Dear Member,

I would like to congratulate you on your membership in the long-term care insurance program for Maccabi members.

The Maccabi long-term care insurance scheme is considered to be the leading and most comprehensive insurance of its kind in Israel.

The insurance scheme incorporates a broad array of rights, and provides the most appropriate solutions for patients requiring long-term care and for their supporting families, both in hospital and at home.

The program offers a fixed monthly allowance throughout the entire eligibility period - including for new members.

The insurance cover is provided by Clal Insurance Company Ltd.

Maccabi Healthcare Services is the policyholder and will continue to ensure, through Clal Insurance, that you receive full insurance cover and the best and most dedicated long-term care when you need it.

If you need long-term care – this policy for Maccabi members offers you security and peace of mind.

Wishing you good health,

Ran Saar

Director General

Maccabi Healthcare Services

Dear Member,

I would like to congratulate you on your membership in the long-term care insurance policy for the members of Maccabi Healthcare Services.

I am happy to present you with this booklet, which includes complete information about the long-term care insurance schemes which have been created especially for the members of Maccabi Healthcare Services.

In the booklet you will find information about the insurance cover, how to receive the services, how to join, and guidelines in the event of a future claim.

Thanks to this insurance policy, you will be able to receive the best treatment and care when you need it.

Remember: the Maccabi Long-Term Care call center at Clal Insurance is available to answer any question you may have at 1-700-505-520.

Wishing you many years of good health,

Daniel Cohen

Senior VP, Head of Health Insurance Division

Clal Insurance Company Ltd.

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* The binding policy is the Hebrew version

Summary of general details about Maccabi Long-term care

Group long-term care insurance policy for members of Maccabi Healthcare Services

(in accordance with full disclosure regulations)

SUBJECT	SECTION	TERMS
General	Name of Policyholder	Maccabi Healthcare Services, hereinafter: Maccabi
	Insurer	Clal Insurance Company Ltd.
	Coverage in the policy	**Nursing home hospitalization** – monthly compensation in respect of the cost of the Beneficiary's stay in a nursing home. **Home nursing care for a Beneficiary staying at home** – providing nursing services by means of a nursing agency, or fixed monthly payment for the employment of a foreign worker, or fixed monthly payment.
	Length of insurance period	From July 1, 2013, or from the day that the insured joins the policy until June 30, 2013. Notwithstanding the above, in the event that the Commissioner of Insurance determines a uniform collective long-term care policy for all health funds (the "Reform"), the policy period will be shortened to conclude on the date when the Reform enters into effect, and in any case no earlier than December 31, 2014.

SUBJECT	SECTION	TERMS
	Continuity	At the end of the insurance period, and in the event that the group policy is not renewed or is terminated for any reason whatsoever by the Insurer, wholly or in part, with regard to all or some of the insured parties, and so long as the insurance event has not occurred, the Insurer will contact in writing each insured party or some of the insured parties for whom the policy is not renewed, and who have been covered by this policy for at least three years, and will offer them the option of transferring to a continuation policy within 90 days of the Insurer's notification. The amount of the insurance in the continuation policy will be in accordance with that stated in this policy, and the ceiling of the period of entitlement for nursing payments will be as defined in this policy (60 months). An insured party transferring to a continuation policy will receive a discount of at least 20% on the insurance premium offered by the Insurer at the time for an individual policy with similar terms, for the entire period of the continuation policy. The transition to the follow-on policy will provide insurance continuity (without any health declaration and without repeat underwriting or revision of previous medical condition), with no qualification period. The insured will be entitled to purchase reduced insurance remuneration in the framework of the continuation policy.
	Conditions for automatic renewal	The policy will be extended for a period of up to three years, at the sole discretion of the Policyholder, who will inform the insured of this at any time in the course of the Initial Insurance Period, up to a date that is no less than six months before the end of the Initial Insurance Period.
	Qualification period	None
	Waiting period	30 days
	Co-payments	None

SUBJECT	SECTION	TERMS
Change in terms	Change in the terms of the policy during the insurance period	12 months after the determining date, and each 12 months thereafter, the Policyholder will be entitled to ask for changes in the terms of the policy, with the approval of the Commissioner of Insurance, in order to apply changes or conditions laid down in laws, regulations or instructions of the Commissioner of Insurance that are valid at the time.
Insurance premiums	Amount and structure of the premiums	As detailed in the table of premium variables on p. 32 of this booklet. The insurance premiums are known for a period of three years, varying according to the age group to which the insured party belongs, and are linked to the known consumer price index (CPI) of July 1, 2008, that is, the May 2008 index published on June 15, 2008.
	Changes in insurance premium during the insurance period	Subject to the authorization of the Commissioner of Insurance, the Policyholder may, at its sole discretion, instruct the Insurer to increase the insurance premium each year, but not before 36 months have elapsed from the determining date. The Insurer will inform all insured parties in advance and in writing. In addition, the Insurer may change the insurance premium beyond the increase in the CPI, if such an increase is necessary as a result of legislation, or on instruction from a government authority, as agreed with the Policyholder.
Conditions for cancellation	Conditions for cancellation of the policy by the Policyholder or the Insurer	The Insurer and/or the Policyholder may not cancel the policy during the insurance period, other than in the following cases, when the insurance will be canceled subject to the provisions of the Insurance Contracts Law 5741 – 1981: •If the premiums are not paid on time. •If the insured party has concealed from the Insurer a substantive fact that would have caused the Insurer not to have accepted him/her into the policy. The insured party may cancel the policy at any time by giving written notification.

SUBJECT	SECTION	TERMS
Exceptions	Exceptions – limits to the Insurer's liability	Section 10 of the policy.
	Exceptions – exceptions in respect of a previous medical condition	Section 11 of the policy.
Additions to nursing insurance	Definition of the insurance event	Poor health and functioning by the insured as a result of illness, accident or defective health, as a result of which he/she is unable to carry out alone a substantial part (at least 50% of the actions) of at least three out of the six everyday activities detailed in the definition of the insurance event, or the insured's poor state of health and functioning due to 'cognitive impairment' (as defined in the definition of the insurance events) determined by an expert physician in this field.
	Length of period of insurance payments	Up to a ceiling of 60 months.
	Type of insurance payments	For a Beneficiary hospitalized for nursing care – compensation For a Beneficiary receiving home nursing treatment – home nursing service provided by a nursing agency, or compensation in the form of a regular monthly nursing allowance for employing a foreign worker, or compensation in the form of a regular monthly nursing allowance.

SUBJECT	SECTION	TERMS
	The amount of the insurance	For nursing home hospitalization: Silver Shield members – compensation at the rate of 40% of the cost of nursing hospitalization, up to a ceiling of NIS 5,000 a month (section 6.1.1 of the policy) Gold Shield members – compensation at the rate of 80% of the cost of nursing hospitalization, up to a ceiling of NIS 10,000 a month (section 6.1.2 of the policy) For home nursing care: a.Home nursing care from a nursing agency (according to the daytime weekday rates): Silver Shield members – 25 hours nursing care a week (section 7.1.1a of the policy) Gold Shield members – 36 hours nursing care a week (section 7.1.1b of the policy) or b.Compensation in the form of a fixed monthly payment for a foreign worker: Silver Shield members – NIS 3,500 a month (section 7.1.2a of the policy) Gold Shield members – NIS 4,500 a month (section 7.1.2b of the policy) or c.Compensation in the form of a fixed monthly payment for nursing care: Silver Shield members – NIS 3,000 a month (section 7.1.3a of the policy) Gold Shield members – NIS 4,000 a month (section 7.1.3b of the policy)

SUBJECT	SECTION	TERMS
	Exemption from payment of premiums	During the period that the Beneficiary is entitled to receive payments, he/she will be exempt from paying premiums.
	Scale of insurance premiums	As detailed in the table of premium variables on p.32 of this booklet.
	The insured party's rights in respect of an increase in premium	None
	Paid-up value	None
	Connection between the amount of the insurance and the age of the insured	There is no connection between the amount of the insurance and the age of the insured at the time of the event, or the age of the insured on joining the policy.
	Deducting compensation from other insurance policies	There is no deduction in respect of nursing compensation or nursing services provided by the state, including under the National Insurance Law. In the event of other third-party liability – in accordance with the provisions of the Insurance Contract Law.

Please note: The insurer's website at www.maccabisiudi.co.il provides the rules used to determine eligibility for the nursing allowance, tests used to determine inability to perform 50% of the activities of daily living (ADL), a sample functional evaluation test, and a link to the Long-Term Care Insurance Purchasing Guide, available on the website of the Commissioner of Insurance. You are entitled to receive a copy of the Long-Term Care Insurance Purchasing Guide by contacting the insurer's call center at 1-700-505-520.

We would be happy to answer any questions or requests for clarification at the Maccabi Long-Term Care call center, tel: 1-700-505-520. To submit a claim, download the forms from www.maccabisiudi.co.il, fill them out completely and send them by fax to 077-638-3119 or by mail to P.O. Box 37190, Tel Aviv 6137002.

The binding terms are the full terms of the policy

* The binding policy is the Hebrew version

Maccabi Long-Term Care

Group long-term care insurance policy for members of Maccabi Healthcare Services

1. Introduction

This policy testifies to the fact that, for payment of the premiums and subject to the terms and provisions and the exceptions detailed below, the Insurer will provide the entitled Beneficiary with a nursing allowance. The nursing allowance will be given in respect of an insurance event taking place during the insurance period, in accordance with that stated in this policy, its terms and restrictions.

2. General definitions

In this policy and any appendix attached to it, the following terms will have the meaning appearing alongside them:

2.1. "The Insurer" – Clal Insurance Company Ltd. (hereinafter: the "Company").

2.2. "The Policyholder" – Maccabi Healthcare Services Ottoman Society no. 227/99 (hereinafter: " Maccabi").

2.3. "Maccabi Shield" – Maccabi Shield – Cooperative Society for Mutual Insurance Against Illnesses Ltd.

2.4. "Member of Maccabi Healthcare Services" – a person who is registered and entitled to receive healthcare services from Maccabi under any law and/or according to the regulations as detailed in the Maccabi Regulations (hereinafter: "Maccabi member").

2.5. "Child" – the son or daughter of a Maccabi member, from birth to the age of 18, registered as a Maccabi member.

2.6. "The Nursing Fund" – a scheme providing nursing cover for members of Maccabi Healthcare Services who joined and/or were joined to it prior to the date of the start of this policy, according to the regulations of the above Fund, as members of the Maccabi Shield Society. The above nursing cover comprises two plans: the "Silver Shield" and the "Gold Shield" , and anyone who joined one of the above plans.

2.7. "The Insured" – a person meeting one of the following conditions:

2.7.1. A member of Maccabi Shield and the children registered with him, who, prior to the determining date, was/were included in one of the two Nursing Fund plans, "Silver Shield" or "Gold Shield", other than a person who, on the determining date, met the definition of needing nursing care according to the definitions set out in the regulations of the Nursing Fund and/or a person who had began to receive a nursing allowance from the Nursing Fund and/or a person meeting the definition of needing nursing care but not entitled to receive a nursing allowance from the Nursing Fund for any reason whatsoever.

2.7.2. A Maccabi member and the children registered with him, who, prior to the determining date, was/were not a member/members of Maccabi Shield and was/were not included in the Nursing Fund, who has/have filled out and signed a written application to join this insurance at the "Gold Shield" level and the Insurer has agreed to insure him/them.

2.7.3. To preclude doubt, it is clarified that all Insured parties under this policy are insured personally, regardless of the insurance or lack of insurance of their spouses, and that the policy will not be revoked with regard to Insured parties in the event of the death or divorce of their spouses. However, in cases where both parents of a child (or children) have canceled their insurance under this policy, the child's (or children's) insurance under this policy will also be canceled automatically. Should one parent cancel the policy (the "Leaving Parent"), his/her child's (children's) insurance will not be canceled unless the leaving parent decides to include the child (children).

2.8. "The Beneficiary" – an Insured party as defined above, to whom an insurance event has occurred and who is entitled to receive a nursing allowance under this policy.

2.9. "The Insurance event" / "Entitling Situation" – one or more of the following two events:

2.9.1. The Insured's poor state of health and functioning due to an illness, accident or health deficiency, as a result of which he is unable to perform alone a substantial part (at least 50% of the action) of at least three of the following six actions:

1. Getting up and lying down – the Insured's independent ability to change position from lying to sitting and/or to get up from a chair, including carrying out this action from a wheelchair and/or bed.
2. Getting dressed and undressed – the Insured's independent ability to put on and/or take off all kinds of items of clothing, including putting together and/or assembling a medical belt and/or artificial limb.
3. Washing – the Insured's independent ability to wash in a bath tub, shower or any other accepted way, including getting in and out of the bath tub or shower.
4. Eating and drinking – the Insured's independent ability to feed himself in any way or means (including drinking, and not eating, with the help of a straw), after the food has been prepared for him and served to him.
5. Continence – the Insured's independent ability to control his bowel movements and/or urination. Failure to control one of these actions, meaning, for example, permanent use of a stoma or catheter in the bladder, or permanent use of diapers or other absorbent pads will be considered as incontinence.
6. Mobility – the Insured's independent ability to move from place to place. Carrying out this action independently and without the help of another person, making use of crutches and/or a cane and/or a walker and/or other device, including a mechanical or motorized or electronic device that is not a wheelchair, will not be considered as impairment of the Insured's independent ability to move. However, confinement to bed or

a wheelchair will be considered as the Beneficiary's inability to move, even if the Insured has the ability to move the wheelchair independently.

2.9.2. The Insured's poor state of health and functioning due to "cognitive impairment" determined by a physician specializing in this field. For this purpose, "cognitive impairment" – impairment of the Insured's cognitive actions and deterioration of his intellectual abilities, including deficient reactions and judgment, deterioration of long-term and/or short-term memory, and lack of orientation in space and time, requiring supervision for most hours of the day, as determined by a physician specializing in the field, due to a health condition such as Alzheimer's or other forms of dementia.

2.10. "Nursing Allowance" –

2.10.1. Nursing home hospitalization – compensation of the Beneficiary in respect of actual expenses paid by the Beneficiary or by his representative for hospitalization in a nursing home as stated in section 6 below.

2.10.2. At-home nursing care – the provision of nursing services at home, or an allowance as stated in section 7 below.

2.11. "Nursing Allowance Ceiling" –

2.11.1. With regard to a Beneficiary staying in a nursing home –

a. According to the Silver Shield plan.

b. According to the Gold Shield plan.

As stated in section 6.1.1, 6.1.2 below.

2.11.2. With regard to a Beneficiary receiving home nursing care –

a. According to the Silver Shield plan.

b. According to the Gold Shield plan.

As stated in section 7.1.1, 7.1.2, 7.1.3 below.

2.12. "Maximum Period of Entitlement to Nursing Allowance" – a cumulative period of no more than 60 (sixty) months (including the accumulation of parts of months), starting after the end of the waiting period, and in respect of which the Beneficiary is entitled to receive nursing compensation.

2.13. "Waiting Period" – a period of 30 days starting on the date that the insurance event occurred, during which the Beneficiary is in a continuous nursing state as defined in the policy, whether at home or in hospital. With regard to this period, the Beneficiary will not be entitled to receive a nursing allowance in respect of the insurance event. To preclude doubt, the Beneficiary will be required to pay the insurance premium during the waiting period too.

2.14. "Insurance Premiums" – the premiums that the Insured is required to pay by the Policyholder under the terms of the policy.

2.15. "Nursing Home" – an institution and/or nursing ward and/or ward for the infirm, including mentally infirm, or a ward in a senior citizen's home or general hospital, or in any other institution approved by the Ministry of Health and/or by the Ministry

of Social Affairs as a nursing home or institution, or approved by the Insurer or its representatives, whose sole or main business is the hospitalization of patients needing nursing care.

2.16. "Nursing Agency" – a corporation whose sole or main activity is to provide nursing services, which has the licenses and permits required by law and by any authority to do so, and which has an agreement with the National Insurance Institute to provide nursing services at home.

2.17. "Insurance Start Date" – with regard to Insured parties as defined in section 2.7.1 above, who have transferred without a break from the Nursing Fund – the determining date as defined below.

With regard to new Insured parties as defined in section 2.7.2 above – on the 1st of the month following the month in which they join this insurance, as stated in section 3.2.2 below.

2.18. "The Determining Date" – July 1, 2008.

2.19. "Application to Join" – a personal application form to join the insurance, including a declaration of health, representing an integral part of the policy, filled out and signed by a Maccabi member wishing to join this insurance as an Insured party.

2.20. "Age" -will be calculated in full years, according to the number of full years from birth to the date in question.

3.Validity of the policy

3.1. Members who were covered by the Nursing Fund:

An Insured person who was a member of the Nursing Fund prior to the determining date will be transferred without a break, without a health declaration, and without repeat underwriting or examination of his previous medical state, and will be insured under this policy as of the determining date, according to the plan to which they belonged in the Nursing Fund, but with the rights accruing to the plan under this policy, other than Insured parties as above whom, on the determining date, were in need of nursing care as defined in the Nursing Fund regulations, and/or had begun to receive a nursing allowance from the Nursing Fund, and/or met the definition of being in need of nursing care but, on the determining date, were not entitled to receive a nursing allowance from the Nursing Fund for any reason whatsoever.

To preclude doubt, it is clarified that there is no qualification period for an Insured person as above, and he will not be required to fill out an application form and/or make a declaration of health when this policy comes into force.

3.2. New members:

A Maccabi member joining this insurance on the determining date or thereafter will be covered by this policy under the Gold Shield plan as of the date of joining, subject to all the following cumulative conditions:

3.2.1. An application to join has been submitted to the Insurer by means of the Policyholder, filled out and signed as required.

3.2.2. The date of joining under this policy will be the 1st of the month following the month in which the member joins, as given in the Maccabi documents sent

to the Insurer each month. This date will represent the start of insurance cover for the Insured under the policy.

3.2.3. The Insurer has approved the application and agreed to include the member in the policy as stated below.

3.2.4. The inclusion of applicants in this insurance requires the completion of a declaration of health, and will be effected after a process of medical underwriting to be carried out by the Insurer.

3.2.5. A newborn infant whose parents or mother are Maccabi members will be automatically included in this insurance, in the plan under which the mother is insured on the date of joining. The Insurer will send a letter to the newborn infant's mother, through Maccabi, informing her that the infant has been included in the insurance. The above letter will note the sections of the policy relating to the scale of cover of newborn infants, and the exceptions set out in the policy relating to genetic defects.

3.2.6. Should an application to join the insurance under this policy be rejected by the Insurer, the applicant can appeal the rejection within 60 days of the date of receiving the decision. The appeal will be heard before the appeals committee with regard to joining, to be set up and convened from time to time.

3.2.7. Notice of the Insurer's decision with regard to rejecting an application for insurance will be given by the Insurer to each applicant for insurance, as well as to the Policyholder. The same is true with regard to decisions of the appeals committee.

3.2.8. An applicant for insurance who does not receive an answer to an application to join submitted by him, after producing a health declaration and all other medical and evidentiary material for the Insurer as required, within 60 days of the date that the said documents are received by the Insurer, will be automatically insured from the starting date of the insurance, under the regular conditions and without any exceptions.

3.2.9. From the date that the applicant signs the declaration of health until the date that the Insurer agrees to insure him, or until the date that he confirms the Insurer's conditions for accepting him into the insurance, and no later than 60 days from the date that the documents as stated in section 3.2.8 are received by the Insurer, there has been no change in his health and physical state that would affect the Insurer's agreement or the terms of the Insurer's agreement to the application to join had it been known.

3.2.10. The applicant to join the insurance has given the Policyholder a bank standing order to pay the insurance premiums, signed by him, or authorization to debit his account

3.2.11. If payments have been made to the Insurer on account of the insurance premiums before the Insurer has agreed to insure the applicant, receipt of said payments will not be considered by the Insurer or by the Policyholder as the Insurer's agreement to draw up the insurance. Payment of insurance premiums after the Insurer's agreement to accept the applicant, and failure to reply to an application to join submitted by the applicant within 60 days

as stated in section 3.2.8 above, will be considered as acceptance of the applicant into the insurance.

3.2.12. Members who have transferred to this insurance from the Nursing Fund and were only covered in the Nursing Fund under the Silver Shield scheme will be entitled to upgrade their cover to the Gold Shield scheme under this policy, subject to the underwriting terms agreed between the Insurer and the Policyholder. These Insured parties will be required to make a declaration of health and medical underwriting only with regard to upgrading to Gold Shield cover.

4.The insurance period:

4.1. The insurance period with regard to each Insured party will begin on July 1, 2013, or from the date that Insured party joined the policy (whichever is later) and end on June 30, 2016. Notwithstanding the above, in the event that the Commissioner of Insurance determines a uniform collective long-term care policy for all health funds (the "Reform"), the policy period will be shortened to conclude on the date when the Reform enters into effect, and in any case no earlier than December 31, 2014.

4.2. Without derogating from that stated above, 12 months after the determining date, and each 12 months thereafter, the Policyholder will be entitled, after consultation with the Insurer, to request changes to the terms of the policy, with the authorization of the Ministry of Finance Capital Markets, Insurance and Savings Commissioner (hereinafter: the "Commissioner of Insurance"), in order to implement changes or conditions set out in laws, regulations or instructions by the Commissioner of Insurance that are valid at the time.

4.3. In any event of non-renewal of the policy by the Insurer or the Policyholder, the Insurer will be obliged to provide cover under the policy only for those insurance events that have occurred prior to the end of the insurance period, and for which a claim has been submitted prior to the end of the limitation period as stated in section 18 below.

5.Continuity:

5.1. In the following cases, and provided that an insurance event under this policy has not occurred, the Insurer will enable Insured parties who have been insured under this policy for at least three years before termination of the insurance to transfer to an individual policy with the Insurer for a lifelong insurance period (hereinafter: the "Continuation Policy"):

5.1.1. In the event that the membership of the Insured in Maccabi has come to an end, or that the insurance period with regard to a particular Insured party has come to an end, the Insurer will contact the Insured party in writing and will offer him the option to transfer to a Continuation Policy within 90 days after the date of termination of his insurance. The start of the insurance period under the Continuation Policy will be retroactive as of the date of termination of the insurance under this policy.

5.1.2. The insurance under this policy is not renewed or is terminated for any reason

whatsoever by the Insurer with regard to all or some of the Insured parties. In this case, the Insurer will write to all Insured parties (or those for whom the policy is not renewed) and offer them the possibility of transferring to the Continuation Policy within 90 days of the date of notice by Insurer. The start of the insurance period under the Continuation Policy will be retroactive as of the date of termination of the insurance.

If there is a change in legislation during the period of this policy, affording Insured parties similar nursing cover to that which exists in this policy, the Continuation Policy will provide additional insurance cover in respect of the cover provided in the group insurance policy that is not given by virtue of the law, in accordance with an agreement between the Policyholder and the Insurer.

5.1.3. The terms of the Continuation Policy will be as follows: an Insured party transferring to the Continuation Policy will receive a reduction in premiums of at least 20% on the insurance premiums offered by the Insurer at the beginning of the insurance period under the Continuation Policy with regard to all those insured by it under a similar policy. This reduction will be in force throughout the insurance period of the Continuation policy.

5.1.4. The amount of the insurance under the Continuation Policy will be as determined in sections 7.1.2, 7.1.3 and 6.1.2, respectively, of this policy, and the period of payment of insurance compensation under the Continuation Policy will have a ceiling for entitlement to a nursing allowance as defined in this policy.

5.1.5. The transition to the Continuation Policy will provide insurance continuity (without a declaration of health and without repeat underwriting or examination of previous medical condition), without an qualification period.

5.1.6. The Insured will be entitled to purchase reduced insurance compensation in the framework of the Continuation Policy.

6.Nursing allowance for a Beneficiary hospitalized in a nursing home:

When an insurance event occurs, after the waiting period and subject to the terms of this policy, the Insurer will indemnify a Beneficiary in a nursing home in respect of actual hospitalization expenses in the nursing home, at the following rates and for the following period:

6.1. Ceiling of nursing allowance for a Beneficiary hospitalized in a nursing home

The ceiling of compensation during the period of entitlement to a nursing allowance, that is, up to 60 months, will be as detailed below:

6.1.1. Silver Shield members – compensation at a rate of 40% of expenses for nursing home hospitalization, up to a ceiling of NIS 5,000 a month.

6.1.2. Gold Shield members – compensation at a rate of 80% of expenses for nursing home hospitalization, up to a ceiling of NIS 10,000 a month.

6.2. Manner of payment of nursing allowance

6.2.1. The nursing allowance under section 6.1 above will be paid against presentation of an original receipt by the Beneficiary or his representative,

together with a legal tax invoice, for payment in practice of the nursing home hospitalization expenses.

Payment will not be made against photocopies of receipts and invoices or true copies of the original. Notwithstanding that stated, if the Beneficiary has submitted a request to another entity for payment, full or partial, in respect of the insurance event, a true copy of the original can be submitted together with confirmation from the entity to whom the original document was submitted with regard to the amount claimed from the other entity. In such a situation, the Insurer will indemnify the Beneficiary in accordance with the provisions of the Insurance Contract Law, providing that in any event the total compensation to the Beneficiary does not exceed the lower of the following two amounts:

a. The Beneficiary's total expenses in practice

b. The amount of the compensation to the Beneficiary as stated in this policy.

6.2.1.1. Compensation will be paid in all cases in which the expenses were paid out in practice prior to the date of compensation. Compensation will be paid to the Beneficiary or to his legal representative.

6.2.2. The insurance compensation will be paid by the 15th of each month in respect of the previous month, subject to confirmation by the Insurer of the receipts or invoices or business receipts that are the subject of the payment.

7.Nursing allowance for a Beneficiary receiving home nursing care:

7.1. When an insurance event occurs, after the waiting period and subject to the terms of this policy, the Insurer will provide a Beneficiary staying in his home with home nursing care services, provided in practice to the Beneficiary by means of a nursery agency as defined above in section 2.16 with which the Insurer is connected, or will compensate the Beneficiary with a fixed monthly allowance, as chosen by the Beneficiary or his representative from the three options as detailed in the following tracks:

7.1.1. Receiving nursing care from a nursing agency (Israeli carer):

a. Silver Shield members – 25 hours a week

b. Gold Shield members – 36 hours a week

7.1.1.1. The Beneficiary will be entitled to receive nursing care from a nurse, for the number of hours as stated above, for a period of no more than 60 months, so long as the Beneficiary meets the definition of an entitling condition as defined in section 2.9 above, at the weekday daytime rate.

7.1.1.2. The Beneficiary can convert the said nursing care hours to the proportionate number of evening / nighttime or Friday / Saturday hours. One weekday nursing care hour will be calculated at not less than the hourly rate for daytime care paid to a not-for-profit organization for the purpose of the National Insurance Institute Nursing Law, as published from time to time.

7.1.1.3. The cost of the service will be paid by the Insurer to the service provider with which it has an agreement.

7.1.1.4. A Beneficiary wishing to increase the scope of the service beyond the quota detailed above will bear the cost of the treatment and/or supervision, to be paid directly to the service provider, at a rate that will be determined in advance in the agreement with the service providers.

7.1.1.5. If there is no nursing agency in the area where the Beneficiary is staying that is able to provide the service as stated above, the Insured will be offered the foreign worker employment track in accordance with section 7.1.2, or an allowance as stated in section 7.1.3, below.

7.1.2. Compensation by fixed monthly payment for the employment of a foreign worker:

a. Silver Shield members – NIS 3,500 a month

b. Gold Shield members – NIS 4,500 a month

The Beneficiary will be entitled to a nursing allowance and will receive payment of a fixed monthly amount as detailed above. The monthly allowance will be paid to him each month if the following cumulative conditions are met:

1. Before the start of said allowance payments, the Beneficiary has produced confirmation of lawful employment of a foreign worker.
2. He produces said confirmation once every 12 months, and/or at the Insurer's request at an earlier date.
3. The allowance period will be up to 60 months, as long as the Beneficiary meets the definition of an entitling condition as stated in section 2.9 above.

7.1.3. Allowance by fixed monthly payment – as detailed below:

a. Silver Shield members – NIS 3,000 a month

b. Gold Shield members – NIS 4,000 a month

Should the Beneficiary or his representative decide not to choose one of the two alternatives in section 7.1.1 or 7.1.2 above, the Beneficiary will receive a nursing allowance as detailed above, in accordance with that stated in this policy, for an allowance period of up to 60 months, as long as he meets the definition of an entitling condition as stated in section 2.9 above.

8.Transferring between plans and tracks:

8.1. The Beneficiary or his representative will be entitled, at any time, to change their decision with regard to the manner of utilization of entitlement under the terms of this policy, and transfer from the at-home nursing care track – both receipt of the service in practice and an allowance in respect of employing a foreign worker or regular payment, to the track of compensation in respect of hospitalization in

a nursing home as stated in section 6 above. In addition, all Beneficiaries will be entitled to transfer from the nursing home hospitalization track to the at-home nursing care track and the reverse, to transfer from the track in which the service is received in practice to the track providing an allowance for employing a foreign worker, or to the regular payment track, as stated in the terms of the policy.

8.2. The application to transfer from one track to another as stated above will be made by application in writing by the Beneficiary or his representative to the Insurer, who will organize implementation of the requested change in accordance with the procedures set out by the Insurer.

8.3. If the Beneficiary or his representative chooses the track providing a fixed monthly nursing allowance for a foreign worker and has not yet arranged or completed the necessary processes for employing a foreign worker, he can choose to receive nursing services from a nursing agency or to receive an allowance. If he chooses to receive payment, he will be paid a nursing allowance in accordance with the nursing track as stated in section 7.1 .3 above, in accordance with his entitlements under the terms of the policy. When his application for a foreign worker is approved, he will receive the nursing allowance according to the foreign worker payment track as of the date of approval by law or the date that the foreign worker starts working in practice, the later of the two dates.

9.Nursing allowance – general:

9.1. The nursing allowance from the Insurer will be paid to the Beneficiary within 30 days of the date that the information and documents required for clarifying its liability are received by the Insurer.

9.2. The Beneficiary will not be entitled to receive a nursing allowance under this policy in respect of the waiting period.

9.3. The nursing allowance under this policy is given in addition to and independent of any nursing payment or nursing service that are given to the Beneficiary by the state in respect of the Insurance event, including under the National Insurance Law (combined version) 5755 – 1995.

9.4. In any situation where the Beneficiary is entitled to receive a nursing allowance in respect of part of a month, the ceiling for the nursing allowance will be proportional to that portion of the month.

9.5. It will not be possible to accumulate entitlement to nursing payments in respect of nursing services under section 7.1 and its subsections, or to nursing home compensation under section 6.1, that has not been utilized to the full ceiling of the nursing allowance by the Beneficiary in a particular month in order to increase the nursing allowance in respect of the Beneficiary in another month. That stated in this section will also apply to partial months, with the necessary changes.

9.6. The periods when the Beneficiary receives a nursing allowance, whether under section 6 or under section 7 and their subsections above, under this policy or under the Nursing Fund, are cumulative periods and in any event will not cumulatively exceed the ceiling of the period of entitlement to a nursing allowance.

9.7. If the Beneficiary is entitled to a nursing allowance under this policy, and a guardian has been appointed for him by the court, the Insurer will pay the insurance compensation to the guardian appointed as stated.

9.8. The Beneficiary's entitlement to receive a nursing allowance will stop on the date when the Insurance event ceases to exist, or when the ceiling of the entitlement to a nursing allowance is reached, or on the death of the Beneficiary, the earliest of these dates. If the Beneficiary dies during the period of entitlement, the nursing allowance will be paid to his estate as stated in section 9.10 below.

9.9. **Repeat nursing care condition** – If the Insurer stops paying the Beneficiary a nursing allowance under this policy, due to an improvement in his condition such that he no longer needs nursing care and is not entitled to a nursing allowance, before the full ceiling of the period of entitlement to a nursing allowance is reached, and afterwards the Beneficiary returns to a condition entitling him to a nursing allowance under this policy, the Beneficiary will be entitled to a nursing allowance as of this date, without an additional waiting period. The cumulative period during which the Beneficiary is entitled to receive a nursing allowance before and after the break will not exceed the ceiling of the period of entitlement to a nursing allowance. To preclude doubt, it is clarified that even in the event that the new nursing care situation is not related to the previous nursing care situation, no additional waiting period will apply.

9.10. **The Beneficiary's death** – should the Beneficiary die while entitled to receive a nursing allowance, and providing the ceiling of the period of entitlement to a nursing allowance has not been reached, his heirs must report to the Insurer. If a Beneficiary dies, the full nursing allowance for that month will be paid, other than for those who receive nursing care services through a nursing agency.

9.11. **Exemption from paying insurance premiums** – during the period in which the Beneficiary is entitled to a nursing allowance, the Beneficiary will be exempt from paying the insurance premium. It is agreed is that the Insurer is required to inform the Beneficiary or his representatives of exemption from payment of insurance premiums immediately on the start of payment of the nursing allowance, and will also inform the Policyholder of this fact. It is emphasized that during the waiting period the Insured is also required to pay the insurance premium as determined in section 2.13 above.

To preclude doubt, if the Insurer ceases payment of the nursing allowance in respect of the Beneficiary before reaching the ceiling of the period of entitlement to a nursing allowance, the Beneficiary's obligation to pay insurance premiums will be renewed as of the date that his entitlement to a nursing allowance comes to an end. The Insurer is required to give notice of resumption of payments of premiums, both to the Beneficiary and/or his representatives and to the Policyholder.

9.12. **Voiding of the policy after reaching the end of the period of entitlement to a nursing allowance** – on reaching the ceiling of entitlement to a nursing allowance in full, the policy will be canceled with regard to the Beneficiary, who will not be entitled to any additional amount or service under this policy.

10.Exceptions to the Insurer's liability

The Insurer will not be liable for the provision of a nursing allowance under this policy in respect of an insurance event taking place within one or more of the periods detailed below:

10.1. **The insurance event occurs to a child who is not yet 12 months old.**

10.2. **The insurance event occurs before the start date of the insurance or after the end of the period of insurance.**

The Insurer will not be required to provide a nursing allowance under this policy in respect of an insurance event that occurs as a result or in respect of one or more of the events given in the following sections:

10.3. **Participation in an illegal activity.**

10.4. **Chronic drunkenness or the use of drugs other than by doctor's prescription.**

10.5. **The Insured party's service in the IDF or another security entity, or participation in any kind of security activity, including military or police action, warfare, revolution, hostile action, nationalist action, riots, strikes, and including passive participation in these events.**

10.6. **Flying in any kind of aircraft, other than as a regular passenger on a civil commercial flight or a private flight in a civilian aircraft approved by the qualified authorities.**

10.7. **Acquired Immune Deficiency Syndrome (AIDS) or any other similar illness or syndrome.**

10.8. **Traffic accident. The term "traffic accident" will be interpreted in accordance with the Compensation for Victims of Traffic Accidents Law 5735 – 1975, or any other law that replaces it.**

10.9. **Nuclear fission or meltdown, radioactive pollution.**

10.10. **Any congenital defect or illness, for genetic for other reasons, including a defect or injury caused due to the pregnancy or birth with which the Insured is born, providing this has been determined by documented medical diagnosis within 12 months of birth.**

11. Stipulation due to previous medical condition – applying to new members only:

This stipulation applies only with regard to Insured parties joining this insurance after the determining date, and does not apply to Insured parties who were members of the Nursing Fund on the determining date.

11.1. **The Insured will not be entitled to receive a nursing allowance in the event of an insurance event for which the actual cause was the normal course of a previous medical condition.**

11.2. **"Previous medical condition" meaning – a set of medical circumstances with which the Insured was diagnosed before the date of joining the insurance, including due to illness or accident; for this purpose: "the Insured was diagnosed" – by means of documented medical diagnosis, or in a process of documented medical diagnosis carried out during the six months prior to the date of joining the insurance.**

11.3. **Validity of stipulation due to previous medical condition: this stipulation, with regard to an Insured aged less than 65 on the date of starting the insurance period, will be valid for a period of one year from the start of the insurance periods. With regard** to an Insured whose age on the date of starting the insurance period is 65 or more, the stipulation will be valid for a period of six months from the start of the insurance period.

11.4. **Validity of stipulation due to a particular medical condition of a particular Insured party:** notwithstanding that stated above, a stipulation regarding the Insurer's liability or the scope of cover in the event of a particular medical condition detailed with regard to a particular Insured party, due to medical underwriting carried out for the Insured party, will be valid for the period given in the insurance list alongside the particular medical condition.

11.5. **Non-application of the stipulation:** this stipulation will not apply if the Insured has informed the Insurer of his previous state of health, and the Insurer has not explicitly restricted the particular medical condition mentioned in the Insured party's notification.

12.The claim:

12.1. The Beneficiary will inform the Insurer of the occurrence of a medical event, as close as possible to the date on which it occurs.

12.2. The obligation and the right to submit and establish a claim applies to the Insured or his representative, and only to them. It is hereby clarified that the Policyholder may not submit and will not submit a claim to the Insurer under this policy, at its initiative or on behalf of the Insured.

12.3. The Beneficiary will produce for the Insurer all the documents that the Insurer requires for clarifying its liability under this policy, and will sign a waiver of confidentiality to enable the Insurer to obtain both medical information and functional information about the Beneficiary. The Insurer will be entitled, at its expense, in a reasonable manner, and within a reasonable period of time as agreed between it and the Policyholder, to carry out any action and to have the Beneficiary undergo functional and/or medical testing by a doctor or other medical service provider on its behalf, at its sole discretion. These obligations apply to the Insured / the Beneficiary both before and during the period in which he is entitled to receive a nursing allowance.

12.4. An Insured party who does not receive a response to a claim submitted by himself and/or his representative, after providing the Insurer with all the medical and/or other documents required as stated above, and after agreeing to undergo functional evaluation or other medical testing if this is required of him, or an Insured party who has undergone functional evaluation as stated but has not received a response to his claim thereafter, may consider himself to be a Beneficiary whose entitlement has been proved under the terms of this policy and for cover by the Insurer. This holds true if 60 days have passed since the claim was submitted to the Insurer as stated above, or if 45 days have passed since implementation of a functional evaluation by the Insurer.

12.5. Functional evaluation of the Beneficiary will be carried out by the Insurer or by a person acting on its behalf, after coordination with the Beneficiary or his representative.

12.6. In the event of an improvement in the Beneficiary's condition such that he is no longer in an entitling condition, the Beneficiary must inform the Insurer of this immediately, and no later than within 30 days of the improvement in his condition.

12.7. In the event of the death of the Beneficiary, and if no other person on his behalf as stated is entitled to receive the nursing allowance under the policy, the Insurer will pay the estate of the Insured party the balance of the nursing allowance that

should have been paid to the Beneficiary for the period in which he was entitled to receive it, and that was not paid prior to his death.

12.8. If a nursing allowance was paid to the Beneficiary and/or to his estate in respect of a period for which he was not entitled to it, whether due to an improvement in his condition and/or due to his death as stated above, the Insurer will be entitled to its repayment. The above amounts will be repaid to the Insurer linked to the CPI, without interest.

13.Appeals committees

13.1. If the Insured party's claim for a nursing allowance is rejected, wholly or in part, for medical and/or other reasons, he will be sent a reasoned notification by the Insurer, drawing his attention to his entitlement to submit an appeal to the appeals committee within 60 days of the date of receiving notification.

13.2. The Insured will be entitled to submit documents and a medical and functional opinion to the appeals committee as he sees fit, or as requested by the committee. In addition, the committee will enable the Insured and/or his representative to appear before it.

13.3. The Insurer will give the committee all the material in its possession relating to the claim, whether given to it by the Insured or obtained other than from the Insured.

13.4. The appeals committee will be authorized to discuss the claim, and accept or reject it in accordance with the terms of the policy.

13.5. Decisions of the appeals committee will be taken by a majority of votes. In the event of an equal number of votes, the director of the insurance department at Maccabi or a person appointed by the executive director of Maccabi will have the right to decide, and his decision will be final, may not be appealed, and will be binding with regard to the Insurer.

13.6. The Insurer will be bound by the decision of the appeals committee, which will be considered as the Insurer's decision in all respects.

13.7. The decision of the appeals committee or an appeal to the committee will not affect the Insured party's right to appeal to legal instances for clarification of his rights under the policy.

13.8. For the purposes of this section, "appeals committee" means a committee comprised of three representatives of Maccabi and three representatives of the Insurer; four of them – two from each party – will make up a legal quorum; and the committee's working methods will be agreed between Maccabi and the Insurer. It is emphasized that at least one of the representatives on the appeals committee will be a doctor by training, and at least one other representative will be a lawyer by training.

Appeals committee regarding joining the insurance policy

13.9. If the application of a applicant wishing to join the insurance as stated in section 3.2 .6 above is rejected, he will be entitled to submit an appeal against his rejection to the appeals committee within 60 days.

13.10. The above appeals committee will comprise a representative of the Policyholder and a representative of the Insurer. The applicant for insurance will present the

committee with all his reasons, both medical and others, and may also present written opinions from his physicians.

13.11. If the members of the above appeals committee do not reach an agreed decision, they will be entitled, by common consent, to bring in a physician in the relevant field whose decision will be binding.

14.Linkage:

14.1. All payments made to the Insurer and by the Insurer under this policy will be linked to the index as detailed below:

14.2. All of the Insurer's payments under the policy will be linked once a quarter, at the beginning of each quarter, to the rate of increase or decrease in the current index as compared with the base index.

14.3. All insurance premiums to be paid by the Insured to the Insurer will be linked once a quarter to the current index as compared with the base index (that is, payments will be linked to the index whether the current index is higher or lower than the base index).

14.4. If payments are made by bank transfer, the date on which payment is made will be the date on which the money is actually transferred to the Insurer or the Insured.

14.5. The following terms will have the meaning appearing alongside them:

"Linkage to the index" – multiplication of the said amount by the ratio between the last index published before the calculation of index linkage and the base index;

"Index" -the consumer price index (including fruit and vegetables) determined by the Central Bureau of Statistics, including any other official index replacing it, even if published by any other government institution that replaces it;

"The base index" – the index known on the determining date;

"The current index" – the index known at the start of the quarter in which the payment is made.

15.Insurance premiums and methods of payment:

15.1. Insurance premiums for each Insured party are as detailed in the table of insurance premiums attached to this policy, and vary in the course of the insurance period according to the age group and insurance group in which the Insured party is insured.

15.2. Insurance premiums for new members under the policy who, on the date of joining, are aged over 50 will be as stated in the table of insurance for new members over the age of 50, attached to the policy. Insured parties who, on the determining date, pay registration fees together with their insurance premiums will continue to pay them according to the spread of registration fees by Maccabi Shield, until payment is completed.

15.3. The Insured party will pay the insurance premiums once a month, as customary for the Policyholder, by direct debit authorization or any other means that the Policyholder uses with regard to its members.

15.4. Payment of the insurance premiums to the Insurer will be made collectively by the Policyholder or its agents for all the Insured parties.

15.5. If the insurance premiums, or part of them, are not paid to the Policyholder on time, the Policyholder will give details of the Insured party to the Insurer, for collection or for cancellation of the policy with regard to an Insured party who has not paid the insurance premiums. During the first 180 days that the Insured party has not paid the insurance premium, the Policyholder will send two warning letters to the Insured party in question, on behalf of the Insurer, at times to be agreed between the Policyholder and the Insurer.

15.6. In the above letters, the Insurer or the Policyholder on its behalf will warn of the Insured party's non-payment and the consequences of non-payment, which is liable to affect the Insured's rights under the policy.

15.7. If warnings as stated in section 15.5 and 15.6 above have been sent and the late insurance premiums have not been paid to the Insurer, an additional notification will be sent to the Insured party on behalf of the Insurer with regard to cancellation of the policy. After notification has been sent as stated above, insurance under the policy will be canceled by the Insurer, subject to the Insurance Contract Law.

It is hereby clarified that until said period of 180 days has elapsed, and until the policy has been canceled as stated above, the policy will remain valid despite the delay in payment of the insurance premiums.

15.8. If the Insured party responds by paying the late insurance premiums as stated above, the Insurer will be entitled, in addition to the insurance premiums, to charge the Insured party an addition of interest on the late payment as set by the Accountant General, from the initial date of the delay and until the date of payment in practice.

15.9. The Policyholder will be entitled, at its sole discretion, to instruct the Insurer to increase the insurance premiums once every 12 months, subject to authorization by the Commissioner of Insurance, but no earlier than 36 months after the determining date. If the Policyholder decides to increase the insurance premiums, the Insurer will inform the Insured parties of this, in advance and in writing.

15.10. In addition, and without derogating from that stated above, the Insurer will be entitled to change the insurance premiums under this policy beyond the increase in the index, if said increase is required as a result of legislative provisions or the instructions of a government authority, in accordance with that agreed with the Policyholder and with the advance authorization of the Commissioner of Insurance.

15.11. Insured parties under this policy will be exempt from paying insurance premiums during their compulsory service in the IDF. Additionally:

15.11.1. Insured parties under this policy who have reached the age of 18 will be exempt from paying insurance premiums in respect of this policy for a period of 12 full months, until they reach the age of 19.

15.11.2. An Insured party who completes compulsory military service and continues to be insured under this policy will be entitled to make up the period of up to 12 months without payment of insurance

premiums, if he has not utilized this entitlement in full prior to his military service.

15.12. Depositing money prior to acceptance of the insurance proposal:

15.12.1. If money is paid to the Insurer on account of the insurance premiums before the Insurer has agreed to insure the applicant, this payment will not be considered as agreement by the Insurer to draw up the insurance.

15.12.2. Rejection of the insurance proposal, or referral for the completion of data, or returning to the Policyholder with an insurance counter-proposal will be carried out within no more than three months from the date of receiving the first regular deposit; or, if the Insurer has contacted the Policyholder or the Insured party, as relevant, with a request for completion of data or with an insurance counter-proposal, six months from the date of receiving the first regular deposit.

15.12.3. If the Insurer has not rejected the insurance proposal, and has not returned to the Policyholder with a counterproposal or requested completion of data, and has not informed the Policyholder that the Insured party has been accepted under the insurance within the said period, the Insured party will be considered as having joined the insurance under regular conditions.

16.Option of purchasing individual nursing policies:

16.1. Each Insured party will be entitled to purchase individual nursing policies from the Insurer (the Individual Policies) for the Insured party's lifetime, in addition to the nursing allowance under this policy.

16.2. The Insured will be given the option of purchasing Individual Policies of two types:

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

16.2.2. An individual policy extending the period of the insurance payments beyond the period of entitlement to a nursing allowance in force under this policy (after entitlement under this policy has been fully utilized for a period of 60 months). The period of entitlement under this individual policy will be for the Insured party's lifetime.

16.3. A member of the Nursing Fund before the determining date who has transferred directly to this policy and wants to purchase an individual policy will complete the application form, which includes a health declaration, and will undergo medical underwriting by the Insurer in accordance with the form in use by the Insurer for policies of this kind.

16.4. The terms of insurance under the Individual Policies will be according to the form of individual policies in use by the Insurer at the time of purchase.

16.5. Insurance premiums collected by the Insurer from the Insured in respect of Individual Policies will be at least 20% lower than the lowest insurance premiums approved by the Commissioner of Insurance in use by the Insurer at that time in respect of

equivalent individual policies for the plan selected by the Insured, for an insured party of a similar age and state of health. Said discount will be in force throughout the life of the Insured.

16.6. The insurance premiums in respect of increasing insurance compensation under this policy for life will be decided between the Insurer and the Policyholder. In addition, the Insurer undertakes to confirm the individual policy with the Commissioner of Insurance.

16.7. An Insured party who joins the insurance after the determining date and wants to purchase the Individual Policies will fill out an application form and will be asked to make a declaration of health and undergo medical underwriting in accordance with the form in use by the Insurer for policies of this kind. In the case of an Insured party aged over 65, the Insurer may asked him to be examined by a doctor on its behalf. To preclude doubt, that stated above will apply also to those who were members of the Nursing Fund and who transfer without a break to insurance under this policy, if they wish to purchase said Individual Policies.

16.8. The Insured will pay the insurance premiums in respect of the Individual Policies directly to the Insurer, without the involvement of the Policyholder

17. Limitation of the Insurer's liability outside the borders of Israel

The Insurer's liability in respect of an insurance event occurring to the Beneficiary when staying outside the borders of Israel will be limited to providing a nursing allowance as stated in the policy, for a period of three months only, unless the Insurer has agreed, in advance and in writing, to accept liability on a different scale. In any event, the nursing allowance will be paid only in Israel. On the Beneficiary's return from abroad, payment of the nursing allowance will continue on the basis of medical documents and in accordance with the terms set out in this policy.

18. Period of limitation

The period of limitation applying to a claim for payment of insurance compensation under this policy is three years from the date that the insurance event occurs.

19. Transfer provisions

19.1. When this policy comes into force, its provisions will apply with regard to all those transferring from the Nursing Fund, in place of the provisions of the Nursing Fund, other than for those who, on the determining date, meet the definition of needing nursing care under the regulations of the Nursing Fund and have not been transferred to this policy.

19.2. A Beneficiary who has been defined as needing nursing care under the regulations of the Nursing Fund (hereinafter: a Need of Care Case) will continue to receive nursing services in accordance with the Nursing Fund regulations, whether or not he receives a nursing allowance and/or received a nursing allowance. It is hereby clarified that said Beneficiary will not be entitled to insurance and insurance compensation under this policy.

Notwithstanding that stated above, if the Beneficiary ceases to fall into the category of Need of Care Case under the regulations of the Nursing Fund, as a result of an improvement in his functional condition, it is agreed that such a Beneficiary will become an Insured party under this policy from the date that he ceases to

meet the definition of Need of Care Case due to an improvement in his functional condition, and from this date will pay insurance premiums to the Insurer as stated in this policy, providing that after the improvement in his functional condition, the Insured party does not meet the definition of the insurance event. If an insurance event as defined by this policy occurs to the Insured in the future, he will be entitled to receive a nursing allowance under this policy for the remaining period of his entitlement to a nursing allowance, that is, up to the ceiling of the period of entitlement to a nursing allowance less the number of months that he was entitled to receive compensation under the regulations of the Nursing Fund.

19.3. If the Insurer rejects the claim of an Insured party who was covered by the Nursing Fund and who transferred to this policy without a break as stated in section 3.1 above, on the grounds that the insurance event took place before the determining date, the burden of proof that the definition of Need of Care Case existed with regard to the Beneficiary prior to the determining date lies with the Insurer.

19.4. If the Insurer proves that the insurance event occurred prior to the determining date, the Insured party will be returned to the responsibility and care of Maccabi Shield in accordance with the regulations of the Nursing Fund. If the Insurer claims, as stated, that the insurance event occurred prior to the determining date, the matter will be brought up for discussion by an exceptions committee, whose members will be representatives of the Insurer and representatives of Maccabi Shield and the Policyholder. The Insurer will be bound by the decision of the appeals committee.

There is nothing in the decision of the appeals committee to derogate from the right of the Insured party to appeal to legal instances for clarification of his entitlement to insurance compensation under the policy.

19.5. If the Insured party's claim is rejected as stated in section 19.3, the Insurer will return in full the insurance premiums paid as of the determining date by the Insured, with the addition of late payment interest as determined by the Accountant General, within 30 days of the date of rejecting the claim, and the claim will be dealt with in accordance with the regulations of the Nursing Fund. It is clarified that the Insurer will not be entitled to turn to the Insured to collect insurance payments that have been paid to him in practice under this policy.

19.6. Notwithstanding that stated in section 10.2, if it emerges that an Insured party who was covered by the Nursing Fund and who transferred to this policy without a break as stated in section 3.1 above became a Need of Care Case prior to the determining date but submitted his claim 12 months after the determining date, he will come under the responsibility of the Insurer under this policy.

19.7. Taxes and duties:

The Insured is liable for payment of all government and other taxes applying under this policy or imposed on the insurance premiums and on insurance compensation or any other payments that the Insurer has to pay under this policy, whether these taxes exist on the date that the policy becomes valid or are imposed at a later date. It is clarified that the insurance premiums on the determining date include all taxes and imposts that apply on this date.

20. Terms Pursuant to the Control of Financial Services Regulations (Insurance) (Collective Health Insurance), 5769-2009

20.1 The policyholder hereby declares and undertakes, with regard to his status as policyholder, that it will act in a loyal and dedicated manner, in favor of the insured parties only, and that it does not gain, and will not gain, any benefit due to its status as the policyholder;

New members

20.2 According to the long-term care insurance policy, the insured is required to pay, at the beginning of the insurance period, insurance premiums, or a part thereof, including in the event that these premiums have been collected after the above date. The insurer will not add the insured to the insurance in question without his express, advance and documented consent, and in the case of an insured party who is the child or spouse of a member of the insured group – the insurer will be entitled to add him after consent has been provided by the same member regarding the addition of his child or spouse.

Renewal

20.3 Section 20.2 will not apply regarding a collective long-term care policy which will be renewed for a additional period with the same insurer, or with another insurer, in the event that the following conditions have been fulfilled:

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

(2) The collective policy was renewed, whether under the same terms or under different terms, in a manner which maintains continuity of insurance with respect to the insurance cover which was in force until the renewal date, and which was included in the collective policy after that date; on this matter, "maintaining continuity of insurance" shall mean maintaining continuity without a renewed evaluation of a prior medical condition, and without a qualifying period.

20.4 The insurer will provide, at the start of the insurance period, to each individual in the insured group, whether they have joined for the first time or on the date of the insurance's renewal of for an additional period, a copy of the policy, a due disclosure form in accordance with the Commissioner's instructions, an insurance details page, as well as additional documents as will be instructed by the Commissioner; in this section, "renewal of insurance" excludes the extension of the insurance period without any change to the insurance premium, and in accordance with the terms of the insurance cover, for a period which does not exceed three months, during which time negotiations will be conducted between the policyholder and the insurer regarding the renewal of the insurance for an additional period.

20.5 The insured will be required to pay insurance premiums, or a part thereof, and will send to the insurer, upon its demand, a copy of the contract between the insurer and the policyholder, within 30 days after the date on which the request submitted by the insured was received.

20.6 In the event that a change occurs in the insurance premiums or in the terms of the insurance cover, on the date of the renewal of the collective long-term care insurance,

or during the insurance period (in this section – the change commencement date), the insurer will deliver to each individual in the insured group, 30 days before the change commencement date, notice in writing which will include details of the aforementioned change; on this matter –

"Change in insurance premiums" – including transferring the obligation for the payment of the insurance premiums from the policyholder to the insured, in whole or in part, or an extension thereof, and excluding a change to the insurance premiums due to the linkage thereof to a predetermined index, or a change in the insurance premiums due to a transition between age groups, as specified in the table of premiums which is attached to the policy;

"Change in the terms of insurance cover" – excluding an extension of the insurance period for a period of no longer than three months, during which time negotiations will be held between the policyholder and the insurer regarding the renewal of the insurance for an additional period.

20.7 The insured is required, on the date of their addition to the collective long-term care insurance, to pay insurance premiums whose collection will commence, under the policy terms, after the above date. The insurer will deliver, to any party which is not the policyholder that pays the insurance premiums, written notice regarding the date on which the collection of the insurance premiums will begin; such notice will be delivered to the insured during the period of three months which precedes the aforementioned date of collection.

20.8 In the event that the insurance has been renewed, or its terms modified, during the insurance period, without the express consent of the insured as specified in section 20.3, and where the insured has notified the insurer or the policyholder, during the period of 60 days after the date of the renewal or modification of the insurance, as applicable, regarding a cancellation of the insurance for the same insured party, the insurance will be cancelled regarding that insured party on the date of renewal or modification of the insurance, as applicable, provided that no claim for the realization of rights under the policy has been filed due to an insurance event which took place during the aforementioned 60 day period.

20.9 The collective long-term care insurance policy will not expire regarding an insured party prior to the end of the insurance period, and all insurance covers under such policy will apply until the end of the insurance period, in the event that the insurer has received insurance premiums for the insured with respect to these covers.

20.10 The insurer will be liable, on an individual basis, towards the insured, regarding the entire amount of insurance compensation, up to the ceiling amount set forth in the collective policy, including in the event that the insured is entitled to received repayment of expenses with respect to an insurance event, and including under another long-term care policy, whether provided by the same insurer or by another insurer.

20.11 In policies where the insurance compensation specified therein is paid according to the rate of damage caused, the insurers will bear the burden of charging amongst themselves, according to the ratio between the ceiling limits for insurance compensation associated with the insurance event, as these are set forth in the insurance policies.

21.General:

21.1. It is clarified that the Policyholder is not the delegate or representative of the Insurer in any way whatsoever, and that the Insurer alone will be responsible for fulfilling its undertakings towards the Insured parties under this policy.

21.2. The address of the parties for the purpose of giving notice with regard to the provisions of this policy are:

The Policyholder: Maccabi Healthcare Services

The Insurer: Clal Insurance Company Ltd.

The Insured: the latest address of the Insured as appearing with the Policyholder.

Any notification sent by registered mail according to the addresses given above will be considered to have been received by the addressee within 72 hours of the letter including the notification being sent by mail, and proof that the letter was handed in at the post office will serve as proof of its delivery.

Insurance premium variables

Table of insurance premium variables

Monthly Insurance Premiums

Age Groups	Silver Long-Term Care	Gold Long-Term Care
0-17	0.00	0.00
18-29	5.05	5.45
30-35	14.34	20.10
36-40	18.69	26.36
41-45	19.49	27.37
46-50	42.82	57.87
51-55	48.08	64.94
56-60	52.12	72.32
61-65	60.10	85.75
66-70	76.46	108.78
71-74	93.93	128.78
75-80	104.54	140.19
81 and more	108.07	148.77

* The premiums vary according to the Insured party's age group, and are linked to the CPI.
* 18-year-olds are given a one-year exemption from payment of the premium. Soldiers in compulsory military service continue to be covered without payment of a premium. After demobilization from compulsory service the balance of the one-year exemption will be paid.

Additional premium for upgrading from Silver Shield to Gold Shield

Age	Up to 53	54-55	56-57	58-59	60-62	63-66	67	68	69	70
Monthly premium	0	10	20	30	40	70	80	100	110	120

Additional premium for new members

Age	Up to 53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70
Monthly premium	0	10	30	50	70	90	110	130	150	170	200	220	240	270	300	320	350	380

* The above premium will be paid in addition to the premium given for the Gold Shield track, for five years.
* The premiums given in the above tables are updated to July 2008, and will be updated quarterly according to the consumer price index.

Useful information about the terms of the policy

Questions and Answers

- **What is long-term care insurance?**

Long-term care insurance is an insurance plan under which the insured pays insurance premiums on a monthly basis, according to his age. This payment ensures that if, in the future, the insured requires long-term care and is unable to function independently in daily life, he will be entitled to receive a monthly insurance allowance from the insurance company. This compensation will enable him to receive indemnification, repayment of expenses or nursing services, according to the terms of the policy.

- **Why did Maccabi Healthcare Services prepare a new long-term care insurance scheme with an insurance company in July 2008?**

In 2001, the Commissioner of Insurance instructed Maccabi Shield to transfer its members to an insurance company. After a protracted legal struggle, the Supreme Court determined that Maccabi Shield, in coordination with the Commissioner of Insurance, was required to transfer the members of Maccabi Shield to an insurance company.

Following this decision, Maccabi created a highly advanced long-term care insurance policy to meet the needs of members requiring nursing care, and published a tender among the insurance companies.

In 2008, Clal Insurance Company won the tender, after having submitted the best offer in terms of both quality of service and price (premiums).

- **What does the extension of the collective policy mean?**

The insurance period which began on July 1, 2008 concludes on June 30, 2013. The parties are currently implementing the option set forth in the agreement between them, and are extending the policy by an additional 3 years. Notwithstanding the above, in the event that the Commissioner of Insurance determines a uniform collective insurance policy for all health funds (the "Reform"), the policy period will be shortened to end on the date when the Reform enters into force, and in any case no earlier than December 31, 2014.

The insurance premiums paid with respect to the rights in the policy will not change, excluding their continued linkage to the index set forth in the policy, and according to the age groups specified in the policy.

- **What is the insurance period according to the policy?**

The insurance period with respect to each insured party begins on July 1, 2013, or from the date on which the same insured joins the policy (whichever is later), and ends on June 30, 2016.

Notwithstanding the above, in the event that the Commissioner of Insurance determines a uniform collective insurance policy for all health funds (the "Reform"), the policy period will be shortened to end on the date when the Reform enters into force, and in any case no earlier than December 31, 2014.

- **What are the policy's main advantages?**

1. In Gold Long-Term Care – the participation ceiling amount in long-term care hospitalization is the highest of all long-term care insurance plans offered to members of all health funds in Israel.
2. Uniformity in the monthly compensation amount throughout the entire eligibility period (excluding linkage to the index, and changes due to the age of the insured) – also for new members.
3. Members have the option to choose any of the four compensation tracks, and to switch between them, at any time!
4. The rights available to those covered by long-term care insurance at home are additional and are not related to their rights under the National Insurance program.
5. Any insured who prefers to stay at home will have the option to choose whether to receive long-term care insurance services or monetary compensation.
6. No qualifying period.
7. Waiting period of 30 days.
8. Appeal committees dealing with rejected insurance claims and with rejected requests to join the insurance are held on an ongoing basis.

- **What role does Maccabi Healthcare Services play in the long-term care insurance?**

Maccabi Healthcare Services is the policyholder, and therefore undertakes to supervise and maintain regular contact with Clal Insurance Company in order to ensure that all members of the long-term care insurance receive their full entitlement under the policy, and the most professional and dedicated care through Clal Insurance Company Ltd.

- **Who is entitled to be insured under long-term care insurance?**

Existing members:

Persons who are members of Maccabi Shield, and the children of such persons who were insured on June 30, 2008 under the nursing fund – the insurance liability for long-term care insurance for such persons has been transferred to Clal Insurance, according to their insurance plan as of the above date. "Silver Long-Term Care" or "Gold Long-Term Care", excluding members of Maccabi Shield who are persons in need of long-term care, according to the nursing fund regulations before the date of the transition to Clal Insurance (before July 1, 2008).

New members:

Members of Maccabi Health Services, and children registered with such persons, who as of July 1, 2008 were not members of Maccabi Shield, and/or were not included in the nursing fund, provided that the member has filled out, on their behalf, an application form to join a Maccabi long-term care policy under the "Gold Long-Term Care" plan, and where the insurer has agreed to insure them. (It is not possible to join the Silver Long-Term Care plan).

- **If I was a member of the Nursing Fund on June 30, 2008, am I automatically insured under the Maccabi Long-Term Care policy?**

As of July 1, 2008 you were transferred and became automatically insured under the policy, with no requirement to fill out an application form or to obtain a medical signature.

All claims by existing members, as defined above (if any), will be evaluated beginning on this date solely according to the provisions of the Maccabi Long-Term Care policy.

- **How can I join the long-term care insurance?**

You can submit an insurance proposal form at any Maccabi branch, or join through the Maccabi Long-Term Care call center at Clal Insurance by calling 1-700-505-520.

How can I transfer from Silver Long-Term Care to Gold Long-Term Care?

Existing insured parties, who were covered according to the nursing fund under the Silver Long-Term Care plan only, will be entitled to submit a request to upgrade their cover to Gold Long-Term Care cover, provided they are no older than 70 as of the upgrade date. These insured parties will be required to fill out a health declaration, including medical signature, only regarding their upgrade to the Maccabi Gold cover.

- **How do I know that my family and I are covered?**

Information regarding your insurance plan and ongoing membership fees is available on the Maccabi Online membership site, under the option for "monthly payment details" or "family payment details".

Additionally, every three months Maccabi produces a periodic summary of charges and credits, including details regarding your insurance covers and the payments which have been collected for them. The printout is sent to your home, and is also viewable online (using a personal password) on the Maccabi Online website at www.maccabi4u.co.il.

An annual report will be sent to you through Maccabi once per year, according to the requirements determined by the Commissioner of Insurance.

- **Will the amount of the premium and monthly compensation (in the event of payment to the insured) remain fixed?**

The insurance premiums paid with respect to the rights in the policy are fixed, excluding linkage to the index specified in the policy, and according to the age groups specified on page 32 of the insurance premiums chapter.

The long-term care compensation ceiling limit is fixed throughout the entire insurance period.

The long-term care compensation paid to the insured is linked to the consumer price index.

- **How long are the qualification and waiting periods for the policy?**

The policy has no qualification period.

The waiting period in case of an insurance event is 30 days after the occurrence of an insurance event. The insured will not be entitled to receive insurance compensation with respect to the waiting period.

- **Who is considered to be a need of care patient entitled to insurance compensation under the policy?**

An insured person who is unable to independently carry out a significant part (at least 50% of the action) of at least three of the following six actions:

Getting up and lying down, getting dressed and undressed, getting washed, eating and drinking, continence, mobility; or

An insured person whose health and functioning are poor due to “cognitive impairment”, as determined by a doctor specialized in the field.

The full definitions are provided in section 2.9 of the policy.

- **What does the long-term care insurance offer members of Maccabi Long-Term Care?**

The plan guarantees insured individuals who require nursing care, so long as this care is needed, a monthly nursing allowance for a period of five years in one of the following tracks:

Indemnification for **nursing hospitalization expenses**, as follows:

Silver Long-Term Care members – indemnification at a rate of 40% of the expenses for nursing hospitalization, up to a ceiling limit of NIS 5,000 a month (linked to the known CPI for July 1, 2008).

Gold Long-Term Care members – indemnification at a rate of 80% of the expenses for nursing hospitalization, up to a ceiling limit of NIS 10,000 a month (linked to the known CPI for July 1, 2008).

At-home nursing care – provision of service or financial compensation according to one of the following three options:

1. Receiving nursing care from a nursing agency (Israeli caregiver):

Silver Long-Term Care members – 25 caregiving hours per week.

Gold Long-Term Care members – 36 caregiving hours per week.

The cost of the service will be paid by Clal Ltd. to the service provider with which it has an agreement.

2. Compensation by means of a fixed monthly allowance to employ a foreign caregiver:

Silver Long-Term Care members – NIS 3,500 per month (linked to the known CPI for July 1, 2008).

Gold Long-Term Care members – NIS 4,500 per month (linked to the known CPI for July 1, 2008).

This payment is conditional upon the presentation of a legal permit to employ a foreign worker at the time the claim is evaluated, and/or at an earlier date, upon demand by the insurer.

3. Compensation by means of a fixed monthly nursing allowance – as specified below:

Silver Long-Term Care members – NIS 3,000 per month (linked to the known CPI for July 1, 2008).

Gold Long-Term Care members – NIS 4,000 per month (linked to the known CPI for July 1, 2008).

- **Do I need to choose my preferred track on the insurance commencement date or on another date?**

The selection of the preferred insurance compensation track is done by the insured after the claim has been approved by Clal Insurance. During the period in which a nursing allowance is received, it is possible to change between tracks at any time, in the sole discretion of the insured, and subject to provision of notice to the insurer.

- **What do I need to do if I have selected the track involving receipt of actual care from an Israeli caregiver?**

In this case, Clal Insurance will be responsible for finding a suitable Israeli caregiver for you. The only thing you need to do is contact the claims call center at 1-700-505-520. The call center is staffed by a social worker who will accompany the entire process until a suitable Israeli caregiver has been found.

The Israeli caregiver's salary will be paid directly by Clal Insurance.

The family will be entitled to demand the replacement of the caregiver in cases where it believes that the selected caregiver does not meet the needs of the insured person in need of care.

- **What should an insured party do in the event of a long-term care claim?**

Fill out the claim form with the addition of the documents specified below, and send it to the address that appears on the form. The claim form includes personal details, and requires the attachment of the following documents:

1. Relevant medical material, including hospitalization summaries (if any).

2. In case of cognitive impairment, attach a diagnosis by a neurologist or psychiatrist.

The claim form can be downloaded from the website of Maccabi Health Services at www.maccabi4u.co.il, or from the website of Maccabi Siudi at www.maccabisiudi.co.il. Claims can also be submitted by calling the claims call center at 1-700-505-520, or in person at any Maccabi branch.

- **Is it possible to cancel the policy?**

The policy cover can be discontinued at any time by submitting written notice to Clal Insurance.

- **Who is not covered by the insurance?**

Members of the Maccabi Shield nursing fund who were considered persons in need of care according to the nursing fund rules before the date of the transfer to Clal Insurance (before July 1, 2008) will not be entitled to inclusion in the new insurance under the policy, and will be treated by the nursing fund of Maccabi Shield according to the rights currently specified in the nursing fund rules.

Members of Maccabi Health Services who were not members of the Maccabi Shield nursing fund on July 1, 2008, and who did not submit a request to join the policy, or who submitted a request to join which was rejected by Clal insurance, will not be covered by the insurance.

Naturally, the provision of insurance cover under the policy is subject to the policy's terms and exceptions.

- **Where can I obtain additional information about the long-term care insurance?**

For all questions related to the subject of payment only, call the service center for members of Maccabi Health Services at *3555 or 1-700-50-53-53.

For questions on all other subjects (excluding payment), call the Maccabi Long-term care call center at 1-700-505-520.

Ways of contacting Maccabi Long-Term Care

(Maccabi Siudi)

Telephone.: 1-700-505-520

Fax: 077-6383171

POB 37190, Tel Aviv

Zip code: 6137002

www.maccabisiudi.co.il

* The binding policy is the Hebrew version

Guidelines for submitting a long-term care claim

When you become aware of the need to claim long-term care under the policy, contact Clal Insurance Company Ltd. in order to request its approval for the receipt of insurance compensation:

Documents to be presented to the insurer when submitting a claim:

- A long-term care claim form (filled out by the insured) – the form includes personal details and a waiver of medical confidentiality, permitting any doctor and/or other entity or institution in Israel and/or abroad to provide the insurance company with all medical information in its possession relating to the insured. If the insured is not competent to sign, his duly appointed guardian may sign on his behalf, and a guardianship appointment letter should be attached to the submitted claim form.
- Attach the following documents to the claim form:

  A. Medical documents, including hospital discharge letters specifying the medical problem (if any)

  B. In case of cognitive impairment, attach a diagnosis from a neurologist or psychiatrist.

  C. National Insurance file and authorizations of eligibility from National Insurance (if any).

  D. Authorization to employ a foreign worker (if any).

Please note!

1. The claim will only be approved if it complies with the instructions specified in the policy.

2. The claim form can be downloaded from the website at www.maccabisiudi.co.il.

What happens next?

- After receiving the documents, the insurer will examine the insurance cover under the terms of the policy. Shortly after submitting the claim, the insured will be asked to undergo an examination by a doctor, nurse, or occupational therapist, on behalf of the insurance company and at its expense, in order to determine whether the condition of the insured entitles him to receive insurance compensation according to the terms of the policy. The examination will be coordinated in advance, and will take place in the home of the insured, or in the nursing home where he resides.
- In cases where clarifications are required, the insurance company will contact you and ask for additional material. In certain cases, the insurance company will request the medical file of the insured directly from the health institutions. In any case, you will receive the insurer's decision in writing.
- If a decision is reached that you are not entitled to receive the insurance compensation, you will be sent written notification specifying the reasons. Reservations regarding the insurer's decision to reject the claim can be addressed to the call center, which will provide instructions regarding the submission of an appeal to the appeals committee.

For clarifications after the submission of a claim, please contact the call center at tel: 1-700-505-520