Maccabi Long Term Care

LTC insurance for members of Maccabi Health Services

1.7.2016

Maccabi LTC

Clal Insurance **Maccabi**

The best Health Services in Israel

Greetings,

Maccabi Health Services acts at all times for the health of its members, and sees in nursing care insurance an important addition which guarantees their future and security. As we know, ADL-dependency does not depend on age and constitutes an emotional and economic burden for the insured and the members of his or her family. We at Maccabi do our best in order to help members cope with these situations, and congratulate you on your decision to be insured with "Maccabi LTC" - the group nursing care insurance for Maccabi members.

On 1st July 2016 new Regulations issued by the Capital Markets, Insurance and Savings Division of the Ministry of Finance come into force, which delineate the rights of persons insured under a uniform group nursing care insurance policy in all Health Funds in Israel.

The new Regulations, which apply to all persons covered under a Health Fund group nursing care insurance policy, stipulate the eligibility requirements for receipt by ADL-dependent patients of a monthly payment according to the age at which the insured joined the policy and the rights of the insured who wishes to move from one Health Fund to another.

For your convenience, attached herewith is a copy of the up to date policy for Maccabi members which specifies the rights of insured members in accordance with the Regulations. It is clarified that all Maccabi members insured under the Fund's group nursing care policy on 30th June 2016 shall automatically be covered by the terms of the new nursing care policy, without needing to fill out an application form or health declaration.

From 1st July 2016 to 30th June 2017 Clal Insurance Company Ltd shall continue to provide the group nursing care insurance to Maccabi members, under the terms of the uniform policy and in accordance with the new Regulations. Upon the expiry of this period, the nursing care insurance of Maccabi members shall pass to an insurer which shall be chosen by Maccabi within the framework of a tender.

Maccabi shall continue to do all it can in order to obtain for those of its members covered by nursing care insurance the best terms available and to promote the rights of all its members.

Wishing you good health,

Kobi Levy (-)

Director of Additional Health Services and Insurance

Maccabi Health Services

Dear Customer,

We congratulate you on joining Clal Insurance's Nursing Care Policy for Maccabi Health Services Members.

Clal Insurance operates in Israel and worldwide and offers a range of insurance and savings products to its private and business customers. The professionalism, personal attention, strength and solidity of Clal Insurance's Health Division, guarantees that you shall always be in good hands.

I am pleased to present you with this booklet which provides comprehensive information about the Nursing Insurance Plan for Maccabi Health Services members.

In order to be enable us to provide you with the best service, we have placed at your disposal a "Maccabi LTC" designated service center, the phone number of which is 1-700-505-520. You may also obtain the information by visiting the Company's website at: www.clal.co.il or the Leumit website at: www.leumit.co.il.

We shall be at your service to answer any question or request and wish you and the members of your family good health and longevity.

Daniel Cohen

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Health Division Director

Clal Insurance Company Ltd

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For the avoidance of doubt, should there be any discrepancy between them, the contents of the relevant original document in the Hebrew language shall override the translated material.

Summary of General Details Regarding the "Maccabi LTC"

Group Nursing Care Insurance Policy for Maccabi Health Services Members

(Pursuant to the "Proper Disclosure" Regulations)

Subject	Paragraph	Terms
General	1. Name of the policyholder	Maccabi Health Services (**"Maccabi"**)
	2. The insurer	Clal Insurance Company Ltd
	3. Coverage under the policy	ADL-dependent hospitalization - Monthly indemnification with respect to the costs of the insured staying in a nursing care institution or permanent monthly compensation for an insured who resides at home.
	4. Duration of the insurance	From 1st July 2016, or if later, from the date on which the insured in question joined the policy, until 30th June 2017.
	5. Continuity	The insured shall be given a right to insurance continuity under the terms set out in paragraph 6 of the policy. An insured under this policy who satisfies the conditions specified hereinafter shall be entitled to transfer to an individual nursing care policy for a period of insurance spanning the rest of his life (**"continuation policy"**), according to the specified dates: 1. The amount of the insurance and the period of paying the insurance benefits under the continuation policy shall not be less than those stipulated for the insured in the nursing care insurance policy for Health Fund members, unless the insured requested this; however, should the Health Services Basket cover which existed at the time of the transfer to the continuation policy be similar to the cover specified in the policy, the insurer shall not be obliged to include the aforementioned cover in the continuation policy; in this regard, **"the Health Services Basket"** shall have the same meaning given to it in the Second Schedule of the Health Insurance Law and the Order made under paragraph 8(g) of that Law 2. The premium payable for the continuation policy shall not exceed the premium which was being charged on the date of the transfer for new participants in a similar individual policy with the insurer; an insured transferring to the continuation policy shall receive a discount on premiums of at least 20% compared to the premiums charged by the insurer at the start of the insurance period under the continuation policy in relation to all those insured with it under a similar policy. This discount shall apply for the entire duration of the continuation policy. 3. During the transition to the continuation policy insurance continuity shall be provided without reevaluation of a preexisting medical condition and without a qualifying period. The entitlement to transfer to a continuation policy as aforesaid, shall be given to whoever has been continuously insured under a nursing care policy for Health Fund members including the previous policy, for a period of at least one year immediately prior to the date on which nursing care insurance for Health Fund members ended, provided that one of the following conditions which are specified in the policy has been satisfied and the insured had not already realized his full rights under the Health Fund members nursing care policy: 1. The Health Fund nursing care insurance ended because the policy was not renewed for some or all of the insured, whether with the insurer or another insurer. 2. The insured's registration with a Health Fund was cancelled under the National Health Insurance Law and he was not registered with another Health Fund. However, until 1st January 2017, the condition of the insured not being registered with another Health Fund shall not apply. An insured in relation to whom this insurance was terminated or is not being renewed in his case as aforesaid, may transfer to the continuation policy within 60 days from the date on which the insurer informed him of this.

General		The period of the continuation policies shall commence retroactively from the date on which this policy ended. Notwithstanding the foregoing, with regard to an insured who on the date on which his Health Fund nursing care insurance was terminated or not renewed was entitled to receive insurance benefits under the terms of the policy, the insurer shall notify the insured as stated in the same subparagraph within 30 days from the date on which the insured's rights to the insurance benefits expired; in the aforementioned notice, the insurer shall offer the insured a transfer to the continuation policy within 60 days from the date of the insurer's notice; an offer as aforesaid, shall only be made if the insured in question has not yet exercised his full rights to receive insurance benefits under the Health Fund nursing care insurance policy.
	6. Automatic renewal conditions	None.
	7. Qualifying period	None.
	8. Waiting period	60 days.
	9. Excess	None. With regard to the insurance benefits ceiling see paragraph 7 of the policy.
Change of terms	10. Changing terms of the policy during the insurance period	As specified in paragraphs 21.1-21.3 of the policy.
Insurance payment	11. Amount and structure of premium	As described in the Premium Variation Table on page 25 of this booklet. Insurance premiums vary in accordance with the age group to which the insured belongs, and are linked to the consumer price index as specified in the policy.
	12. Change of premium during the insurance period	As specified in paragraphs 21.1-21.3 of the policy.
Cancellation terms	13. Conditions for cancellation of policy by the policyholder or the insurer	Neither the insurer nor the insured may cancel the policy during the insurance period other than in the following cases, in which case the insurance shall be cancelled subject to the provisions of the Insurance Contract Law, 5741-1981: • The insurance fees (premiums) were not paid on time. • As a result of non-disclosure by the insured of a material fact knowledge of which could have induced the insurer to deny him insurance cover And likewise the case referred to in paragraph 21.2 of the policy. The insured may cancel the policy at any time by an instruction in writing
Exclusions	14. Exclusion due t o existing medical condition	As set out in paragraph 10.4 of the policy
	15. Exclusions to the insurer's liability	. As set out in paragraphs 10.1-10.3 and 10.5-10.7 of the policy.
Supplements to nursing care insurance	16. Definition of insurance event	A poor state of health and impaired ability to function resulting from an illness, accident or ailment because of which the insured cannot carry out on his own a substantial part (at least 50%) of 3 or more of the 6 activities specified in paragraph 4.2 of the policy, or a poor state of health and impaired ability to function which is attributable to "cognitive impairment" as defined in paragraph 4.1 of the policy and determined by a mental health specialist.
	17. Period for payment of insurance	Up to a maximum of 60 months.

	benefits	
	18. Type of insurance benefits	Indemnification - wit respect to an insured who resides in a nursing institution. Compensation - with respect to an insured who resides at home.
Supplements to nursing care insurance	19. Amount of monthly insurance benefit	**In the case of an insured who joins from 1st July 2016:** The monthly insurance benefit for an insured residing at home (compensation): • First joined up to the age of 49 - NIS 5,500 • First joined between the ages of 50 and 59 - NIS 4,500 • First joined from the ages of 60 or older - NIS 3,500 The monthly insurance benefit for an insured staying in an institution (indemnification): • First joined up to the age of 49 - 80% and not more than NIS 10,000. • First joined between the ages of 50 and 59 - 80% and not more than NIS 6,500. • First joined from the ages of 60 or older - 80% and not more than NIS 4,500. **In the case of an insured who joined the previous policy up to 30th June 2016 and transferred to this policy sequentially:** If he had been a member of the Gold Nursing Care Plan: • For an insured residing at home - a monthly insurance benefit of NIS 5,500 (compensation). • For an insured staying in an institution - monthly insurance benefit of 80% and no more than NIS 10,000 (indemnification). If he had been a member of the Silver Nursing Care Plan: For an insured residing at home - a monthly insurance benefit (compensation): • First joined up to the age of 49 - NIS 5,500 • First joined when over the age of 50 - NIS 4,500 The monthly insurance benefit for an insured staying in an institution (indemnification): • First joined up to the age of 49 - 80% and not more than NIS 10,000. • First joined when over the age of 50 - 80% and not more than NIS 6,500.
	20. Exemption from payment of premium	Exists.
	21. Premium scale	As set out in the Premium Variation Table on page 25 of this booklet
	22. Insured's rights with respect to premium increases	None
	23. Disposal value	None.
	24. Linkage between insurance sum and age of the insured	There is no connection between the amount of the insurance benefits and the age of the insured at the time of the event. A connection does exist between the age of the insured at the time when he first joined the Health Fund policy and the amount of the insurance, as detailed in paragraph 19 above.
	25. Setting off of benefits against other insurances	There is no setoff with respect to any nursing care benefit or service provided by the State, including under the National Insurance Law. In the case of other third party liability – in accordance with the provisions of the Insurance Contract Law.

Kindly note - On the insurer's website, the address of which is www.clal.co.il, you will find the rules for determining entitlement to nursing care benefit., the tests for defining inability to carry out 50% of all ADL activity, a sample functional assessment form, and a link to the Purchaser's Guide to Nursing Care Insurance which is published on the Insurance Commissioner's website. You are entitled to receive the Purchaser's Guide to Nursing Care Insurance by calling the Maccabi LTC Center, which shall be at your service to answer any query, on 1-800-505-520.

A claim may be filed by filing out the forms which are available on the insurer's website - www.clal.co.il. and sending them by fax to 077-6383119 or by post to the following address: POB 37190 Tel Aviv, Postcode 6137002

The binding terms are the full policy terms.

For the avoidance of doubt, should there be any discrepancy between them, the contents of the relevant original document in the Hebrew language shall override the translated material.

"Maccabi LTC" Group Long Term Care Insurance Policy for Members of Maccabi Health Services

1. Introduction

This policy attests to the fact that in return for payment of the premiums and subject to the terms, conditions and exceptions detailed below, the insurer will provide the eligible insured with a nursing benefit. The nursing benefit shall be given with respect to an insurance event which occurred during the insurance period in accordance with this policy, its terms and conditions.

2. General Definitions

In this policy and in any exhibit attached to it the following terms shall have the meanings appearing alongside them:

2.1 **"The insurer"**: Clal Insurance Company Ltd (hereinafter: **"the Company**').

2.2 **"The policyholder"**: Maccabi Health Services Ottoman Society No. 227/99 (hereinafter: **"Maccabi"** and/or **"Maccabi Health Services"**).

2.3 **"Maccabi Shield"** : Maccabi Shield - Cooperative Society for Mutual Insurance Against Illnesses Ltd.

2.4 **"Member of Maccabi Healthcare Services"** or **"Maccabi member"**: a person who is registered and entitled by law and/or according to the provisions set out in the Maccabi Regulations to receive healthcare services from Maccabi.

2.5 **"Child"**: A Maccabi member who is under the age of 18.

2.6 **"The Nursing Fund"**: A nursing cover plan for members of Maccabi Healthcare Services who joined and/or were joined to it prior to the commencement date of this policy, according to the Regulations of the above Fund, as members of the Maccabi Shield Society. The above nursing cover is comprised of two plans: the "Silver Shield" and the "Gold Shield", and anyone who joined one of the above plans.

2.7 **"The previous policy"** - A group nursing care policy provided by the previous insurer to members of Maccabi Health Services on 30th June 2016.

2.8 **"The Insured**" - a person who satisfied one of the following conditions:

1. **Existing insured** - A member of Maccabi Health Services who had been insured under the previous policy on the eve of the determining date.
2. **New insured -** A Maccabi member who on the eve of the determining date was not insured under the previous policy and who

the insurer agreed to insure after the determining date.

For the avoidance of doubt, it is clarified that all persons insured under this policy are insured individually, without any connection to the insurance or lack of insurance of their spouses or parents, and that the policy shall not be revoked with regard to those insured under it in the event of the death or divorce of their spouses or the revocation of the insurance of the parents of an insured child.

2.9 **"Nursing care benefits":**

1. Nursing home hospitalization: Indemnification of the insured against expenses actually incurred by the insured or his representative with respect to staying in a nursing institution as specified in paragraph 7 below.
2. Domestic nursing care: The provision of compensation. as specified in paragraph 7 below.

2.10 **"The nursing care benefits ceilings"**: As set out hereinafter in paragraph 7 below.

2.11 **"The waiting period":** As set out hereinafter in paragraph 8.

For the avoidance of doubt, with regard to this period, the insured shall not be entitled to receive nursing care benefits following an insurance event, although he shall be obliged to pay the premiums.

2.12 **"Premium":** The premium which the insured is obliged to pay under the terms of the policy.

2.13 **"Institution"** - A department in a nursing home, hospital or other institution for nursing care dependent or mentally frail patients which specializes in-patient treatment for ADL-dependent patients and which has been approved as a nursing care institution by the Ministry of Health under the Public Health Ordinance or by the Ministry of Welfare and Social Services, or another institution which the insurer has approved.

2.14 **"The insurance commencement date"**: With regard to existing insured as defined in paragraph 2.8.1 above, who transferred sequentially from the previous policy - on the determining date as defined hereinafter.

With regard to new insured as defined in paragraph 2.8.2 above (excluding a "transferring insured") on 1st of the month following the date on which participation in this policy was renewed as specified hereinafter in paragraph 4.2.1.

In the case of a "transferring insured" - From the date on which cover ended under the policy of the previous Fund.

2.15 **"The determining/commencement day/date"**: 1st July 2016.

2.16 **"Application to join"**: An individual application form to join this insurance, including a health declaration, which constitutes an integral part of the policy and which was filled out and signed by a Maccabi member who wishes to be insured under this policy.

2.17 **"The Adjudication of Interest Law"**: The Adjudication of Interest and Linkage Law, 5721-1961.

2.18 **"Age at which the insured first joined LTC insurance for Health Fund members"** : The age at which the insured joined a long term care insurance policy for members of any Health Fund, since which time he has been continuously insured, including continuity which was preserved upon switching from one Health Fund to another under paragraph 18 below. **Notwithstanding the foregoing, until 1st January 2017 "Macabbi Health Services" only shall be inserted instead of "any Health Fund"**, and **"transfer from the previous policy to the new policy"** shall be inserted instead of **"transfer from one Fund to another under paragraph 18 below"**.

2.19 **"Transferring insured"**: A person insured under a Health Fund nursing care policy who on the eve of moving to another Health Fund had been insured under a nursing care policy for Health Fund members, and all as from 1st January 2017, apart from in relation to the provisions of paragraphs 18.1.1 and 18.1.2.

2.20 **"Eligible insured"**: As defined in paragraph 1 of the Regulations.

2.21 **"Previous Fund"**: A Health Fund which an insured was registered with on the eve of moving to another Health Fund.

2.22 **"Nursing care insurance for Health Fund members"** - Group nursing care insurance which was arranged for members of a Health Fund, under a different policy in which in which one or more Health Funds hold the policy for their members. **Notwithstanding the foregoing, until 31st December 2016 "Health Fund" shall be replaced with "Maccabi Health Services" only.**

3. "The Insurance Event"

An insurance event is the occurrence of one or more of the following events:

(a) "Cognitive impairment as determined by a mental health specialist; in this regard, **"cognitive impairment"** - diminished cognitive activity and intellectual ability of the insured, including impaired understanding and judgment, his long term or short term memory and disorientation in place and time to the extent that according to the

determination of a mental health specialist he requires supervision during most hours of the day, due to a disorder such as: Alzheimer or various forms of dementia.

(b) A deterioration in the insured's state of health and ability to function due to an illness, accident or disorder, as a result of which he is unable to carry out independently a substantial part (at least 50%) of at least 3 of the following activities:

1. **Getting up and laying down** - The independent ability of an insured to move from a laying position to a sitting position and to get up from a chair, including a wheelchair or bed;
2. **Dressing and undressing** - The independent ability of an insured to dress himself in items of clothing of any kind and to undress, including the fastening or assembly of a medical belt or artificial limb;
3. **Bathing** - The independent ability of an insured to wash himself in a bath, shower or in another acceptable manner, including to enter and exit from a bath or shower;
4. **Eating and drinking** - The independent ability of an insured to feed himself in any way or by any method, other than through a straw, but including drinking through a straw, after the food has been prepared for and served to him;
5. **Continence** - The independent ability of an insured to control his bowels and bladder functions; a lack of control over either of these functions manifesting itself, for example, in the permanent use of a stoma, a bladder catheter, nappies or various kinds of absorbent towels, shall be regarded as inability to control bowel or bladder function.
6. **Mobility** - The independent ability of an insured to move from place to place unassisted; an insured shall not be regarded as substantially mobility-impaired if he is dependent upon crutches, a walking stick, walking frame, wheelchair or any other accessory including mechanical, motorized or electronic accessories which enable him to move around freely.

4. Validity of the policy

4.1 **Members who were included in the previous policy**:

An insured who on the eve of the determining day was insured under the previous policy shall be transferred sequentially without a health declaration, and without re-underwriting or a reexamination of his previous medical condition and shall be insured under this policy from the determining day, according to the rights stipulated in this policy, the age when the insured first subscribed to the nursing care insurance for Health Fund members, and the program which the insured had in the previous policy ("Nursing Silver" or "Nursing Gold") and all as described in paragraph 7, apart from an insured as aforesaid in relation to whom an insurance event existed on the determining day under the previous policy.

4.2 **New insured:**

A Maccabi member who joined this insurance policy on or after the determining day shall be insured within the framework of this policy, as detailed hereinafter:

4.2.1 The date of joining under this policy shall be the 1st of the month following the month in which the member joined. This date shall constitute the start of insurance cover for the insured under the policy.

4.2.2 An infant who was born or joined as a Maccabi member until the age of 12 months, shall automatically be covered by this policy. The Insurer shall send a letter through Maccabi to the newborn infant's parent and/or lawful guardian through Maccabi, informing him that the infant has been included in the insurance. The aforementioned letter shall point out the paragraphs in the policy which concern the scale of cover of newborn infants, and the exceptions set out in the paragraph 10.6 of this policy.

4.2.3 Should an application by an insurance candidate o join the insurance under this policy be denied by the insurer, the applicant can appeal against the rejection decision within 60 days of the date of receiving the decision. The appeal shall be heard before the Insurance Application Appeals Committee, which is to be set up and convene from time to time.

4.2.4 Notice of the insurer's decision to reject the insured's application to join the policy shall be given by the insurer to each insurance applicant, as well as to the policyholder. Decisions of the Appeals Committee shall also be given to each insurance applicant and the policyholder.

4.2.5 Should an insurance applicant not receive an answer to an application to join which had been submitted by him, after submitting a health declaration and all other medical and evidentiary material required by the insurer, within 60 days of the date on which the said documents were received by the insurer, he will be automatically be insured from the insurance commencement date as defined in paragraph 2.14 above, under the regular conditions and without any exceptions.

4.2.6 A transferring insured: Notwithstanding all of the foregoing, from 1st January 2017, the insurance commencement date in the case of a "transferring insured" shall be the date on which the insurance with the previous Fund ended. From the aforementioned date, a transferring insured may join this policy without a health declaration, subject to the Regulations and the conditions stipulated therein.

5. The Insurance Period

5.1 The insurance period under this policy in relation to every insured shall commence on 1st July 2016 or, if later, on the date on which the insured in question joined the policy, and shall expire on 30th June 2017.

5.2 Should the policy not be renewed by the insurer or the policyholder, the insurer shall only be obliged to provide cover under the policy vis-à-vis an insurance events which had occurred during the insurance period , the claim regarding which was filed before the end of the limitation of actions period specified in paragraph 17 below.

6. Right to insurance continuity through an individual policy

6.1 An insured under this policy who satisfies the conditions specified in paragraph 6.2 below, shall be entitled to switch to an individual nursing care insurance policy providing lifelong cover (**"continuation policy"**), within the time period specified in paragraph 6.3 below, the terms of which shall be as follows:

1. The amount of the insurance and the period during which the insurance benefits shall be paid under the continuation policy, shall not be less than those granted to an insured under a Health Fund members nursing care policy, unless the insured requested this; however, if at the time of transition to the continuation policy, the cover provided by the Health Services Basket shall be similar to the cover specified in the policy, the

insurer shall not be obliged to include the aforementioned cover in the continuation policy; in this regard, **"the Health Services Basket"** shall be as described in the Second Schedule to the Health Insurance Law and the Order issued pursuant to paragraph 8(g) of that Law;

2. The premiums under the continuation policy shall not be higher than the premiums being charged during the changeover period to new participants in a similar individual policy with the insurer;

3. During the transition to the continuation policy, insurance continuity shall be provided without a reevaluation of a preexisting medical condition and without a qualifying period.

6.2 The entitlement to switch to a continuation policy as stated in paragraph 6.1, shall be given to whoever has been continuously insured under a nursing care policy for Health Fund members for a period of at least one year immediately prior to the date on which the nursing care insurance for Health Fund members ended, provided that one of the following conditions which are specified hereinafter in the policy has been satisfied and the insured had not already realized his full rights under the Health Fund members nursing care policy:

1. The Health Fund nursing care insurance ended because the policy was not renewed for some or all of the insured, whether with the insurer or another insurer.

2. The insured's registration with a Health Fund was cancelled under the National Health Insurance Law and he was not registered with another Health Fund. However, until 1st January 2017, the condition of the insured not being registered with another Health Fund shall not apply.

6.3 An insured in relation to whom this insurance was terminated or is not being renewed in his case as stated in paragraph 6.2 above, may switch to the continuation policy within 60 days from the date on which the insurer informed him of this.

6.4 The period of the continuation policies shall commence retroactively from the date on which this policy ended.

6.5 Notwithstanding the provisions of paragraph 6.3 above, with regard to an insured who on the date on which his Health Fund nursing care insurance was terminated or not renewed was entitled to receive insurance benefits under the terms of the policy, the insurer shall notify the insured as stated in the same subparagraph within 30 days from the date on which the insured's rights to the insurance benefits expired; in the aforementioned notice, the insurer shall offer the insured a transfer to the continuation policy within 60 days from the date of the insurer's notice; an offer as

aforesaid, shall only be made if the insured in question has not yet exercised his full rights to receive insurance benefits under the Health Fund nursing care insurance policy.

7. The Amount of the Insurance Benefits

7.1 The amount of the monthly insurance benefit to which the insured is entitled, shall be calculated according to his age on the date on which he first joined the Health Fund members nursing care insurance policy and the place where the insured resides during the period with respect to which he is being paid the benefit, as set out in the following table:

Place where the insured resides	**Age at which first joined the Health Fund members group nursing care insurance policy**		
	Up to 49	**50-59**	**60 and over**
Monthly insurance benefit for an insured residing at home (compensation)	NIS 5,500	NIS 4,500	NIS 3,500
Monthly insurance benefit for an insured staying in an institution (indemnification):	NIS 10,000	NIS 6,500	NIS 4,500

7.2 Notwithstanding the provisions of paragraph 7.1, the amount of the insurance benefit which shall be paid to an insured who was staying in an institution on the date when he became entitled to the monthly insurance benefit shall not exceed 80% of the sum which the insured actually paid to that institution.

7.3 Notwithstanding the provisions of paragraph 7.1, in the case of the categories of existing insured set out below, instead of "Age at which first joined the Health Fund members group nursing care insurance policy", which is specified in the above Table, the age shall be referred to as written next to them:

7.3.1 An insured under a group nursing care policy for members of the Maccabi Health Services Health Fund –

7.3.1.1 If he joined the "Gold Nursing" insurance plan from the age of 49-50;

7.3.1.2 If he joined the "Silver Nursing" from the age of 59-60;

From 1st January 2017 the following provisions shall also apply:

7.3.2 An insured under the "Nursing Care Mushlam Plus" nursing policy for members of Clalit Health Services, who joined the policy from the ages of 60 to 64 -59;

7.3.3 An insured under a nursing care policy for members of Meuhedet Health Fund, who joined "Meuhedet Gold" between the ages of 50 to 65 - 49;

7.3.4 An insured under a nursing care policy for members of Leumit Health Fund who had joined "Leumit Nursing" from the age of 60 to 64 -59.

In accordance with the provisions of paragraph 7.3.1 above, existing insured as defined in paragraph 2.8.1 above shall be entitled to the following nursing care :

Program within the previous policy	**Age when joined Maccabi Group Nursing for first time**	**Monthly insurance benefit for an insured who resides at home (compensation)**	**Monthly insurance benefit for an insured who stays in an institution (indemnification)**
Gold Nursing	Any age	NIS 5,500	80% of the sum which the insured actually paid to the institution and not more than NIS 10,000
Silver Nursing	Up to age 49	NIS 5,500	80% of the sum which the insured actually paid to the institution and not more than NIS 10,000
	Aged 50 and over	NIS 4,500	80% of the sum which the insured actually paid to the institution and not more than NIS 6,500

7.4 **Age**

The insured's age for the purpose of determining premiums and the initial joining age shall be calculated in complete years according to the number of complete years which have elapsed since the month in which the insured was born.

7.5 **Method of paying insurance benefits to an insured who is staying in an institution**

7.5.1 The insurance benefits under paragraphs 7.1-7.3 above shall be paid upon presentation of original receipts by the insured or his representative, together with a tax invoice as required by law, for payment of the actual expenses of hospitalization in the nursing institution. A copy of receipts or invoices as aforesaid may be submitted, if accompanied by an explanation regarding who the original documents

were sent to and a letter from the person who received them confirming the sum which had been paid with respect to those documents or an explanation regarding who the original documents were sent to and why he cannot produce them.

In accordance with the foregoing, should the insured submit a request to another party for payment of all or part of any sum which is attributable to an insurance event, he shall submit a copy together with a letter from that party confirming the sum which he had demanded and which had been paid with respect to the documents in question. In such a scenario, the insurer shall indemnify the insured in accordance with the provisions of the Insurance Contract Law, 5741-1981, provided that the total indemnification paid to the insured shall not exceed the lower of the following two sums:

A. The insured's total expenses in practice.

B. The amount of the indemnification payable to the insured as specified in this policy.

7.5.2 The indemnity shall be forthcoming whenever the expenses were actually paid before the date of the indemnity. The indemnity shall be paid to the insured or his lawful representative.

7.5.3 The insurance benefits shall be paid by the 15th of each month with respect to the previous month, subject to the insurer's approval of the receipts or invoices upon the strength of which the indemnity is being provided and the provisions of paragraph 9.3 below.

8. Waiting Period

The insurer shall pay the insured the insurance benefits to which he is entitled under the terms of the policy from the date on which the waiting period ends; not more than one waiting period shall be counted unless more than 12 months elapsed since the date on which an insurance event ceased to exist in relation to it; for the purposes of this paragraph, **"waiting period"** - a period beginning on the date on which the insurance event occurred and ending 60 days thereafter, provided that during the entire period an insurance event exists in relation to the insured.

9. Nursing Benefits - General

9.1 Subject to the terms of the policy, an insured shall be entitled to receive insurance benefits as long as he satisfies the conditions specified in paragraph 3.

9.2 Notwithstanding the provisions of paragraph 9.1, an insured shall be entitled to receive insurance benefits for a period of 60 months , beginning from the end of the waiting period as described in paragraph 8 (above and hereinafter: **"the eligibility period ceiling"**), under the policy during the period of which the insurance event occurred and subject to the provisions of paragraphs 18.1.1 and 18.1.2, after deduction of the periods during which he received insurance benefits under a nursing insurance policy for Health Fund members.

9.3 Nursing benefits from the Insurer shall be paid to the insured within 30 days of the date on which the insurer received the information and documents required for clarifying its liability.

9.4 The nursing benefits under this policy are given in addition to and independently of any nursing benefit or nursing service which are or shall be given to the insured by another entity, including the State, with respect to the insurance event, including under the National Insurance Law [Consolidated Version], 5755 – 1995, excluding a situation in which insurance benefits are paid to an insured who is staying in an institution, in which case the provisions of paragraph 7.5.1 above shall apply.

9.5 Should the insured be entitled to receive nursing benefits during part of a month, the nursing benefits ceiling shall be applied proportionately according to the ratio of that part the whole of the month.

9.6 It shall not be possible to accumulate entitlement to nursing benefits for indemnification in a nursing institution under paragraph 7 by the insured not utilizing them in a particular month up to the nursing benefits ceiling, in order to enlarge the insured's nursing benefits given under another month. The provisions of this paragraph shall equally apply to parts of a month, *mutatis* mutandis.

9.7 The periods during which the insured received nursing benefits, which under this policy or under a nursing policy for Health Fund members, including the previous policy and the Nursing Fund, are cumulative periods and in any event shall not cumulatively exceed the eligibility period ceiling for nursing benefits .

9.8 Should a guardian have been appointed by the court for an insured who is entitled to nursing benefits under this policy, then the insurer shall pay the insurance benefits to the guardian who was appointed as aforesaid.

9.9 The insured's entitlement to receive nursing benefits shall end on the date when the insurance event ceases to exist, or when the nursing benefits entitlement ceiling has

been reached or on the death of the insured, whichever of them occurs first. If the insured dies during the period of entitlement, the nursing benefits shall be paid to his estate as stated in paragraph 9.11 below.

9.10 **Death of the insured** - Should the insured die at a time when he was entitled to receive nursing benefits and had not reached the eligibility period ceiling for nursing benefits, the insurer's estate shall report this to the insurer. Should the insured die, his estate shall be paid the full monthly nursing benefits for the month in which he died.

9.11 **Release from payment of premiums -** An insured shall be released from having to pay premiums during a period in which he is in receipt of nursing benefits. It is agreed is that the insurer shall inform the insured or his representatives of his exemption from payment of insurance premiums immediately upon payment of the nursing benefits, and shall also inform the policyholder of this fact. It is emphasized that during the waiting period the insured shall also be required to pay the insurance premiums.

For the avoidance of doubt, should the insurer stop paying nursing benefits to the insured before the eligibility period ceiling has been reached, the insured's obligation to pay insurance premiums shall be renewed from the date on which his entitlement to a nursing allowance came to an end. The Insurer shall be obliged to give notice that premium payments have been resumed both to the insured and/or his representatives and to the policyholder.

9.12 **Rescission of the policy upon expiry of the nursing benefit payment period -** Upon the expiry of the nursing benefit payment period, the policy shall be rescinded in relation to the insured in question, and he shall not be entitled to any further sum or service under this policy.

10. No cover shall be provided under this policy for an insurance event which occurred:

10.1 as a result of service in a security force or Police unit, or participation in military or Police operations, combat or hostile activities;

10.2 as a result of nuclear fission, nuclear fusion or radioactive contamination;

10.3 as a result of using or addiction to drugs, unless the drugs were prescribed by a physician other than for the purpose of rehabilitation from drug addiction;

10.4 as a result of a preexisting medical condition, subject to the provisions of the Control of Insurance Business Regulations (Conditions in Insurance Contracts)(Provisions regarding a Preexisting Medical Condition), 5764-2004; with regard to this paragraph an eligible insured shall be regarded as insured under a replacement contract with the

same insurer or another insurer as specified in paragraph 6(a)(2) of the aforementioned Regulations;

10.4.1 "Preexisting medical condition" shall mean - a set of medical circumstances which were diagnosed in the insured before the date on which the insured joined the policy, including as a result of an illness or accident; in this regard "diagnosed in the insured" - by a documented medical diagnosis or a documented medical diagnostic process which was made or took place in the six months which preceded the date on which the insured joined the policy.

10.4.2 Application of the preexisting medical condition exclusion- This exclusion with regard to an insured who was less than 65 years of age when the insurance period began, shall apply for a period of one year from the start of the insurance period. With regard to an insured who was 65 years of age or older when the insurance period began, the exclusion shall apply for a period of six months from the start of the insurance period.

10.4.3 Application of the specific medical condition exclusion for a particular insured - Notwithstanding the foregoing, in the event of a particular medical condition recorded in relation to a particular insured due to medical underwriting carried out for the insured, the Insurer's liability shall be excluded or the scope of the cover shall be reduced for the period stipulated in the policy schedule in relation to that medical condition.

10.4.4 Non-application of the exclusion- Where the insured informed the insurer about his preexisting condition in his health declaration and the insurer did not expressly exclude cover with respect thereto, this **exclusion shall not apply.**

10.5 **An insurance event which occurred before the start of the insurance period or after the expiry of the insurance period, subject to the provisions of paragraphs 18.1.1 and 18.1.2 below;**

10.6 **An insurance event which occurred initially during the first 36 months of the insured's life;**

10.7 **An insurance event which occurred as a result of a road accident, as defined in the Road Accident Victims Compensation Law, 5735-1975 or a work accident as defined in the National Insurance Law [Consolidated Version], 5755-1995 and recognized as such by the National Insurance Institute.**

11. The Claim

11.1 The insured shall inform the insurer of the occurrence of an insurance event, as close as possible to the date on which it occurred.

11.2 The insured or his representative shall be exclusively responsible for and entitled to submit and establish a claim. It is hereby clarified that the policyholder may not and shall not submit a claim to the insurer under this policy, either on its own initiative or on behalf of the insured.

11.3 The insured shall submit to the Insurer all the documents which it requires in order to clarify its liability under this policy, and shall sign a waiver of confidentiality to enable the insurer to obtain both medical information and functional information about the insured. In its sole discretion, the insurer will be entitled, at its expense, in a reasonable manner, and within a reasonable period of time as agreed upon between it and the policyholder, to carry out any action and to have the insured undergo functional and/or medical testing by a physician or other medical service provider acting on its behalf. These obligations apply to the insured both before approval of the claim and throughout the entire period in which he is entitled to receive nursing benefits.

11.4 An insured who does not receive a response to a claim within 60 days of filing it by himself and/or through his representative, despite having submitted all necessary medical and/or other documents to the insurer which were required as aforesaid, and having agreed to undergo a functional assessment or other medical examination should he be required to do so, or within 45 days of undergoing a functional assessment as aforesaid, shall be regarded as having proved his entitlement under the terms of this policy and to the cover which it provides.

11.5 Functional evaluation of the Insured shall be carried out by the insurer or by a person acting on its behalf, after coordination with the insured or his representative.

11.6 The insured shall be obliged to inform the insurer immediately should his condition improve to the point where he is no longer entitled to benefits under the policy.

11.7 Should the insured die without having nominated another person to receive the nursing benefit under the policy on his behalf, the insurer shall pay to his estate the balance of the nursing benefit which ought to have but had not been paid to the insured during a period in which he had been entitled to receive it.

11.8 Should a nursing benefit have been paid to the insured and/or to his estate during a period in which he was not entitled to it, whether due to an improvement in his condition and/or due to his death as aforesaid, then the insurer shall be entitled to

reimbursement. The aforementioned sums shall be returned to the insurer together with linkage differentials but without interest.

12. Appeal committees

12.1 Should an insured's claim for receipt of nursing benefits be fully or partially denied, for medical and/or other reasons, he shall be sent a notice by the insurer setting out the reasons for its decision and advising him of his right to lodge an appeal with the Appeal Committee within 60 days of the date on which he was served with the notice.

12.2 The Insured shall be entitled to submit documents and a medical and functional opinion to the Appeal Committee as he sees fit, or as requested by the Committee. In addition, the Committee shall permit the insured and/or his representative to appear before it.

12.3 The Insurer shall forward to the Committee all the material in its possession relating to the claim, whether given to it by the insured or obtained through another source.

12.4 The Appeal Committee shall be authorized to discuss the claim, and to allow or deny it in accordance with the terms of the policy.

12.5 The Appeal Committee's decisions shall be by majority vote. In the event of a tied vote, the Director of Maccabi's Insurance Department or a person appointed by Maccabi's CEO shall have the right to determine the matter, and his decision shall be final, peremptory and binding on the insurer.

12.6 The Insurer shall be bound by the Appeal Committee's ruling, which for all intents and purposes shall be regarded as the insurer's decision.

12.7 A referral to or ruling by the Appeal Committee shall not prejudice the rights of the insured to apply to the courts for judicial clarification of his entitlement under the policy.

12.8 For the purposes of this paragraph, "Appeals Committee" shall mean a committee comprised of three representatives of the policyholder and three representatives of the insurer, while four of them - two from each party - shall constitute a quorum; and the Committee's *modus operandi* shall be agreed between the policyholder and the insurer. It is emphasized that at least one of the representatives on the Appeals Committee shall be a trained physician, and at least one other a trained lawyer.

Insurance Application Appeals Committee

12.9 Should an insurance candidate's application to join the policy be rejected, he shall be entitled to submit an appeal against his rejection to the Appeal Committee within 60 days.

12.10 The aforementioned Committee shall comprise of a representative of the policyholder and a representative of the insurer. The insurance candidate shall plead all his medical and other reasons before the Committee, and may also present written opinions from his physicians.

12.11 Should the members of the aforementioned Appeal Committee fail to reach a unanimous decision, they shall be entitled to appoint a physician agreeable to both of them who has expertise in the relevant field and whose decision shall be binding on the Committee.

13. Index Linkage

13.1 Linkage differentials as defined in the Adjudication of Interest Law shall be added to the monthly insurance benefits as described in paragraph 7, from the last index to have been published prior to the commencement date.

13.2 Linkage differentials as defined in the Adjudication of Interest Law shall be added to the monthly premiums, from the last index to have been published prior to the policy commencement date.

14. Premiums and the manner of paying them

14.1 The premium for each insured shall be as listed in the premiums table attached to this policy and they shall vary during the insurance period according to the insured's age group. The premiums shall be calculated according to the age of the insured on the date of payment.

14.2 In accordance with the policyholder's standard practice, The insured shall pay the premium once a month by direct debit authorization or any other means used by the policyholder with respect to its members.

14.3 The policyholder or its agent shall pay the premiums to the insurer collectively for all those insured under the policy.

14.4 Should the insured fail to pay the insurance premiums, or part of them, to the policyholder on time, the policyholder shall forward his details to the insurer for collection or for cancellation of the policy in relation to the insured in question. During the first 180 days of not paying the insurance premiums, the insured shall send via the policyholder two warning letters to the insured on dates to be agreed between the policyholder and the insurer.

14.5 In the aforementioned letters, the insurer, or the policyholder on its behalf, shall remind the insured of his non-payment and warn him of its consequences, which are likely to involve damage to the insured's rights under the policy.

14.6 Where warnings as stated in paragraphs 14.4 and 14.5 above had been sent and the insured did not pay the premiums which were in arrears to the insurer, an additional notice shall be sent to the insured on behalf of the insurer, informing him of the cancellation of his cover under the policy, following which his insurance under the policy shall be cancelled by the Insurer, subject to the Insurance Contract Law, 5741-1981.

It is hereby clarified that until said period of 180 days has elapsed, and until the policy has been cancelled as aforesaid, the policy shall remain in force despite the insurance premium arrears.

14.7 Depositing money prior to acceptance of the insurance proposal:

14.7.1 Should money be paid to the insurer on account of the insurance premiums before it has agreed to provide cover for the applicant, this shall not be interpreted as agreement on the insurer's part to provide the insurance.

14.7.2 The rejection of the insurance proposal or a request for the completion of data shall be carried out within 3 months, or if the insurer asked the insurance candidate for completion of data, as the case may be, within six months, from the date of receiving the advance on account of the premium.

14.7.3 Should the insurer not reject the insurance proposal, ask for completion of data, or inform the insurance candidate that his application to join the policy has been accepted, within the said period, the insured party shall be regarded as having joined the insurance policy under the standard terms.

14.7.4 Should an insurance event occur within the foregoing time period, before the insurance candidate's acceptance had been notified, the insurance candidate shall be entitled to insurance benefits if according to the medical underwriting terms to this policy relating to insured persons with similar profiles, in so far as relevant, the insurer would have informed the insured of his acceptance to this policy had the insurance event not have occurred.

15. Disposal and redemption values and the insured members' Reserve

15.1 Surpluses shall not accumulate to the credit of an insured under the policy for the purpose of receiving disposal or redemption values.

15.2 Notwithstanding what is stated in paragraph 15.1 above, premiums that were paid for all persons insured under a specific group nursing care policy for Health Fund members, shall be used in the future to cover long term liabilities of those having cover as aforesaid after deduction and additions as instructed by the Commissioner.

16. Option of purchasing individual nursing policies and continuation terms

16.1 Each insured may purchase an individual nursing policy from the insurer (**"the individual policies"**) for the insured lifetime, in addition to the nursing benefits under this policy.

16.2 The insured shall be given the option of purchasing one of two kinds of individual policies:

16.2.1 A lifetime individual policy providing compensation upon the occurrence of an insurance event.

16.2.2 An individual policy which extends the period of the insurance benefits beyond the ordinary eligibility period under this policy (after entitlement under this policy has been fully utilized for a period of 60 months). The eligibility period under this individual policy shall be for the Insured party's lifetime.

16.3 A person insured under this policy who wishes to purchase an individual policy shall fill out a membership application form including a health declaration and undergo the insurer's medical underwriting in accordance with the version commonly used by the insurer in relation to policies of this kind..

16.4 The insurance terms set out in the individual policies shall reflect those commonly being used by the insurer at the time of purchase.

16.5 Insurance premiums collected by the insurer from the insured with respect individual policies shall be at least 20% lower than the lowest insurance premiums approved by the Commissioner of Insurance and being charged by the insurer at that time under equivalent individual policies for the plan selected by the insured, in the case of an insured of a similar age and state of health. The said discount shall apply throughout the insured's life.

16.6 The question of the insurance premiums to be charged with respect to an extension of the insurance benefits under this policy for life, shall be resolved between the insurer and the policyholder. In addition, the insurer undertakes to obtain approval for the individual policy from the Commissioner of Insurance.

16.7 An insured who joins the insurance after the determining date and wants to purchase an individual policy shall fill out an application form and shall be asked to make a health declaration and undergo medical underwriting in accordance with the form in use by the insurer for policies of this kind. Where the insured party is aged over 65, the insurer may ask him to be examined by its pyysician. For the avoidance of doubt, the foregoing provision shall equally apply to an insured who had been insured under the previous policy and moved over without a break to insurance under this policy, should he wish to purchase an individual policy as aforesaid.

16.8 The insured shall pay the insurance premiums for the individual policies directly to the insurer, without the involvement of the policyholder**.**

16.9 The terms of the continuation policy referred to in paragraph 6 above shall be as follows: An insured moving over to the continuation policy shall receive a discount on premiums of at least 20% compared to the premiums which were being charged by the insurer at the start of the continuation policy insurance period to all its insured customers under a similar policy. This discount shall apply throughout the entire period of the continuation policy.

17. Limitation of Actions

The limitation of actions period for a payment of insurance benefits claim under this policy shall be three years from the occurrence of the insurance event.

18. Transitional Provisions

18.1 The following provisions shall apply in relation to a transferring insured:

18.1.1 Provided that the following conditions are satisfied, an insurer during a previous period of nursing care insurance for Health Fund members, shall pay the insurance benefits of a transferring insured:

18.1.1.1 The insured is eligible to be paid insurance benefits with respect to an insurance event that occurred during the previous insurance period;

18.1.1.2 The insured filed an additional claim to receive insurance benefits within a period of not more than 12 months from the date on which the insured ceased to be eligible to receive benefits as stated in paragraph 18.1.1.1 above.

18.1.2 Where the previous insurer paid the insurance benefits as stated in paragraph 18.1.1 –

18.1.2.1 The previous insurer may set off against the insurance benefits which it paid the premiums for the period during which they were not paid to the insurer as aforesaid;

18.1.2.2 The new insurer shall reimburse the insured for the premiums that were paid for the period up until the insurance event occurred as aforesaid.

18.2 As from 1st January 2017, the following provisions shall apply in relation to a transferring insured:

18.2.1 An insured with respect to whom an insurance event occurred on the eve of his leaving the previous Fund may join this policy while maintaining insurance continuity and without a reevaluation of his medical situation, within 90 days from the date on which the insurance event ceased to exist in relation to him, provided that the insured in question had not yet utilized his full rights to receive insurance benefits under the nursing care insurance policy for Health Fund members; the period during which an insured shall be entitled to the insurance benefits under this policy shall be reduced by the periods during which he

received insurance benefits under the nursing care insurance policy for Health Fund members.

18.2.2 Should it be shown by the insurer that the insurance event which occurred to the transferring insured happened for the first time before the insurance commencement date, and existed continuously in his case until he joined this policy, he shall not be entitled to any insurance cover, the insurance which began from the date of joining this policy shall be cancelled and the premiums which he had been charged shall be returned to him.

18.3 Transitional provisions applying to an insured whose registration with a Health Fund was cancelled:

18.3.1 The insurer shall enable an insured whose registration with a Health Fund had been cancelled as stated in paragraph 18..3.2 below to join this policy (hereinafter: **"the new insurance policy"**), provided that he was registered with Maccabi after the registration had been cancelled as aforesaid, and that:

18.3.1.1 his medical condition was examined with regard to the period which elapsed from the date on which the registration was cancelled until the date on which he joined the new insurance policy and his participation was approved by the insurer;

18.3.1.2 the insurance period shall commence from the date on which he joined the new insurance policy;

18.3.1.3 the insurance benefits shall be calculated according to the insured's age on the date on which he joined the new insurance policy;

18.3.1.4 periods in which the insured received insurance benefits under the prior nursing care policy for Health Fund members shall be deducted from the insurance benefits period under the new insurance policy.

18.3.2 An insured whose registration with a Health Fund was cancelled is an insured who:

18.3.2.1 left the Health Fund, whose registration in it was cancelled under the National Health Insurance Law, 5754-1994 and who was not registered with another Health Fund aside from the one in relation to which his registration was cancelled as

aforesaid due to loss of eligibility to receive health services under the said Law because he was not a resident as defined therein;

18.3.2.2 on the eve of leaving the Health Fund the insured had been continuously covered under a nursing care policy for Health Fund members for a period of at least one year;

18.3.2.3 the insured joined the new insurance policy within four years from the date on which his registration with a Health Fund had been cancelled;

18.3.2.4 the insured applied to join this policy within 120 days of registering with Maccabi.

18.4 Provisions regarding convalescents transferring from the Nursing Fund or the previous policy:

18.4.1 A person who is defined as ADL-dependent under the Nursing Fund Regulations (hereinafter in this paragraph: **"ADL-dependent"**) or who is entitled to nursing benefits under the previous policy (hereinafter in this paragraph: **"LTC insured"**) on the determining day, shall continue to receive nursing services under the Nursing Fund Regulations, regardless of whether he receives and/or has received nursing benefits or not, or nursing benefits under the previous policy, as the case may be. It is clarified that such an insured shall not be entitled to cover and insurance benefits under this policy.

Notwithstanding the foregoing, should the insured cease to be Adl-dependent as defined in the Nursing Fund Regulations or an LTC insured under the previous policy as a result of an improvement in his functional condition, it is agreed that such an insured shall be insured under this policy from the date on which he ceased to be ADL-dependent or an LTC insured, as the case may be, as a result of an improvement in his functional condition, and that from that date he shall pay the premiums to the insurer as stipulated in this policy, provided that after the improvement in his functional condition, the insured is not subject to an insurance event. Should an insurance event as defined in this policy occur to the insured in the future, he shall be entitled to nursing benefits under this policy for the remainder of the nursing benefits eligibility period, that is, until the eligibility period ceiling for nursing benefits is reached, after deducting the number of months in

which the insured was entitled to receive benefits under the Nursing Fund Regulations or the previous policy, as the case may be.

18.5 In the case of an existing insured - Where the insurer has shown that the insurance event first occurred before the determining date, the insured shall be referred back to the previous policy and his entitlement shall be determined according to its terms.

18.6 In the case of an eligible insured - Where the insurer has shown that the insurance event first occurred before the insurance commencement date, and continued to exist continuously in relation to him until he joined this policy, he shall not be entitled to any insurance cover, the insurance which began from the date of joining this policy shall be cancelled and the premiums which he had been charged shall be returned to him.

19. Taxes and Levies

The insured must pay all the government and other taxes applying to this policy, which are charged on the premiums and insurance benefits and on all the other sums which the insurer is obliged to pay under the policy, whether such taxes existed on the date on which the policy came into force or shall be charged at a later time. It is clarified, that the premium on the determining day, includes all taxes and levies which applied at that time.

20. Conditions in Accordance with the Control of Financial Services (Insurance)(Group Health Insurance), 5769-2009

20.1 The policyholder declares and undertakes that in its capacity as a policyholder it works exclusively, faithfully and diligently for the welfare of the insured and that it does not and shall not derive any personal benefit from being the policyholder;

20.2 Should the insured be obliged under the terms of a group nursing care insurance policy, to pay premiums or parts of them, at the start of the insurance period, including if their collection begins at a later date, the insurer shall not provide the insured with cover under the policy in question, without its express prior consent, which shall be documented, and if the insured is a child or spouse of a member of the group of those insured - the insurer may join him to the policy after the member in question had consented to his child or spouse joining the policy.

20.3 Paragraph 20.2 shall not apply to a group nursing care policy which shall be renewed for a further period with the same or a different insurer, if the following conditions are met:

(1) The group policy was in force with regard to the group of insured persons for at least three years before the date of its renewal;

(2) The group policy was renewed whether upon the same or different terms, while maintaining insurance continuity as regards the insurance cover that was in force up to the date of the renewal and which was including in the group policy after that date; in this regard, "maintaining insurance continuity" - maintaining continuity without a reexamination of a preexisting medical condition and without a qualifying period.

20.4 Upon the commencement of the insurance period, an insurer shall give to each individual insured under the group policy, whether he is joining for the first time or renewing his insurance cover for an additional period, a copy of the policy, a proper disclosure form in compliance with the Commissioner's instructions, an insurance information sheet and such additional documents as the Commissioner shall direct;

20.5 Notwithstanding the contents of paragraph 24.4 above, where the group insurance was renewed for a further period with the same insurer or extended for a period of no more than three months, during which negotiations were conducted between the policyholder and the insurer on renewing the policy for an additional period, without any change in the premiums and the other terms of the insurance cover, the insurer shall give to each individual insured under the group policy a notice regarding renewal of the insurance, provided that it shall state that –

20.5.1 The period of the insurance has been extended and no changes have been made to the terms of the insurance cover.

20.5.2 The insured may receive a copy of the policy documents.

20.5.3 The insured may inspect the policy documents and where he may do so.

20.6 Where the insured is obliged to pay insurance premiums or part of them, the insurer shall send to the insured, at his request, a copy of the contract between the insurer and the policyholder, within 30 days from the date on which the insurer received the insured's request.

20.7 Should any change be made to the premiums or other terms of the insurance cover, on the date of the group health insurance's renewal or during the insurance period (in this subsection - the change commencement date), the insurer shall

give to each individual insured under the group policy who had been insured under it on the eve of the change commencement date, a written notice including a description of the change in question, at least 60 days before the change commencement date.

20.8 Should the period of the policy have expired without being renewed, whether with the same or another insurer, the insurer shall give to all or some of the persons insured, at least 30 days from the date when the insurance period expired, a written notice informing them that the insurance cover has expired, the right of each of them to insurance continuity through the mechanism of an individual health insurance policy and to receive a discount on premiums, in so far as each of these rights shall be relevant, and informing them of any other right bestowed on the individual resulting from termination of the policy.

20.9 Where the relationship between the insured and the policyholder has ended, the insurer shall give to each individual who had been insured under the group policy, within 30 days, and at the very latest 90 days, from the date on which it learned of the termination of the relationship as aforesaid, a written notice informing him that the insurance has expired and his rights under the group policy.

20.10 Where upon the date of joining the group nursing care insurance policy the insured shall be obliged to pay the premiums as provided in the terms of the policy, the insurer shall give to anyone paying such premiums who is not the policyholder a written notice informing him of the date on which collection of the premiums shall commence; the aforementioned notice shall be given to anyone who had been paying the premiums during the three months which preceded the collection date as aforesaid.

20.11 Should the insurance be renewed or its terms changed during the insurance period, without the insured's express consent having been requested as stated in paragraph 24.3, and the insured or the policyholder gave notice during the 60 days following the date on which the insurance was renewed or altered, as the case may be, of the cancellation of his participation in the insurance, his cover under the policy shall be cancelled from the date on which the policy was renewed or its terms altered, as the case may be, provided that no claim was filed to utilize rights under the policy due to an insurance event which occurred during the 60 day period as aforesaid.

20.12 A group nursing care insurance policy shall not expire with regard to an insured before the insurance period ends, and all the insurance covers under the terms of that policy shall continue to be provided until the end of the insurance period, provided that the insurer had received premiums with regard to the insured in order to do so.

20.13 The insurer shall be severally accountable towards the insured for the full amount of the insurance benefits up to the liability ceiling stipulated in the group policy, even if the insured had also been entitled to have the expenses incurred following an insurance event reimbursed under another nursing care insurance policy, whether with the same or another insurer.

20.14 In policies which pay insurance benefits according to the degree of damage sustained, the insurers shall split the compensatory burden between them according to the ratio between the insurance benefits ceilings pertaining to the insurance events as specified in the insurance policies.

21. General

21.1 This policy is subject to the Control of Financial Services Regulations (Insurance)(Group Nursing Care Insurance for Health Fund Members), 5776-2015 (above and hereinafter: **"the Regulations"**).

21.2 Should the Regulations be amended during the period of the policy, the terms of the policy shall be changed accordingly, and the insurer may change the insurance premiums, pursuant to an agreement between the Health Fund whose members are insured under the policy as aforesaid and the insurer, or cancel the policy, and all subject to the Insurance Commissioner's endorsement.

21.3 It is clarified that in accordance with the agreement between the policyholder and the insurer, should the aforementioned Regulations be amended and the terms of the policy changed accordingly, the premiums may be revised, on condition that the parties' joint actuary shall determine that the change in question, in the amount requested by the insurer, is required due to the aforementioned amendment to the Regulations.

21.4 It is clarified that pursuant to an agreement between the policyholder and the insurer, the monies referred to in paragraph 15.2 above shall be administered by the insurer, in accordance with the Insurance Commissioner's instructions or approval.

21.5 Should any sum due under this policy be paid by bank transfer the date on which the payment was made shall be the day on which the monies were actually transferred to the insurer or to the insured.

21.6 The parties' addresses for the purpose of giving notices in connection with the provisions of this policy are:

The policyholder: Maccabi Health Services, 27 Hamered Street Tel Aviv.

The insurer: Clal Insurance Company Ltd, 36 Raoul Wallenberg Street Tel Aviv.

The insured: The insured's last address as stated in the policyholder's records. Any notice which shall be sent by registered post to the addresses listed above, shall be regarded as having been received by the addressee within 72 hours from the time the envelope containing the notice was handed over at a post office and in order to prove delivery it shall be enough to prove that the letter was deposited at the post office.

Premium Variation Table

From Age	Insured's monthly premium in NIS
0-17	0
18-29	6.12
30-35	22.56
36-40	29.59
41-45	30.72
46-50	64.95
51-55	72.89
56-60	81.17
61-65	96.25
66-70	122.09
71-74	144.54
75-80	157.35
81 and over	166.98

* The premiums are correct as at April 2016 (the month in which the booklet was produced) and are linked to the Consumer Price Index.
* The premiums vary according to the insured's age group.

Questions and Answers

What is Long Term Care Insurance?

LTC insurance is an insurance plan within the framework of which the insured pays a monthly premium commensurate with his age. The payment guarantees him that should he heaven forbid become ADL-dependent in the future and incapable of performing daily functions independently, in accordance with the terms of the policy he shall be entitled to monthly insurance benefits from the insurance company, in the form of a monthly compensation payment, if he resides at home, or reimbursement of expenses, if he is hospitalized in a nursing institution.

What does LTL insurance provide for those insured under the "Maccabi Long Term Care" policy?

The plan guarantees that an insured who has become, and for as long as he remains, ADL-dependent, shall receive monthly nursing benefits for a period of five years (60 months in all), subject to the terms of the policy. As explained in paragraph 7 of the policy, the level of entitlement is determined by the age at which the insured first joined the Health Fund's LTL policy, and continuity of insurance thereafter (commencing from 1st January 2017 - including if he switched from one Health Fund to another).

Who is defined as an ADL-dependent patient for the purposes of receiving insurance benefits under the policy?

An insured who is incapable of independently carrying out a substantial part (at least 50%) of at least 3 of the following 6 activities:
Getting up and laying down, dressing and undressing, bathing, eating and drinking,, controlling bowel and bladder functions, moving from place to place;
or an insured whose is in a poor state of health and whose ability to function has been largely curtailed due to "cognitive impairment" as determined by a mental health specialist.
The full definitions can be found in paragraph 3 of the policy.
An insured's condition at the time of filing a claim to realize his rights is determined, *inter alia*, through a functional and/or cognitive examination and by collecting medical material.

For how long is cover provided under the policy?

The period of the insurance cover for all those insured shall be from 1st July 2016 or, if later, from the date on which they joined the policy, to 30th June 2017. Maccabi shall take steps to have the LTC insurance extended to beyond this period, through an insurance company of its choosing, subject to the Insurance Commissioner's endorsement of the policy and the provisions of the Legislative Arrangement.

Who may be insured under the LTC policy?

Existing insured: The rights of a Maccabi member insured under the "Maccabi LTC" policy when it expires on 30th June 2016 shall automatically continue under the new policy without the need for underwriting.
New insured - A Maccabi member of any age who joined the "Maccabi LTC" policy from 1st July 2016, including insured members who shall have switched from another Health Fund in which they had been insured under an LTC policy, and from 1st January 2017 they shall be received sequentially in accordance with the conditions set out in the Regulations.

Soldiers

Soldiers are not entitled to be insured under an LTC policy for Health Fund members. However, a simple process exists for a released soldier wishing to do so to join the "Maccabi LTC" policy through uncomplicated medical underwriting, provided not more than four years shall have elapsed between the date of his enlistment in the army and the date of his joining the policy, that on the eve of his enlistment the insured had been insured under a Health Fund LTC policy for at least a year and that he exercised his aforementioned right within 120 days from the date on which he joined Maccabi.

What is the Maccabi Shield Nursing Fund?

Until 30th June 2008 LTC cover was provided in accordance with the Maccabi Shield Nursing Fund Regulations. On 1st July 2008 members of Maccabi Shield switched to the previous policy "Maccabi LTC", without a break, without having to fill out a membership application and without medical underwriting. On 1st July 2008, the only members still covered by the Maccabi Shield Nursing Fund were those known to be "ADL-dependent", as defined in the

Nursing Fund Regulations. Convalescents who were covered by the Nursing Fund and who are no longer "ADL-dependent" as defined in the Nursing Fund Regulations are continuing to be insured under this policy, subject to payment of the requisite premiums and after deduction of the months of entitlement within the framework of Maccabi Shield.

How can I join the LTC insurance policy?

An application form for joining the policy can be found on the Clal Insurance Company website: www.clal.co.il, on the Maccabi Health Services website: www.maccabi4u.co.il or may be obtained through directly contacting Clal Insurance Company's "Maccabi LTC" Service Center on: 1-700-505-520 or from any of Maccabi's branches.
The health declaration can be filled out with the insurance company directly by calling 1-700-505-520.
The form may be submitted directly to Clal Insurance Company by Email: maccabisiudi@clal-ins.co.il, fax 077-6383171 or through Maccabi Health Services' branches.

Will the premium and the monthly benefit (in the event of payment to an insured) remain the same?

The premium payable during the period of this insurance policy is fixed apart from changes attributable to moving between age groups and CPI linkage as described on page 36 of this booklet.
The nursing benefit ceiling shall be constant throughout the entire period of the policy. The nursing benefit paid to the insured is index linked.

How long is the waiting period for the policy?

The waiting period for payment of the insurance benefits is 60 days from the occurrence of an insurance event. It is clarified that , as specified in paragraphs 2.11 and 8 of the policy, the insured shall not be entitled to receive nursing benefits with respect to the waiting period.

Do I have to decide on my chosen track at the start of the insurance, or at another time?

The rights under the policy are realized according to the place where the insured resides - at home or in an institution. Should the insured change his type of residence while in receipt of nursing benefit, the manner in which he receives the benefit may be changed accordingly, subject to notifying the insurer.

What does the insured person have to do in the event of a long-term care claim?

Fill out a claim form, attach to it the documents specified on the form, and send it to the address that appears on the form. The claim form includes personal details, and the documents specified in the body of the form must be attached.

The claim form can be found on the Clal Insurance Company website: www.clal.co.il, on the Maccabi Health Services websites: www.maccabi4u.co.il , www.maccabisiudi.co.il or can be obtained by calling the Clal Insurance Company Claims Center on: 1-700-505-520 or from any of Maccabi's branches.

Can I cancel the policy?

The policy can be cancelled and the cover terminated at any time, by written notification to Clal Insurance Company, and the cancellation shall take effect on the first day of the next calendar month.

Where can I get further information about the long-term care insurance?

Answers to questions regarding payments may be obtained by calling the "Maccabi Health Services" Members' Service Center on: *3555 or 1-700-50-53-53.

For any other clarification concerning LTC insurance (excluding in relation to payments) you may call Clal Insurance's "Maccabi LTC" Service Center on: 1-700-505-520, or send a letter by fax : 077-6383171, post: POB 37190 Tel-Aviv Postcode 6137002, or online: www.maccabisiudi.co.il.

All the foregoing information is subject to the full terms of the policy. In the event of a contradiction the terms of the policy shall take precedence.

For the avoidance of doubt, should there be any discrepancy between them, the contents of the relevant original document in the Hebrew language shall override the translated material.

Maccabi LTC

To join and for information:

1-700-505-520

***8494**

www.maccabisiudi.co.il

www.clal.co.il

It is clarified that Maccabi is not in any way an agent or representative of the insurer and that the insurer shall be responsible for honoring its obligations towards the insured under this policy.

Maccabi LTC

Group Long Term Care Insurance

For members of Maccabi Health Services

Through Clal Insurance Company Ltd