnosis that took place during the six months prior to the date of joining the Insurance.

- 1.22. **Medication:** A chemical or biological substance designed for treatment of the medical condition of the Insured, to prevent worsening of the medical condition of the Insured (including prevention of the development of additional medical conditions) or to prevent recurrence of the medical condition of the Insured, as the result of disease or accident, and which has been approved by the qualified authorities in Israel and is included in the list of approved medications and/or by the qualified authorities in one or more of the recognized countries.
- 1.23. **Service providers under agreement:** A general-government hospital and/or private hospital that has been approved in advance by the Insurer, and in addition, physicians and/or a medical institution connected **by agreement with the Insurer**, the name of which is specified in the Insurance Proposal, from which and solely from which the Insured will be entitled to receive the health services specified in this Policy, all this subject to the terms of the Policy.
- 1.24. **Insurance fees:** The amount for this Policy that the Payer and/or the Insured must pay the Company, according to the terms of the Policy, as specified on the Insurance Details Page.
- 1.25. **The Payer:** The person or corporation that enters into a relationship with the Insurer according to the Policy for the purpose of paying the premium, and the name of which is specified on the Insurance Details Page and the Proposal.
- 1.26. **Co-pay:** The share of an expense due to an insurance event that is to be paid by the Insured, as specified on the Insurance Details Page. It is hereby clarified that the duty of the Insurer to make any payment shall apply only to the expenses of the Insured beyond this co-pay amount.
- 1.27. **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.
- 1.28. **Health basket:** As defined in the Health Insurance Law.
- 1.29. **Health/medical services:** All the medical services to which the Insured is entitled according to the terms of this Policy.
- 1.30. **Primary health services:** Services provided by an attending physician according to the terms of this Policy.
- 1.31. **The Insurance Contract Law:** The Insurance Contract Law 5741 - 1981.
- 1.32. **Dollar:** United States Dollar

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. A deliberate deceptive concealment on the part of the Insured of a matter that he/she knows is an essential matter, shall be 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 deliberately acted deceptively.
- 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 deliberately provided fraudulently.
 - 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 deception:
 - 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 the Insurer was paid insurance fees before the Insurer gave its agreement to draw up the insurance, the payment shall not be construed as agreement of the Insurer to draw up the insurance. In this case, the Insurer will, within 90 days from the date of receipt of the insurance fees for the first time, 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 insurance candidate 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. **Taxes and charges:** The payer or the Insured, according to the case at hand, is required to pay the Insurer the insurance fees and government and other taxes that apply to the Policy or that are charged on insurance fees, on insurance amounts and on any other payments that the Insured is obligated to pay according to the Policy, whether these taxes exist on the date of drawing up the Policy or are imposed at a later date.
- 2.4. **Statute of limitations:** The period of limitation of a claim for payment of insurance benefits for an insurance event according to this Policy is three years from the occurrence of the insurance event. If the grounds for the claim is a disability that is caused the Insured by an accident as specified in Section C below, the period of limitation will be counted from the date that the Insured had the right to claim insurance benefits according to the terms of the insurance contract.
- 2.5. **Notices:** The Insured must notify the Insurer of any change of address in a letter. A notice that is sent by the Insurer to the last address known to it of the Insured shall be considered a notice properly delivered.
- 2.6. **Changes:** The Insurer shall be entitled to change, from time to time, the list of service providers under agreement.
- 2.7. **Jurisdiction:** The exclusive and sole place of jurisdiction regarding any matter related to and stemming from this Policy is the authorized courts in Israel only, according to Israeli law, and no other court whatsoever shall have any authority. The law that applies to claims arising from and/or related to this Policy is the Israeli law.
- 2.8. **Health Statement:**

The Insured shall provide the Insurer with a health statement and waiver of medical confidentiality.
- 2.9. **Claims and Insurance Benefits:**
 - 2.9.1. 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. 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.
 - 2.9.2. The Insured shall attach to the notice of an insurance event form all the relevant medical documents regarding the insurance event, including diagnoses, a history of the event (anamnesis) and, if payments were made by the payer and/or by the Insured - 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.

- 2.9.3. The Insured will cooperate with the Insurer before and after submission of the claim and will do all that is necessary to enable the Insurer to inquire about its obligation to pay according to the Policy and its scope.
- 2.9.4. The Insurer shall be entitled, according to its discretion, to pay insurance benefits or part thereof directly to the service providers, or to pay them to the Insured against original receipts (or, in the absence of an original receipt, against 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 these documents or along with an explanation of whom the original documents were sent to and the reason that he/she cannot provide them). The Insured is entitled to receive from the Insurer, upon his/her demand, a letter of monetary commitment to the service provider that enables him/her to receive medical services, as long as there is no disagreement regarding his/her entitlement to it according to the Policy.
- 2.9.5. The insurance benefits to which the Insured is entitled as reimbursement of expenses that were paid in Israeli currency - shall be paid in Israeli currency and linked to the Consumer Price Index from the date they were paid by the Insured until the date of payment of the insurance benefits. The insurance benefits by force of this Policy shall be paid in Israeli currency, according to the following details:
- For the purpose of examining the limit of liability**, the insurance benefits to which the Insured is entitled due to reimbursement of expenses paid in Israeli currency shall be calculated according to the dollar value of each payment according to the type of exchange rate according to which the Insured paid the insurance fees, known on the date of payment of the insurance benefits. In the matter of this section, "index" - the Consumer Price Index published by the Central Bureau of Statistics or in the absence of such publication, an index published by another official entity that replaces it, or any index specifically for health services.
- 2.9.6. Insurance benefits to which the Insured is entitled as reimbursement of expenses paid in a currency other than Israeli currency - shall be converted from the currency in which they were paid to US Dollars and from that to Israeli currency, according to the rate known on the date of payment of the insurance benefits of the type of exchange rate according to which the Insured paid the the insurance fees.
- 2.9.7. **The Insured shall not be entitled to insurance benefits that exceed the limit of liability. The total insurance benefits paid, for the purpose of examining the limit of liability, shall be calculated according to the known US Dollar value of every payment according to the type of**

exchange rate according to which the Insured paid the insurance fees on the date of making the payment.

- 2.9.8. If the Insured has died, the Insurer will pay the balance of insurance benefits to the medical service provider that it undertook to pay. In the absence of a commitment to a service provider or if a balance remains after payment according to the said undertaking, it will pay the balance to the estate or the heirs of the Insured, according to a will probate order and/or according to an inheritance order.
- 2.9.9. The Insured shall not be entitled to insurance benefits that exceed the insurance amount, and the Insurer shall pay the Insured and/or the service providers under agreement up to this amount.
- 2.9.10. If the Insured is entitled to coverage of expenses paid according to this insurance in full or in part in the framework of another policy with another insurance company, the Insurer shall pay its proportionate part of the actual expenditures, according to the scope and ratio of the coverage to which the Insured is entitled from all the insurers. The Insured must notify the Insurer immediately upon the creation of multiple insurance.
- If the Insured deliberately does something that could prevent the Insurer from clarifying its obligation or burdening it, the Insurer will not be obligated to pay insurance benefits except to the extent that it would have been obligated to do so if this had not been done.
- 2.10. **Medical examination:** The Insurer shall be entitled to demand of the Insured, in a reasonable manner, 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.
- 2.11. **Additional period of extension of the insurance period:**
- 2.11.1. The Insured is entitled to apply to the Insurer to extend the insurance period for an additional period of time. The extension of the insurance period shall be subject to the approval of the Insurer and completion of a new Health Statement in advance and in writing. It is hereby clarified that at the end of the insurance period, as defined in the Policy, the insurance shall not be extended automatically.
- 2.11.2. The Insurer shall be entitled to change the insurance fees at the beginning of the extension of this Policy. The insurance fees for the additional insurance period shall be calculated according to the number of days of extension according to the rate of insurance fees in effect with the Insurer at the time that the extension begins and according to the specifications of the chapter on Definitions, in the section "Insurance period."
- 2.12. **Cancellation of insurance:**
- 2.12.1. In the case that the Insured and/or the payer 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.
- 2.12.2. In the case described in Section 2.1.2 above, the Insurer is entitled to cancel the Policy according to the Insurance Contract Law.

- 2.12.3. If the insurance Policy is cancelled prior to the end of the insurance period, the Insurer will return to the Insured 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, and after deduction of handling charges. Regarding this matter, "handling charges" - expenses of the Insurer in producing the insurance policy, expenses of issuing the insurance card of the Insured and any other expense accompanying the process of producing a policy that shall not be less than the insurance fees for two months under this Policy.
- 2.12.4. The Insured is allowed to cancel the Policy by written notice to the Insurer at any time.
- 2.13. **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 of 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.
- 2.14. **Changes in insurance fees and insurance terms:**
- 2.14.1. The insurance fees according to this Policy shall be determined according to the age of the Insured on the date of purchase of the Policy, as specified on the Personal Details Page.
- 2.14.2. The Insurer shall be entitled to change the insurance fees and the conditions of this Policy. This change shall be valid on the condition that the Commissioner of Capital Markets, Insurance and Savings has approved the change and it shall become effective 30 days after the Insurer notifies the Insured of this in writing.
- 2.14.3. A change in the insurance fees as said in Section 2.14.2 above shall not take into consideration a change in the health condition of the Insured (if such a change occurred) during the period preceding the said change.

Chapter B: Undertaking of the Insurer

The Insurer shall pay the Insured at a service provider under agreement as follows:

3. Expenses during hospitalization and expenses not during hospitalization as follows:

3.1. Expenses in a general-government hospital in Israel:

If the Insured is hospitalized in a general-government hospital in Israel, the Insurer shall pay for these expenses for a period not exceeding 90 days:

3.1.1. **Expenses for hospitalization, including X-rays, medication, physicians, surgeon, intensive care, anesthetist, catheterization, general services, including nursing services (herein: "hospitalization expenses").**

3.1.2. It is hereby clarified that the Insurer shall pay hospitalization expenses to general-government hospitals. The Insurer shall not indemnify the Insured and/or the service provider for hospitalization expenses insofar as the Insured was hospitalized in a private hospital and/or received and/or paid for private medical services during his/her said hospitalization.

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

3.2.1. Referral by a physician.

3.2.2. A new fracture.

3.2.3. Dislocation of a shoulder or elbow.

3.2.4. An injury requiring stitching by means of sutures or other means of stitching.

3.2.5. Aspiration of a foreign object into the trachea.

3.2.6. Penetration of a foreign object into an eye.

3.2.7. Infants up to the age of two months with a fever of over 38.5 degrees Celsius.

3.2.8. Snake bite.

3.2.9. Transportation by ambulance to an emergency room from the street or another public space due to a sudden event.

3.2.10. Approval by the Insurer.

3.2.11. The emergency inquiry ends in non-elective hospitalization.

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

3.3. Medical expenses that are not in the framework of hospitalization, provided by a service provider under agreement:

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

3.3.1. **Medical treatment/consultation:** Medical treatment/consultation solely by a service provider under agreement, with a co-pay as specified on the Insurance Details Page.

- 3.3.2. **Laboratory tests, X-rays, bandaging:** Tests provided to the Insured solely by a laboratory and/or clinics that are service providers under agreement.
- 3.3.3. **First aid:** First aid provided to the Insured by a first aid station of Magen David Adom solely in cases of emergency.
- 3.3.4. **Medications:** Up to 200 dollars for the entire insurance period. This amount shall be paid for medications that are prescribed by a physician under agreement and that are purchased at pharmacies that are service providers under agreement, with the deduction of the co-pay amounts as specified on the Personal Details Page.
- 3.3.5. **Ambulance expenses:** The Insurer shall pay the expenses of transportation by ambulance in the case of a medical emergency after which the Insured is hospitalized, one time only during the insurance period and on the condition that the Insured is not entitled to coverage of this expense by any another entity.
- 3.3.6. **Emergency dental treatment:** Up to 200 dollars for the entire insurance period. The Insured shall be entitled to receive the emergency services and first aid dental care listed below only, for emergency dental treatment provided solely by dental clinics that are service providers under agreement, solely as first aid treatment, if the treatment is required due to an accident and/or a sudden outbreak of pain, as listed in the following:
 - 3.3.6.1. Extensive caries, temporary filling.
 - 3.3.6.2. Open space in a tooth, temporary filling.
 - 3.3.6.3. Exposed neck of tooth, material to prevent sensitivity.
 - 3.3.6.4. Acute inflammation, extraction of nerve or embalming material.
 - 3.3.6.5. Abscess originating in a tooth, drainage of abscess and/or treatment by closure.
 - 3.3.6.6. Compacted food, treatment of gums.
 - 3.3.6.7. Inflammation under the crown, rinsing and/or drug treatment.
 - 3.3.6.8. Pain following extraction, pain relief.
 - 3.3.6.9. Pressure sores under an existing prosthesis, release of pressure sores.
 - 3.3.6.10. Treatment to relieve or end pain.
 - 3.3.6.11. Examination and X-ray of painful teeth.
 - 3.3.6.12. Provision of an appropriate prescription for pain relief in the case that treatment is not possible at the time.
- 3.4. **Expenses of transporting a corpse:**

In the case of the death of the Insured, the Insurer shall pay for the expenses of transporting the corpse from Israel to the Insured's country of origin, up to a maximum amount of 5,000 dollars, **solely if the expense is not paid by any other entity.**

To eliminate doubt, the undertaking of the Insurer for medical expenses with regard to an insurance event that occurred within the insurance period and the treatment of which was not completed before the end of the insurance period, shall continue for an additional period of 90 days after the end of the insurance period.

The undertaking of the Insurer in this chapter (Chapter B) shall not exceed a total amount of 100,000 dollars for the entire insurance period (the limit of liability does not accumulate if the insurance periods are extended).

4. General Exclusions to the Policy

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

- 4.1. An insurance event that occurred prior to the date of commencement of the insurance.
- 4.2. An insurance event that occurred during the qualification period.
- 4.3. A preexisting medical condition: an insurance event substantially caused by the normal course of a preexisting medical condition that occurred to the Insured during the period in which a restriction applies.

A restriction because of a preexisting medical condition concerning an insured whose age at the beginning of the insurance period is -

- 4.3.1. Less than 65 years - shall apply for a period not exceeding one year from the beginning of the insurance period;
- 4.3.2. 65 years or more - shall apply for a period not exceeding half a year from the beginning of the insurance period.
- 4.4. An insurance event that occurred after the end of the insurance period.
- 4.5. Insanity, mental disorders and/or mental diseases and/or mental treatments and/or psychological treatments and/or psychiatric disorders, suicide or attempted suicide, self-injury whether or not intentional, alcoholism, drug use with the exception of use of medical drugs according to a physician's instructions.
- 4.6. Participation of the Insured in extreme sports according to the list that appears on the Company website. For this matter, "extreme sport" is - fields of sport considered to be especially dangerous and that require high levels of difficulty and/or physical effort by those that engage in them. 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).
- 4.7. Sports activity in the framework of a sports association registered according to the Sports Law 5748 - 1988 and/or professional sports and/or competitive sports activity that includes the payment of wages.
- 4.8. Sexually transmitted diseases.
- 4.9. A road accident, as defined by the Road Accident Victims Compensation Law 5735 - 1975.
- 4.10. National Insurance Law (Consolidated Version) 5755 - 1995.
- 4.11. The insurance event was caused or is the outcome of the service of the Insured in any of the type of security force, including: standing army or reserve service or professional army or the police.

- 4.12. Passive participation of the Insured in an act of sabotage or terrorism of any type and/or in war and/or in a belligerent action of hostile forces, organized or not organized, and only if the Insured is not entitled to coverage from any other entity of the medical expenses that arise from such an event.
- 4.13. Expenses of pregnancy and/or childbirth and/or ectopic pregnancy and/or expenses due to treatments/routine ongoing tests or monitoring prior to pregnancy and/or genetic counseling and/or complications of pregnancy, including bed rest during pregnancy, and/or childbirth.
- 4.14. Fertility or infertility treatments.
- 4.15. Expenses of treatment of a premature infant or infant that has been born.
- 4.16. Social services care of infants and/or children, well-child clinics, supervision or routine testing of children.
- 4.17. Child development treatments, including learning disabilities, speech, occupational therapy, etc.
- 4.18. Periodic tests, routine and/or follow-up tests - that are not due to an active medical problem, cosmetic or restorative surgery, experimental surgery, inoculations, gum therapy and/or surgery, dental treatments (with the exception of first aid included in the framework of emergency dental treatment).
- 4.19. Organ transplant.
- 4.20. Rehabilitation, physical therapy, mechanical therapy, hydrotherapy, alternative therapy, homeopathy, alternative medications, healing programs, acupuncture, chiropractic, optometry.
- 4.21. Medical aids, with the exception of medical aids provided on loan due to an accident event.
- 4.22. Spectacles and/or contact lenses, hearing aids and prostheses of any kind.
- 4.23. Medical expenses due to active participation of the Insured in activities: civil war, underground or camouflaged activity, rebellion, riots, sabotage, fights, violence, terrorism, strikes and/or illegal activity.
- 4.24. An insurance event caused by nuclear fission or nuclear fusion or radioactive contamination.
- 4.25. Experimental medication - a medication that has not been approved by the qualified authorities in Israel nor by the qualified authorities in recognized countries for the treatment of the medical indications that the Insured requires.
- 4.26. Experimental medical treatments of any type or kind.
- 4.27. Treatments, tests and surgery outside the State of Israel.
- 4.28. Consequential damage of any kind.
- 4.29. Actions of any kind because of which the Insured is obligated to pay compensation to a third party according to the Civil Wrongs Ordinance.
- 4.30. Emergency room expenses - with the exception of that stated in Section 3.2.
- 4.31. The Insurer shall not pay and shall not be liable for an insurance event that occurred during the insurance period the treatment of which continues after the insurance period, except in the following cases:
 - 4.31.1. Hospitalization that began within the insurance period defined in Section 1.8.

- 4.31.2. Medical expenses not during hospitalization during a period of up to 90 days as defined in Chapter B.
- 4.32. Hospitalization expenses and/or expenses not during hospitalization that could have been deferred until the return of the Insured to his/her country of origin, as determined by a specialist in the field.
- 4.33. The Insured is medically fit, according to the opinion of a specialist in the field, to return to his/her country of origin for the purpose of receiving medical care.
- 4.34. Medical services provided to the Insured not by means of service providers under agreement with the Insurer.

Chapter C: Riders for Additional Insurance Fees

To eliminate doubt, all the definitions, exclusions and general terms of the Policy also apply to Chapter C.

It is hereby clarified that the undertaking of the Insurer according to this rider shall apply on the condition that the basic insurance and this rider were in effect at the time of the occurrence of the insurance event, as set forth in this rider.

5. Medical Air Transport

If this rider was purchased and this is specified on the List Page, upon occurrence of an insurance event, the Insurer shall compensate the Insured, subject to the terms set forth in this rider below and subject to the general conditions, definitions and exclusions listed in the basic Tour & Care policy ("the Policy") to which this rider is attached.

5.1. Definitions

Medical air transport:

Air transport on a regular aircraft service and/or a special aircraft, accompanied by a medical team suited medically to the condition of the Insured being transported from Israel to a foreign country, on the terms set forth below. This is on the condition that a physician on behalf of the Insurer, in coordination with the attending physician in Israel, determine that there is liable to be need for medical intervention in the course of the flight and on the additional condition that the medical transport is possible and required from a medical point of view.

5.2. The undertaking of the Insurer

Medical air transport - The Insurer will enable medical air transport as defined above, on the condition that this is a case of an event because of which the Insured was entitled to reimbursement of medical expenses under the basic Tour & Care policy and will transport the Insured to a foreign country.

The means of transfer shall be determined by a physician on behalf of the Insurer in coordination with the attending physician in Israel, after receiving information about the medical condition of the Insured and the possibilities for treatment. The liability of the Insurer according to this rider is conditional upon performance of the medical air transport by means of the Insurer and/or an entity acting solely on its behalf.

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

The total maximum undertaking of the Insurer according to this rider shall not exceed \$10,000.

5.3. **Cancellation of the rider:**

The validity of this rider will expire upon the occurrence of one of the following cases, whichever comes first:

- 5.3.1. When the basic Tour & Care policy to which this rider is attached is cancelled for any reason.
- 5.3.2. Upon cessation of payment of insurance fees for the basic policy and/or for this rider, subject to the instructions of the basic policy and subject to the Insurance Contract Law.

5.4. **Miscellaneous:**

This rider is subject to all the terms of the basic Tour & Care policy, including exclusions, to which it is attached and it constitutes an integral part thereof.

6. **Death or Loss of Organs (in Israel only)**

If this rider was purchased and this is specified on the List Page, upon occurrence of an insurance event, the Insurer shall compensate the Insured, subject to the terms set forth in this rider below and subject to the general conditions, definitions and exclusions listed in the basic Tour & Care policy ("the Policy") to which this rider is attached.

It is hereby clarified that the undertaking of the Insurer according to this rider shall apply on the condition that the basic insurance policy and this rider are in effect at the time of the insurance event, as set forth in this rider.

6.1. **Definitions:**

In this rider:

6.1.1. **Accident:**

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

6.1.2. **Loss of organs:**

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

6.2. **The undertaking of the Insurer:**

If there occurred to the Insured in Israel within the insurance period death or loss of organs the direct cause of which was an accident, insurance benefits will be paid as follows:

- 6.2.1. **Death of the Insured** – In the case of death of the Insured **due to an accident**, the beneficiaries, and in the case that no beneficiaries were named – the legal heirs of the Insured or the executors of his/her estate, according to the inheritance order and/or the will probate, will be paid insurance benefits according to the amount specified on

the table of the limits of liability in the Policy on the condition that the Insured was over the age of 18 (inclusive) and up to the age of 75 (inclusive) on the date of the accident.

- 6.2.2. **Loss of Organ(s)** - In the case that an Insured, over the age of 18 and up to the age of 75 (inclusive) at the time of the accident, suffered a loss of organ(s) (as defined in Section 6.1.2 above), he/she will be entitled to the percentage specified in the table of the limits of liability in the Policy. For example, if the Insured suffered the loss of a leg, and the maximum insurance specified is \$10,000, the Insured in this case will receive: $60\% \times \$10,000 = \$6,000$.

An Insured who at the time of the insurance event had not reached the age of 18 years shall be entitled to half of the above-said compensation.

If the Insured had an existing disability prior to the accident event (according to medical documentation), the rate of the existing disability will be deducted from the percentage for loss of an organ for which the Insured is entitled to payment according to this section.

Organ	Organ	Right	Left	
One eye	30%	Arm	75%	65%
Two eyes	100%	Forearm	65%	55%
One ear	20%	Hand	60%	50%
Two ears	50%	Thumb	25%	20%
Leg (above the knee)	60%	Index finger	15%	12%
Thigh	70%	Middle finger	12%	8%
Foot	50%	Ring finger	10%	8%
Big toe	5%	Pinkie finger	12%	10%
Other toe	3%	Knuckle	one-third of the percentage listed above	

The percentages noted in this table refer to 100% loss of the said organ.

Organs that are not listed in the above table - in any case in which loss of an organ/s (as defined in Section 6.1.2 above) occurs, the amount of compensation shall be determined according to the determination of a medical expert in the field and shall be paid as a percentage of the maximum insurance amount specified in the table of limits of liability for the Policy. For example, if the Insured suffered the loss of an organ as defined in Section 6.1.2 above, and the organ is not listed in the above table, and a physician determined that this is a case of 10% disability and the maximum insurance amount listed is \$10,000, the Insured in this case will receive: $10\% \times \$10,000 = \$1,000$.

A disability of the Insured prior to the accident event (according to medical documentation) will be deducted according to the percentage of the existing disability, from the percentage of loss of the organ for which the Insured is entitled to payment according to this section.

The total maximum liability of the Insurer according to this rider shall not exceed \$10,000.

6.3. Exclusions

The Insurer shall not pay insurance benefits according to this rider if the death and/or loss of organs was caused directly or indirectly by or as a result of:

- 6.3.1. Disfigurement (plastic) disability.
- 6.3.2. Earthquake, volcanic eruption, nuclear fission, nuclear fusion, radioactive contamination.
- 6.3.3. Active participation of the Insured in military activity, police activity, underground activity, revolution, rebellion, riots, disturbances, sabotage, terrorism, strike, illegal activity.
- 6.3.4. 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.
- 6.3.5. 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.
- 6.3.6. Deliberate self-inflicted injury or suicide or attempted suicide, whether the Insured is of sane mind or not.
- 6.3.7. Sports activity in the framework of a sports association registered according to the Sports Law 5748 - 1988 and/or competitive sports activity and/or professional sports activity (that constitutes his/her primary occupation or that involves monetary payment).
- 6.3.8. 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).
- 6.3.9. Use of explosives.
- 6.3.10. Mental illnesses, deliberate self-endangerment, with the exception of self-defense and rescue of lives.
- 6.3.11. Alcoholism or drug use by the Insured.
- 6.3.12. Death or disability as the result of medical or surgical treatment.
- 6.3.13. A work accident as defined in the National Insurance Institute Law.
- 6.3.14. If the damage was caused as the result of a hostile act under the Benefits for Victims of Hostile Acts Law, 5730 - 1970.

6.3.15. A road accident, as defined in the Road Accident Victims Compensation Law, 5735 - 1975.

6.4. **Cancellation of the rider:**

The validity of this rider will expire upon the occurrence of one of the following cases, whichever comes first:

6.4.1. When the basic Tour & Care policy to which this rider is attached is cancelled for any reason.

6.4.2. Upon cessation of payment of insurance fees according to the said in the section Cancellation of the Policy, in the general terms of the Policy and subject to the Insurance Contract Law.

6.5. **Miscellaneous:**

This rider is subject to all the terms of the basic Tour & Care policy, including the exclusions, to which it is attached and it constitutes an integral part thereof.

Table of Limits of Liability for the Policy

Main Areas of Coverage	Limits of Liability
Limit of liability for policy	\$100,000
Medical expenses during hospitalization	Up to 90 days
Medical expenses not during hospitalization	
Treatment, consultation with physician	Included in the limits of liability
Laboratory tests, bandaging, X-rays	Included in the limits of liability
First aid at a Magen David Adom station	Included in the limits of liability
Medications	\$200
Expenses for transport by ambulance	Included in the limits of liability
Emergency dental treatment	\$200
Transportation of a corpse	\$5,000
Part C: Riders for Extra Insurance Fees	
Medical air transportation	\$10,000
Death or total loss of organs due to an accident event (up to age 18 , half the amount)	\$10,000

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

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