LEUMIT NURSING

Group Nursing Care Insurance for Leumit Customers

Through Clal Insurance

Clal Insurance **Leumit**

For details 1-800-702-702 **Because we care**

Dear Insured,

I wish to congratulate you on your decision to be insured with Leumit Nursing, our Group Nursing Care Insurance Policy for Leumit members with Clal Insurance Company.

Leumit is committed to its customers, and this insurance with Clal Ltd constitutes an additional component in the services which we offer and which provide a comprehensive solution at all times.

The Leumit nursing insurance policy provides a solution which is compatible with the needs of the nursing care-dependent insured and members of his family - whether the insured opts for long-term hospitalization in a nursing care institution or nursing-care at home.

The terms of this insurance policy have been determined in accordance with the Control of Financial Services Regulations (Insurance)(Group Nursing Care Insurance for Health Fund Members), 5776-2015, which were enacted by the Minister of Finance. The Regulations provide that all the Health Funds shall offer their members a uniform policy, the terms of which have been determined by the aforementioned Regulations.

Leumit, which is the policyholder, shall make sure that when the moment of truth arrives, should you or your loved ones heaven forbid become nursing care-dependent, you shall be entitled to the financial assistance necessary in order to receive dedicated and appropriate care.

Wishing you perfect health,
Nissim Alon, CEO (-)

Leumit Nursing
Customer Service Center: **Tel:** 1-800-702-702 | **Fax for joining:** 077-6383949 | **Fax for claims:** 077-6383024
Clal Insurance Company Ltd | Health Division | POB 723 Tel Aviv 6100701 | **www.leumit.co.il**

Dear Customer,

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

In order to be enable us to provide you with the best service, we have placed at your disposal a "Leumit Nursing" designated service center, the phone number of which is 1-800-702-702. 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
(-)
Health Division Director
Clal Insurance Company Ltd

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*[*In order to give meaning to the foregoing page numbers, the translator has written and emboldened the page numbers in square brackets where they appear in the original text, on the left hand side of the translation]*

For further information, call the "Leumit Nursing" Center on 1-800-702-702
All the information and forms can be found at one site: www.leumit.co.il

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.

Questions and Answers

1. What is nursing care insurance?

Nursing care insurance is insurance within the framework of which the insured pays a monthly premium. The payment guarantees him that should he heaven forbid become ADL-dependent in the future and incapable of performing daily functions independently (as defined in the policy), he shall be entitled to monthly insurance benefits from the insurance company, during the period specified in the policy. The benefits shall be paid to him either by way of participation in expenses (indemnification) or in the form of a fixed monthly payment, in accordance with the policy definitions.

2. What is a Uniform Nursing Care Policy for Health Fund members?

In the wake of the Ministry of Finance (Control of Insurance) Reform (**"the Reform"**), from 1.7.16 onwards, group nursing care insurance cover for Health Fund members, including those insured with Leumit Health Services, shall be uniform and identical. The definitions of a nursing care insurance event, division according to age groups, and the nursing care benefits percentage have been determined by the Ministry of Finance's Insurance Supervision Unit and apply to all those insured under Health Fund nursing care insurance policies in Israel. The new uniform insurance policy enables continuity of cover where the insured transfers his membership from one Health Fund to another, as well as the absorption of eligible policyholders whose group nursing care cover has expired (the foregoing shall apply from 1.1.17).

3. Which insurance company is providing the policy?

Clal Insurance Company Ltd has been providing group nursing care insurance cover for Leumit Health Services' members since 2009. Clal Insurance shall also be the insurer under the new policy.

4. Who is entitled to nursing care insurance?

Existing insured:

All Leumit Health Services customers who were insured under the "Leumit Nursing" policy on 30.6.16 shall automatically be covered under the new policy without any action being required on their part. It is recommended to make sure that all members of the family, including children, are insured under the "Leumit Nursing" Policy. We would emphasize, that parents may insure their children, notwithstanding that they are not insured themselves. The insurance cover is provided gratuitously for children under the age of 18.

New insured:

A Leumit Health Services customer who shall join this nursing care insurance from 1.7.16 subject to approval by Clal Insurance, including:

An insured who transferred from another Health Fund:
From 1.1.17, a new Leumit customer who had nursing care insurance with another Fund on the date on which he joined Leumit so that he shall be continuously insured under a nursing care policy.

Eligible insured:

A Leumit customer who is not insured under the Leumit Nursing policy but who was insured under a group nursing care policy which expired after 1.1.11 and who is 60 years of age or older, and all in accordance with the provisions of the Reform pertaining to this matter.

5. Do the amounts of the premium and the monthly benefits vary?

As a result of the coming into force of the Reform, the amounts of the monthly benefit, the period of the benefit and the division of the insured into different age groups have changed for all the insured, in all the nursing care policies of all the Health Funds in Israel. A full breakdown of the insurance benefits appears on pages 15-16 of the policy. The monthly premium varies according to the insured's age. A table of the monthly premiums and the age groups appear on page 20 of the policy.

The monthly premium being paid by the insured and the amounts of the nursing care benefit being paid to them, are linked to the consumer price index as set out under the premium tables and insurance sums on pages 15-16 and 20/paragraphs 9 and 14 of the attached policy.

6. **When is a patient classified as nursing care-dependent thus entitling him to insurance benefits under the policy?**

An insured who due to his poor state of health and impaired ability to function resulting from an illness, accident or ailment cannot carry out on his own a substantial part (at least 50%) of 3 or more of the following 6 activities: getting up and lying down, dressing and undressing, bathing, eating and drinking, using the toilet and moving about (independently); or
An insured who has been determined by a mental health specialist to be suffering from "cognitive impairment".
See the detailed eligibility definitions on pages 13-14 and in paragraph 4 of the attached policy.

7. **How is a claim submitted?**

The claim form published on the insurer's website www.clal.co.il must be filed out and forwarded to the address appearing on that form, together with the documents specified therein. Should the insurer reject the claim, the insured may apply to an Appeals Committee. For further details you may call the Service Center on 1-800-702-702.

8. **Is it necessary to decide on a compensation/indemnification track when making the claim?**

The insured chooses the track (home-compensation/institution-indemnification) according to the place in which he resides when the insurance benefits are paid by the insurer. During the nursing care benefit period it is possible to change track and transfer from staying at home to residence in an institution, and vice versa.

9. Where can additional information be obtained from about nursing care insurance?

For information about the terms of the policy and to download forms, you can visit the Leumit website at www.leumit.co.il or the Clall Insurance website at www.clal.co.il.
To join or clarify claims you may phone the "Leumit Nursing" Center at Clal Insurance on 1-800-702-702.
For clarifications regarding payment of the monthly insurance fees (the premiums) for the nursing care insurance, you may phone the "Leumit" Center on 1-800-507-507 or *Leumit/*507 from a mobile phone.

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Summary of General Details Regarding the Leumit Group Nursing Care Policy for Leumit Health Services Members

Subject	Paragraph	Terms
General	**1. Name of the policyholder**	Leumit Health Services (**"Leumit"**)
	2. The insurer	Clal Insurance Company Ltd
	3. Coverage under the policy	Monthly **indemnification** with respect to the costs of the insured staying in a nursing care institution or 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 7 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 transition 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 section 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; 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.

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General		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. 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 9 of the policy.
Change of terms	**10. Changing terms of the policy during the insurance period**	As specified in paragraph 1.2 of the policy.
Insurance payment (Premium)	**11. Amount and structure of premium**	As specified in paragraph 14.1 of the policy.
	12. Change of premium during the insurance period	As specified in paragraphs 1.2 and 14.1 of the policy. The amount of the premium varies according to the data specified in the premium tariffs table in paragraph 14.1 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: (a) The premium was not paid when due as specified in paragraph 14.3 of the policy. (b) As a result of non-disclosure as specified in sections 6-8 and 43 (subject to the provisions of section 54) of the the Insurance Contract Law, 5741-1981. (c) As specified in paragraph 1.2 of the policy.

	14. Terms of cancellation by the insurer	The insured may cancel the policy at any time by an instruction in writing.
Exclusions	**15. Exclusions to the insurer's liability**	As set out in paragraphs 13.1-13.3 and 13.5-13.7 of the policy.
	16. Exclusion due to existing medical condition	As set out in paragraph 13.4 of the policy.
Supplements to nursing care insurance	**17. 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.
	18 Period for payment of insurance benefits	Up to a maximum of 60 months.
Supplements to nursing care insurance	**19. 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.
	20. Amount of monthly insurance benefit	**<u>In the case of an insured who joins from 1st July 2016:</u>** 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. **<u>In the case of an insured who joined up to 30th June 2016:</u>** 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 64 - NIS 4,500 • First joined from the ages of 65 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 64 - 80% and not more than NIS 6,500. • First joined from the ages of 65 or older - 80% and not more than NIS 4,500.
	21. Exemption from payment of premium upon occurrence of an insurance event	Exists.
	22. Table of premium tariffs	As specified in paragraph 14.1 of the policy.
	23. Insured's rights with respect to premium increases	None
	24. Disposal value	None.
	25. 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 20 above.
	26. Setting off of benefits against other insurances	None.

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. To obtain your copy phone the insurer's call center on 1-800-702-702.

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 077-6383024 or by post to the following address: POB 723 Tel Aviv, Postcode 6100701

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.

Nursing Care Insurance Policy for Members of Leumit Health Services

1. General

1.1 **The Control Regulations**

This policy is subject to the Control of Financial Services Regulations (Insurance)(Group Nursing Care Insurance for Health Fund Members), 5776-2015.

1.2 **Changing the policy terms**

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.

1.3 **All the provisions contained in this policy concerning transfer of insured between Health Funds, including provisions regarding the operation of the transfer and the definition of a transferring insured, shall apply from 1st January 2017.**

2. Introduction

In return for payment of a premium, in accordance with the provisions and terms of this policy and subject to the exclusions and qualifications specified hereinafter, the insurer shall compensate or indemnify the insured with regard to the insurance event which occurred during the insurance period, if it occurred, after the waiting period, for the duration of the nursing care benefit period, as defined hereinafter, up to the insurer's maximum liability.

3. General definitions

In this policy and in every exhibit attached to it, the following terms shall have the meanings given next to them. Anything stated in this policy in the singular shall be deemed to include the plural and vice versa. Anything stated in this policy in the masculine gender shall be deemed to include the feminine gender and vice versa.

It is clarified that the following definitions appear in descending order in accordance with the letters of the alphabet and according to the subject, and no meaning should be attributed to that order beyond what has been stated.

3.1 **"Nursing care insurance for Health Fund members"** - Group nursing care insurance which was arranged for members of a Health Fund, under a single policy, in which one or more Health Funds hold the policy for their members.

3.2 **"Home"** - Any place which is not an institution, as defined hereinafter in paragraph 3.18.

3.3 **"Application to join"** - An application form to join this insurance, which constitutes an integral part of the policy and which was filled out and signed by the insurance candidate or which was filled out during a telephone conversation which was documented in reliance upon information that was given by the insurance candidate, who is a new insured.

3.4 **"The insurance fee/premium"** - The insurance fee which the insured is obliged to pay to the insurer under the terms of the policy, through Leumit.

3.5 **"The determining date"/"the commencement date"** - 1st July 2016. This policy is a continuation of the previous policy as defined hereinafter.

3.6 **"The Commissioner"** - The Commissioner of Capital Markets, Insurance and Savings.

3.7 **"Joining for the first time"** - The joining of an insured to a nursing care insurance policy for the members of any Health Fund, from the commencement of which he shall have insurance continuity, including from 1st January 2017, continuity which shall be preserved upon a transfer from one Fund to another under section 12 of the Regulations.

3.8 **"Health Insurance Law"** - National Health Insurance Law, 5754-1994.

3.9 **"Child"** - A son or daughter of a Leumit member, from his date of birth until the age of 18, who is registered with Leumit.

3.10 **"Leumit"** - Leumit Health Services/Leumit Health Fund

3.11 **"Insured"** - A Leumit member who is a new insured or eligible insured or existing insured.

3.12 **"Eligible insured"** - An insured who satisfied all of these conditions:

- He was insured under a last entitling policy on the date on which the insurance period of that policy expired and he was not insured under a Health Fund nursing care policy on the date on which the application to join under section 3(b) of the Regulations was submitted;
- He was at least 60 years of age on the commencement date, or if later,on the date on which the insurance period specified the last entitling policy under which he was insured expired;
- No insurance event existed with regard to him on the date on which he applied to join a Health Fund members group insurance plan;
- He does not receive insurance benefits under a last entitling policy under which he was insured.

3.13 **"New insured"** - An insured who is not an existing insured or an eligible insured, including a transferring insured.

3.14 **"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..

3.15 **"Existing insured"** - A person who had been insured under the previous policy on the eve of the commencement date, and who continued to be insured sequentially under this policy.

3.16 **"Insurer"** - Clal Insurance Company Ltd.

3.17 **"Previous insurer"** - The insurer under the previous policy, Clal Insurance Company Ltd.

3.18 **"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.

3.19 **"The insurance commencement date"** - In the case of an existing insured - The determining date or, in the case of a new insured, as specified hereinafter.

(a) Where the application to join was received by the insured by 15th (inclusive) of the calendar month, the insurance commencement date shall be the 1st of that calendar month;

(b) Where the application to join was received by the insured after 15th of the calendar month , the insurance commencement date shall be the 1st of the calendar month following the month in which the application was received. It is clarified that, in any event, the determining date regarding the commencement of the insurance **shall be the date on which the application to join arrived** under subparagraphs (a) or (b) above, including where the approval process includes the submission of medical material and/or clarification in connection with underwriting and/or an Appeals Committee.

The insurance commencement date in the case of a transferring insured - The date on which the insurance with the previous Fund ended.

3.20 **"Insurance candidate"** - A Leumit member who wishes to join the insurance being provided within the framework of this policy as a new insured, and has submitted an application to do so.

Cover is provided to the insured within the framework of this policy on an individual basis, and without any dependence on his/her spouse's existing insurance status. Similarly, the joining of an insured to the policy shall not means that cover will automatically be provided for his/her spouse or other members of his/her family as well.

3.21 **"Last entitling policy"** - An entitling group policy which expired during the period from 25th Tevet 5771 (1st January 2011) and 2nd Tevet 5777 (31st December 2016) or by a later date if it was specified in a policy that was renewed by 19th Tevet 5776 (31st December 2015) as the date on which the policy expired, and it was not renewed with any insurer.

3.22 **"Entitling group policy"** - A nursing care insurance policy, including a health insurance policy which provides nursing care insurance cover, which was made for a group in a unified policy, but excluding a policy to which one of the following applies:

- The policy is one which a Health Fund took out for its members.
- The marketing or renewal of the group policy received prior written approval from the Commissioner after the commencement date.

3.23 **"Previous policy"** - A group nursing care policy provided by the previous insurer to Leumit members under the name of "Leumit Nursing" which ended at midnight on 30th June 2016.

3.24 **"Health Fund"** - As defined in section 2 of the Health Insurance Law.

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

3.26 **"Receiving Fund"** - A Health Fund which a transferring insured registered with after leaving a previous Fund.

3.27 **"The Insured Members' Reserve"** - As defined in section 16 of the Regulations.

3.28 **"Monthly nursing care benefit"** - The monthly sum of money which the insurer undertakes to pay with respect to an insurance event, as stated hereinafter in paragraph 9.

3.29 **"Waiting period"** - As set out hereinafter in paragraph 10. 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.

3.30 **"Regulations"/"the Regulations"** - The Control of Financial Services Regulations (Insurance)(Group Nursing Care Insurance for Health Fund Members), 5776-2015.

4. The Insurance Event

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

4.1 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.

4.2 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:

4.2.1 **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;

4.2.2 **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;

4.2.3 **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;

4.2.4 **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;

4.2.5 **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.

4.2.6 **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.

5. The Insurance Period

In the case of every insured, the cover under this policy shall be provided from the insurance commencement date, as that term is defined in paragraph 3.19 above, until 30th June 2017.

6. Reply to the application to join

6.1 Notice of the insurer's decision regarding the acceptance of the insurance candidate's application to join the policy and/or its rejection, shall be given to the insurance candidate and to Leumit, within 15 days from the date on which the application to join was submitted, or should the insurer require additional documents and data from the insured, within 30 days from the day on which the requested data and documents were submitted to the insurer by the insured. It is clarified that nothing in the foregoing shall alter the insurance commencement date as defined in paragraph 3.19 above.

6.2 An insurance candidate who did not receive a reply to the application to join which he submitted after handing over to the insurer a health declaration and all the medical and factual material which was requested by the insurer, within the period stipulated in paragraph 6.1 above, shall automatically be insured from the aforementioned date, upon the standard terms, as if the insurer had agreed to insure him at the requested time.

6.3 Should the application of an insurance candidate be rejected by the insurer, the insurance candidate may appeal against the rejection decision within 60 days from receiving it. The appeal shall be heard before the Insurance Application Appeals Committee, as stated hereinafter in paragraph 19.

7. Right to insurance continuity through an individual policy

7.1 An insured under this policy who satisfies the conditions specified in paragraph 7.2 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 7.3 below, the terms of which shall be as follows:

7.1.1 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 section 8(g) of that Law;

7.1.2 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;

7.1.3 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.

7.2 The entitlement to transfer to a continuation policy as stated in paragraph 7.1, 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:

7.2.1 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.

7.2.2 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.

7.3 An insured in relation to whom this insurance was terminated or is not being renewed in his case as stated in paragraph 7.2 above, may switch to the continuation policy within 60 days from the date on which the insurer informed him of this.

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

7.5 Notwithstanding the provisions of paragraph 7.3 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.

8. The Age of the Insured

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 from the month in which the insured was born.

9. The Amount of the Insurance Benefits

9.1 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

The amount of the insurance benefits is linked to the May 2016 index which was published on 15th June 2016.

9.2 Notwithstanding the provisions of paragraph 9.1, 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:

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

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

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

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

9.2.2.2.1 If he joined the "Gold Nursing Care" insurance from the age of 50-49;

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

9.2.2.3 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;

9.3 Notwithstanding the provisions of paragraph 9.1 above, the amount of the monthly insurance benefit which shall be paid to an insured who resides 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 the institution.

10. 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.

11. Entitlement to Insurance Benefits

11.1 An insured is entitled to receive insurance benefits as long as he satisfies the conditions specified in paragraph 4, subject to the terms of the policy.

11.2 Notwithstanding the provision in paragraph 11.1 above, an insured shall be entitled to receive insurance benefits for 60 months, beginning from the end of the waiting period as described in paragraph 10, by virtue of the policy, during the period of which the insurance event occurred and subject to the provisions of paragraph 21.1 below, after deduction of the periods in which he received insurance benefits under a Health Fund members nursing care insurance policy.

12. Liability of the Insurer - Payment of the Monthly Nursing Care Benefits

12.1 An insured as stated in paragraph 11 above, is entitled to receive monthly nursing care benefits for up to 60 months with respect to all the insurance events collectively (hereinafter: **"the nursing care benefits payment period"**).

12.2 The insured shall notify the insurer of the insurance event as soon as possible after the date on which it occurred by submitting a claim for receipt of the monthly nursing care benefits (hereinafter: **"the Claim Form"**). For the avoidance of doubt, it is clarified that Leumit may not submit a claim on behalf of an insured and that only the insured or his attorney may discharge the obligation to submit and/or prove the claim.

12.3 Within the framework of the Claim Form, and at such additional times as the insurer shall request, the insured shall furnish the insurer with such medical and other documents as it shall reasonably require in order to evaluate his claim and which attest to the existence of the insurance event, as well as such other and/or additional documents as the insurer shall reasonably demand and which are needed to clarify its liability under the policy.

12.4 The insured shall sign and submit together with the Claim Form a waiver of medical confidentiality form, which shall enable the insurer to obtain information about the insured's medical and functional condition. It is clarified that the waiver of medical confidentiality form shall only be used in so far as necessary in order to determine the rights conferred and obligations imposed by the policy.

12.5 The insurer may conduct, at its own expense, in a reasonable manner and for a reasonable period of time which shall not exceed 30 days from the date on which the Claim Form was submitted to the insurer, any investigation and have the insured examined by a physician or other medical services provider acting under its auspices, as it shall in its sole discretion see fit. The insured shall be obliged to cooperate with the investigation and/or with regard to examination as aforesaid before approval of the claim.

It is clarified, that the functional assessment of the insured shall be carried out after prior coordination with the insured, or a member of his family or his attorney.

12.6 The insurer shall reply to the insured within 30 days from the date on which the Claim Form was submitted, provided that the insured furnished the insurer with all the necessary documents and presented himself for a functional assessment, in so far as it was requested by the insurer.

12.7 An insured who did not receive a reply to the Claim Form within the time period stated in paragraph 12.6 above, and despite having furnished the insurer with all the medical and other documents and having presented himself for a functional assessment or other medical examination as aforesaid, shall be regarded as an insured whose entitlement has been fully recognized under the terms of the policy.

12.8 Should an insured's claim for recognition as ADL-dependent following the occurrence of an insurance event and receipt of the nursing care benefit be rejected or partly rejected, the insurer shall forward a notice to the insured detailing the reasons for the rejection. The notice shall also explain the insured's right to lodge an appeal against its decision with the Appeals Committee and the procedure for doing so in accordance with the provisions of paragraph 19 below.

12.9 Should the insured's claim for recognition of his ADL-dependent status be approved, he shall be paid the nursing care benefit within 30 days from the day on which the insurer received the information and documents required to clarify its liability in one of the following tracks:

Compensation

The monthly compensation shall be paid to an insured who resides at home by the 10th of each calendar month. It is clarified that the monthly compensation, the amount of which shall be determined in accordance with the provisions of paragraph 9 above, shall be paid in the form of a fixed amount, regardless of the expenses which were actually incurred by or with respect to the insured.

Indemnification

The monthly indemnification the amount of which shall be determined in accordance with the provisions of paragraph 9 above, shall be paid to an insured who resides in a nursing institution in exchange for presentation of a tax invoice from that institution with regard to his hospitalization costs.

The insured may reach a come to an arrangement with the insurer according to which the insurer shall pay the institution directly and without the insured having to present the insurer with a tax invoice.

Where the nursing institution is being paid on the basis of a Ministry of Health code, the indemnification shall be paid under the provisions of paragraph 9 above according to the expense actually incurred by the insured and/or the members of his family who shall attach documents attesting to the contribution paid by each of them in order to fund the code. It is clarified that an insured in relation to whom an insurance event occurred under this policy and who was hospitalized in a nursing institution at Leumit's expense in accordance with the Health Insurance Law, shall be entitled to receive indemnification under the provisions of paragraph 9 above against the contribution which he actually paid. The indemnification shall be paid upon presentation of a letter from Leumit confirming that the aforementioned amount was paid.

Where insurance benefits are being paid by an additional insurer the insured may produce a copy of a tax invoice together with a letter from the other insurer confirming the amount that was paid under the second policy. The indemnification shall be paid by the 10th of each calendar month with respect to expenses incurred in the previous month.

It is clarified that as specified hereinafter in paragraph 16 (entitled "Release from Payment of Premium"), from the date on which the nursing care benefit was paid the insured shall be exempt from payment of the premium.

12.10 An insured, who had been residing at home, and who moved to a nursing institution or an insured who had been staying in a nursing institution and who moved back to his home, shall inform the insurer of the change as aforesaid. The change shall take effect from the date on which it actually occurred and the payment shall be calculated according to the total number of months during which the insured was ADL-dependent and the principles described hereinafter in paragraphs 12.11 and 12.12.

12.11 Should the insured be entitled to receive the monthly nursing benefits for part of a month, the monthly nursing benefit ceiling shall be applied proportionately in relation to that part of the month.

12.12 It is clarified that in the case of an insured staying in a nursing institution, the indemnification track monthly nursing benefits to which he is entitled, and which were not utilized in a particular month, cannot be accumulated in order to enlarge the amount of the nursing benefit payable in another month. The provisions of this paragraph shall equally apply, *mutatis mutandis*, to parts of a month.

12.13 Where a guardian has been appointed by a court for an insured who was entitled to receive insurance benefits under this policy, the insurer shall pay those insurance benefits to the guardian who had been appointed as aforesaid.

12.14 The insurer may, at its own expense, in a reasonable manner, at any time during the period in which the nursing benefits are being paid, conduct any investigation and have the insured, after prior coordination with him, examined by such physician or other medical services provider acting under the insured's auspices, as it shall in its sole discretion see fit. The insured shall be obliged to cooperate with such an investigation and/or examination as aforesaid whilst ever the nursing insurance benefits are being paid.

12.15 The insured's entitlement to receive the monthly nursing benefit shall end on the date on which he ceased to be ADL-dependent and/or upon his death.

12.16 Should an insured become disentitled to nursing benefit under this policy due to **an improvement in his condition and a return to ADL independence**, he shall notify the insurer of this immediately and not later than 30 days from the date on which he became disentitled to the nursing benefit.

The insurer shall be entitled to recoup from the insured and/or from whoever shall take his place, the nursing benefits which were paid pursuant to this policy during a period in which the insured was not entitled to a nursing benefit as aforesaid, together with linkage differentials as stated in paragraph 15 below. Linkage differentials and interest shall be calculated from the 31st day following the date on which the insured ceased to be entitled to the nursing benefit until the date on which the outstanding sum shall actually be paid.

12.17 Should the insured die, heaven forbid, without having nominated another person to receive the monthly nursing benefit on his behalf, the insurer shall pay the balance of the monthly insurance benefit to which the insured had been entitled before his death to his estate or heirs.

Where the insurer had been paying the monthly nursing benefit to a third party in accordance with the insured's written instructions, it shall pay the balance of the monthly nursing benefit to that third party. It is clarified that should the insured heaven forbid die, the insurer shall be entitled to collect from his estate any overpayments with respect to the period following his death, together with linkage differentials and interest as stated in paragraph 15 below.

12.18 **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.

13. Exclusions

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

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

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

13.3 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;

13.4 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 section 6(a)(2) of the aforementioned Regulations;

13.5 before the start of the insurance period or after the expiry of the insurance period, subject to the provisions of paragraph 21.1 below;

13.6 initially during the first 36 months of the insured's life;

13.7 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.

Definitions for the purposes of paragraph 13.4:

"Preexisting medical condition" -

A set of medical circumstances which were diagnosed before the date on which the insured joined the policy, including as a result of an illness or accident; in this regard "diagnosed" - by a documented medical diagnosis or a documented medical diagnostic process which was made or took place in the six months which preceded the original joining date for the purposes of a preexisting medical condition, as defined above.

"Exclusion due to a preexisting medical condition" - A general exclusion in an insurance contract which exempts the insurer from liability, or reduces the insurer's liability or the extent of the cover, due to an insurance event which was actually caused by the normal progression of a preexisting medical condition, and which occurred to a beneficiary or insured during the period in which the exclusion applied. The preexisting medical condition exclusion shall apply to the insured in the following cases and for the following periods:

Where the insured was under 65 years of age on the determining date – For a period which shall not exceed one year from the original joining date for the purposes of a preexisting medical condition.

Where the insured was 65 years of age or older on the determining date – For a period which shall not exceed half a year from the original joining date for the purposes of a preexisting medical condition.

Notwithstanding the foregoing, the exclusion to the insurer's liability or to the extent of the cover due to a particular medical condition which was specified in the insurance schedule in relation to a specific insured, if it was specified, shall be for the period which was stipulated in the insurance schedule next to the medical condition in question.

The exclusion due to a preexisting medical condition shall not take effect if the insured informed the insurer about his preexisting condition and the insurer did not expressly exclude cover with respect to the particular medical condition in the insurance schedule which was mentioned in the insured's declaration.

14. The Premium and Manner of Payment

14.1 The monthly premium

The premium for each insured shall be as listed in the following table (hereinafter: "The premiums table"). The premium shall vary during the insurance period according to the insured's age on the date when the premium is actually paid and linkage to changes in the index.

Age of insured on date of premium payment	Amount of premium in NIS
0-18	0
19-25	7.99
26-30	15.96
31-35	24.93
36-40	38.78
41-45	51.94
46-50	74.94
51-55	87.26
56-60	100.42
61-65	116.35
66-70	132.28
71-75	148.90
76+	157.91

The premium is linked to the March 2016 index which was published on 15.4.16 (which was known at the time of preparing this policy booklet)

The insurer may give notice of an increase in the insurance premiums, subject to the Commissioner's approval.

14.2 The insured shall pay the premium to the insurer through Leumit once a month through a bank standing order or credit card debit instruction.

14.3 Should a premium or part of it not be paid when due, the following month the insured shall be sent a notice informing him that he has not paid the premium, that he must redeem the outstanding sum and the manner in which he is to do so. Should the outstanding sum not be paid as aforesaid within 30 days of the insurer's written redemption demand, the insurer may inform the insured in writing that the policy shall be cancelled in another 30 days should the debt not yet have been paid off.

15. Index Linkage

15.1 Linkage differentials as defined in the Adjudication of Interest Law shall be added to the monthly insurance benefits as described in paragraph 9, from the last index to have been published prior to the commencement date.

15.2 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.

16. Release from Premium Payments

An insured who is eligible to receive insurance benefits under the terms of the policy shall be released from payment of premiums for the period during which he is eligible to receive them.

17. Renewal of Premium Payment after Cessation of Eligibility

Should an insured become disentitled to receive insurance benefits under the terms of the policy he must pay the premiums. The insurer shall be obliged to inform the insured and Leumit of the renewal of the insured's obligation to pay the premium.

18. Disposal and Redemption Values and the Insured Members' Reserve

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

18.2 Notwithstanding what is stated in paragraph 18.1 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 of additions as instructed by the Commissioner.

19. Appeal Committees

19.1 An insured or insurance candidate shall be entitled to demand that the insurer convene the Appeal Committee in each of the following cases:

- An insurance candidate's application to join the policy was rejected;
- An insured's claim for payment of nursing care benefit was fully or partially denied.
- The insurer determined that the insurance event occurred to an existing insured before the determining date.

19.2 The Appeal Committee shall be authorized to hear, accept or deny the claim in accordance with the terms of the policy.

19.3 An insured shall submit his request for an Appeal Committee hearing within 60 days from the day on which he received the insurer's detailed decision in one of the cases specified in paragraph 19.1 above. The insured may submit documents and a medical opinion to the Appeal Committee as he shall see fit or as shall be determined by the Committee. Once an appeal has been lodged, the insured's attorney may appear before the Committee.

19.4 The insurer shall transfer to the Committee all the material concerning the claim which it has in its possession, whether it was obtained from the insured or through other means.

19.5 The Appeal Committee shall convene to hear a claim within a reasonable time and by no later than 30 days from the day on which the claim was submitted to it. In urgent cases the Committee shall convene as soon as possible.

19.6 The Appeal Committee shall comprise of an identical number of representatives from the insurer and from Leumit. At least one member of the Committee shall be a trained physician and at least one a trained lawyer. The Committee's decisions shall be taken by majority vote. In the event of a tied vote the CEO of Leumit, or a Leumit employee appointed by him, shall have the right to determine the matter, and his decision shall be final, binding and peremptory from the insurer's point of view.

19.7 The period between the lodging of the appeal and the Committee's decision shall not be counted for the purpose of determining the limitation of actions period applying to an insured's claim.

19.8 A referral to or decision by the Appeal Committee shall not prejudice the rights of the insured or his attorney to file a law suit in the courts in order to determine his entitlement under the policy.

20. 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, subject to the contents of paragraph 19.7 above.

21. Provisions relating to transferring insured

21.1 From the determining date onwards the following provisions shall apply in relation to a transferring insured:

21.1.1 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:

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

21.1.1.2 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 21.1.1.1 above.

21.1.2 Where the previous insurer paid the insurance benefits as stated in paragraph 21.1.1 -

21.1.2.1 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;

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

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

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.

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

21.3.1 The insurer shall enable an insured whose registration with a Health Fund had been cancelled as stated in paragraph 21.3.2 below to join this policy (hereinafter: **"the new insurance policy"**), provided that he was registered with Leumit after the registration had been cancelled as aforesaid, and that:

21.3.1.1 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;

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

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

21.3.1.4 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.

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

21.3.2.1 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 n 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;

21.3.2.2 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;

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

21.3.2.4 The insured applied to join this policy within 120 days of registering with Leumit.

21.4 Transitional provisions regarding a person who had been ADL-dependent under the previous policy and in relation to whom an insurance event no longer existed: A person who had been entitled to nursing care benefits under the previous policy (hereinafter in this paragraph: **"an ADL-dependent insured"**) on the determining date, shall continue to receive nursing care benefits under the previous policy, subject to its provisions. It is clarified that such an insured shall not be entitled to insurance cover and benefits under this policy. Notwithstanding the foregoing, should the insured cease to be defined as ADL-dependent under the previous policy as a result of an improvement in his functional situation, it is agreed that from the date on which he was determined to be no longer ADL-dependent he shall be covered by and pay the premiums to the insurer specified in this policy.

21.5 In relation to an existing insured - Where the insurer has proved that an insurance event first occurred before the determining date, the insured shall be returned to the previous policy and his entitlement shall be determined according to its terms.

21.6 In relation to an eligible insured - Where the insurer has proved that the insurance event first occurred to the eligible insured before the insurance commencement date, and applied to him continuously until he joined this policy, he shall not be entitled to cover under any insurance policy, his insurance shall be cancelled from the date on which he joined this policy and he shall be reimbursed for the premiums that were collected from him.

22. 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 fixed premium in the above table, includes all taxes and levies which currently exist.

23. General

23.1 It is clarified that in accordance with the agreement between Leumit and the insurer, the Reserve referred to in paragraph 18.2 above shall be administered by the insurer, in accordance with the instructions or approval of the Insurance Commissioner.

23.2 Any notice which shall be mailed by one of the parties to the address as recorded of another of the parties shall be regarded as having been received by the other party. In order to prove that the notice had been delivered to the addressee it shall be enough to show that the notice was deposited with the Postal Authority.

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

Leumit: Leumit Health Services, 23 Sprintzak 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 Leumit's records.

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

24.1 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;

24.2 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.

24.3 Paragraph 24.2 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.

24.4 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;

24.5 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 -

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

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

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

24.6 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.

24.7 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.

24.8 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.

24.9 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.

24.10 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.

24.11 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.

24.12 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.

24.13 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.

24.14 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.

Leumit Nursing
Customer Service Center: **Tel:** 1-800-702-702 | **Fax for joining:** 077-6383949 | **Fax for claims:** 077-6383024
Clal Insurance Company Ltd | Health Division | POB 723 Tel Aviv 6100701 | **www.leumit.co.il**

Guidelines for Filing a Claim

In order to file a claim, the guidelines appearing in the claims pack should be followed and, *inter alia*, the following documents submitted:

- A Nursing Care Claim Form (which should be filled out by the insured) - The Form includes personal details and a waiver of medical confidentiality, which authorizes any physician and/or entity or other institution in Israel and/or abroad to transfer to the insurer all the medical information in his/its possession concerning the insured. Should the insured not be competent to sign, his guardian may do so, in which case a Guardianship Form should be sent together with the Claim Form.
- A functional assessment questionnaire, filled out exclusively by the treating physician.
- Medical documents including hospital discharge forms which support the medical claim (should they exist).
- In the event of cognitive impairment, a neurologist's or psych-geriatrics specialist's report should be attached.
- The file and entitlement confirmations (if they exist) from the National Insurance Institute.
- Authorization for the employment of a foreign worker (if one exists).

Kindly note! The claim shall only be approved if it complies with the provisions of the policy.

The claims pack may be downloaded from the following websites:
Leumit - www.leumit.co.il
Clal - www.clal.co.il

What happens next?

- Upon receiving the documents, the insurer shall check to see whether the claim is covered by the terms of the policy. In certain cases, in the insurer's discretion, shortly after the claim was filed, the insured shall be asked to be examined by a physician, nurse or occupational therapist appointed by the insurer and at its expense in order to determine whether the insured's condition makes him eligible for insurance benefits under the terms of the policy. The examination shall be coordinated in advance and shall be conducted at the insured's home or the nursing institution where he resides.

- In cases where clarifications are necessary - the insurer shall ask the insured to furnish additional material. In some cases the insurer shall order the insured's medical file directly from the health institutions.
- In each case the insurer's decision will be sent to the insured in writing.
- Should it become clear that the insured is not eligible for the insurance benefits, he shall be sent a written notice explaining the reasons for the rejection and informing him of ways to appeal should the insured wish to challenge the insurer's decision to disallow the claim.

Clarifications after submitting the claim may be obtained by calling the Service Center on: 1-800-702-702.

Leumit Nursing
Customer Service Center: **Tel:** 1-800-702-702 | **Fax for joining:** 077-6383949 | **Fax for claims:** 077-6383024
Clal Insurance Company Ltd | Health Division | POB 723 Tel Aviv 6100701 | **www.leumit.co.il**

Additional services for Leumit Nursing members

ADL-dependency is a trying situation for the patient, the members of his family and those around him. We at Leumit Nursing, do everything possible in order to alleviate this predicament and provide assistance.

Those insured with Leumit Nursing shall be referred to preferred service providers in the following areas:
Home nursing care:

- Coordination and provision of nursing services by an Israeli care provider.
- Care provision in situations of pre-ADL-dependency.
- Advice, guidance and placement service for foreign workers.
- Advice on adapting the insured's home to the ADL-dependent situation.

For the insured who resides in an institution:

- Location, adaption and guidance services for additional services institutions.

For further details call Leumit Nursing at Clal Insurance on 1-800-702-702.

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.

For general information, handling of claims and to join Leumit Nursing

Call the Leumit Nursing Center at Clal Insurance

Tel: 1-800-702-702

or visit our website at: www.leumit.co.il

Postal address:

Clal Insurance Company Ltd

POB 723 Tel Aviv 6100701

LEUMIT

Because we care