Maccabi SIUDI

Long-term care insurance for the members of Maccabi Health Services

January 1, 2019

The Phoenix
Maccabi – Best healthcare services in Israel

It is clarified that Maccabi is not an agent or a representative of the Insurer in any manner and that the Insurer shall be responsible for fulfilling its undertakings towards the Insureds in accordance with this Policy.

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	paid to the Insured staying in an institution on the date of entitlement to the monthly insurance benefits will not exceed a rate of 80% of the amount the Insured actually paid to the institution.
Change of terms and Insurance Premiums	In the event the instructions set forth by the Insurance Commissioner or the terms of insurance change during the Insurance Term, the Insurance Premiums are likely to change, subject to the approval of the Insurance Commissioner.
Insurance costs	As stated in the Schedule.
Cancellation	The insurance shall be canceled in accordance with the provisions set forth in Section 26 of the Policy.
Settlement and redemption values	No excess payments will accumulate in favor of the Insured in the Policy for the purpose of receiving settlement and redemption values.
Continuity	1. The Insurer will allow an Insured whose registration at the health fund was canceled and who did not register in another health fund and did not realize the full insurance benefits in a long-term care insurance program for the members of any health fund, to transfer to an individual insurance policy upon the occurrence of the events and under the conditions set out in Section 6.1 – 6.4 of the Policy. 2. In the event the long-term care insurance for the health fund members was terminated as a result of failure to renew the Policy for the entire members that are insured with any insurer, the Insurer will add the entire Insureds that were insured in the said Policy to a mutual group long-term care insurance policy for an insurance term for life, and all upon the occurrence of the events and under the conditions set out in Section 6.5 of the Policy.

Coverages in the Policy

Name of coverage	Description of coverage	The sum claimed	The period of time as of commencement of the insurance in which the Insured can claim and obtain benefits (Qualification Period)	The period after the occurrence of the Insured Event after which the Insured will be entitled to benefits (Waiting Period)
Monthly benefits as a result of a long-term care condition	As stated in Section 8 of the Policy. Monthly benefits or indemnity depending on the place where the Insured stays, for a period of up to 60 months for an Insured who is unable to perform by himself a material part (at least 50% of the action) of at least 3 of the following six actions: Standing up and lying down; Dressing and undressing; Washing; Eating and drinking; Continence; Mobility. and/or in a condition of mental frailty.		No	60 days, subject to Section 11 of the Policy.
Notes	**Regarding reimbursement of expenses in a long-term care institution**: The insurance company will pay the actual expenses, up to the limit set out in the Policy. Please note, if you have coverage that is identical in another policy			

	you will not be entitled to additional reimbursement beyond the actual amount of expenses and subject to the terms set forth in the insurance program. For your information, the internet website of the Company includes the rules, criteria and functional evaluation form (www.fnx.co.il).

1. **Waiting period** – a period commencing on the date in which the Insured Event occurred and that expires 60 days thereafter, and on the condition that the Insured Event occurs with respect to the Insured during this entire period.
2. **Transferring Insured** – a Transferring Insured or an Entitled Insured, within their meaning in the Control on Financial Services Regulations (Insurance) (Group Insurance for Health Fund Members) 5776-2015 and in respect of which there is an Insured Event that is in effect after they joined the long-term care policy for Maccabi members, shall be entitled to insurance benefits under this Policy, with deduction of periods in which they received insurance benefits by virtue of a long-term care insurance policy for the members of the health fund or by virtue of another group long-term care insurance policy, as stated in the Regulations.
3. Linkage differentials as of the index that was known on June 30, 2016 shall be added to the amount of the insurance benefits.

"Maccabi SIUDI" – Group long-term care insurance for the members of Maccabi Health Services

1. Introduction

This Policy hereby witnesseth that in return for payment of the Insurance Premiums and subject to the terms, provisions and exclusions set out hereunder, the Insurer shall provide to the Entitled Insured insurance benefits. The insurance benefits shall be paid in respect of an Insured Event that occurred during the insurance term, in accordance with the provisions set forth in this Policy including terms and exclusions thereof.

2. General definitions

As used in this Policy and any Annex thereof, the following terms shall have the respective meanings set forth beside them below:

2.1 The Insurer	The Phoenix Insurance Co. Ltd.
2.2 The Policyholder	Maccabi Health Services, Ottoman Society no. 227/99 (hereinafter: "Maccabi" and/or "Maccabi Health Services").
2.3 Maccabi MAGEN	Maccabi MAGEN – Cooperative Society for Mutual Insurance against Illness Ltd.
2.4 "Member of Maccabi Health Services" or "Maccabi Member"	Whoever is registered and is entitled to receive health services from Maccabi in accordance with the law and/or the Maccabi regulations set out in the Maccabi Regulations. And anyone whose registration and entitlement were canceled as aforesaid and was not registered in another health fund, however except for anyone whose registration and entitlement were canceled as aforesaid and is not a "resident" within its meaning in the National Health Insurance Law 5754-1994.
2.5 Child	A Maccabi Member under the age of 18.
2.6 Long-term Care Fund Regulations	A long-term care program for the Members of Maccabi Health Services that joined and/or that were added before July 1, 2008, in accordance with the regulations of the said fund, as members in the Maccabi MAGEN Society.
2.7 The Previous Policy	A group long-term care insurance policy for the Members of Maccabi Health Services that expired on December 31, 2018.
2.8 The Insured	Whoever fulfills one of the following conditions: 2.8.1 Existing Insured – a Member of Maccabi Health Services who was insured under the Previous Policy on December 31, 2018. 2.8.2 New Insured – a Maccabi Member who was not insured under the Previous Policy on December 31, 2018 and whom the Insurer agreed to insure after the said date. **For the avoidance of doubt, it is clarified that all Insureds under this Policy are insured in this Policy irrespective of the insurance or the absence of insurance of their partners or parents, and that the Policy will not be canceled in respect of Insureds in the event of death or**

	divorce of their partners, or in the event of cancellation of the insurance of the parents of an insured child.
2.9 Long-term care benefits/insurance benefits	2.9.1 Long-term care hospitalization – reimbursement of expenses (indemnity) to an Insured for actual expenses that the Insured or his representative paid for the stay in a long-term care institution, in accordance with the provisions set forth in Section 8 hereunder. 2.9.2 Long-term care at home – payment of compensation as stated in Section 8 hereunder.
2.10 Limit of long-term care benefits	As stated in Section 8.1 hereunder.
2.11 Waiting Period	As stated in Section 11 hereunder. **For the avoidance of doubt, with respect to this period the Insured shall be entitled to long-term care benefits for the Insured Event.** **In addition, even during the Waiting Period the Insured shall be obligated to pay insurance benefits.**
2.12 Insurance Premiums	The premium that the Insured is obligated to pay in accordance with the terms set forth in the Policy.
2.13 Institution	A long-term care department or a department for mentally frail patients in a nursing home, a hospital or another institution that mainly engages in the hospitalization of long-term care patients and that was approved as a long-term care institution by the Ministry of Health in accordance with the provisions set forth in the Public Health Ordinance or the Ministry of Labor, Social Affairs and Social Services, or any other institution approved by the Insurer.
2.14 Insurance Commencement Date	With respect to an **Existing Insured,** as defined in Section 2.8.1 above – the Effective Date. With respect to a **Transferring Insured** – as of expiration date of the group long-term care insurance in the previous period. With respect to a **New Insured**, as defined in Section 2.8.2 above, except for a "Transferring Insured" within its meaning in Section 2.18 – the date of filing the Joining Application for the insurance – as stated in Section 4.2.1 hereunder.
2.15 Joining Application	A personal application to join the insurance, and that includes a health declaration, that constitutes an integral part of the Policy and that was filled and signed by a Maccabi member who wishes to join this insurance as an insured.
2.16 Adjudication of Interest and Linkage Law	Adjudication of Interest and Linkage Law, 5721-1961
2.17 The age the Insured first joined the long-term care insurance provided to the	The age in which an Insured joined a long-term care insurance for the members of any health fund and as of which the said Insured is insured continuously, including continuity

health fund members	that is maintained when the member transfers from one health fund to another, in accordance with the provisions set forth in Section 2.20 hereunder.
2.18 Transferring Insured	An Insured in a long-term care provided to the members of the health fund who, shortly before transferring to another health fund was insured in a long-term care insurance provided to the health fund members.
2.19 Entitled Insured	Within its meaning in Section 1 of the Control on Financial Services Regulations (Insurance) (Group Insurance for Health Fund Members) 5776-2015 (hereinafter: the "**Regulations**").
2.20 Previous Health Fund	The health fund in which the Insured was registered shortly before transferring to Maccabi Health Services.
2.21 Long-term care insurance for the health fund members	Group long-term care insurance that was taken out for the health fund members in another policy in which one or more health fund is the policyholder with respect to its members. **Notwithstanding the said, until December 31, 2016 only "Maccabi Health Services" will come instead of "health fund."**
2.22 Effective Date	January 1, 2019.
2.23 The Commissioner	The Commissioner of Capital Markets, Insurance and Savings, within its meaning in the Control on Financial Services (Insurance) Law, 5741-1981.
2.24 Pre-Existing Medical Condition	A set of medical circumstances that were diagnosed in the Insured prior to the date the Insured joined the insurance, including as a result of an illness or an accident; for the purpose of this matter "diagnosed in the Insured" – by way of a documented medical diagnosis or in a process of a documented medical diagnosis that occurred in the six months that preceded the joining date to the insurance.
2.25 Effect of the exclusion resulting from Pre-Existing Medical Condition	This exclusion concerns an Insured whose age on the Insurance Commencement Date is less than 65 years of age and shall be in effect for a period of one year as of the Insurance Commencement Date. Regarding an Insured whose age on the Insurance Commencement Date is 65 years of age or above, the exclusion shall be in effect for a period of six months as of the Insurance Commencement Date.
2.26 Effect of the exclusion in respect of a specific medical condition with respect to a specific Insured	Notwithstanding the aforesaid, an exclusion to the liability of the Insurer or the scope of coverage on the grounds of a specific medical condition that was stated with respect to a specific insured and that results from medical underwriting performed to the Insured, shall be in effect for the period that was stated in the Schedule by that specific medical condition.
2.27 Non-applicability of the exclusion	This exclusion shall not be in effect if the Insured notified the Insurer regarding his previous medical condition and the Insurer did not exclude explicitly the specific medical condition specified in the notice of the Insured.
3. The Insured Event	

The Insured Event is the occurrence of one or more of the following events:	
A.	Mental frailty diagnosed by a specialist in the field; for the purpose of this matter "mental frailty" - impairment of the Insured's cognitive functioning and decrease in his intellectual capacity, including impairment of judgment and understanding, decrease in short term and long-term memory and disorientation in time and place that require observation during most hours of the day according to the determination of a specialist in the field originating from a medical condition such as Alzheimer's or different forms of dementia.
B.	Deteriorated functioning and health conditions of the Insured as a result of an illness, accident or health impairment for which the Insured cannot perform a material part (at least 50% of the action) of at least 3 of the following actions: 1. **Standing up and lying down**: The autonomous ability of the Insured to transfer from recumbent to sedentary position and/or standing up from a chair including performance of this action from a wheelchair and/or a bed; 2. **Dressing and undressing** - The autonomous ability of an Insured to wear or remove any articles of clothing including attaching and/or putting a medical belt and/or an artificial limb; 3. **Washing** - The autonomous ability of an Insured to wash in a bathtub, shower in a shower or in any customary manner, including entering and exiting from the bathtub or the shower; 4. **Feeding and drinking** - The autonomous ability of an Insured to feed his body in any means or way (including drinking and not feeding by a straw), after the food was prepared and served to him; 5. **Continence** - The autonomous ability of the Insured to control bowel movement and/or urination. Lack of control over any of these actions that means, for example: permanent use of stoma or a catheter in the bladder or permanent use of diapers or different absorbents shall be deemed as incontinence; 6. **Mobility** - The autonomous ability of an Insured to ambulate from place to place without the help of others. The use of crutches and/or cane and/or walker or any other accessory including a mechanical or motorized or electronic accessory shall not be deemed as impairment of the autonomous ability of the Insured's locomotion. It should be emphasized that the inability of an Insured to move without a wheelchair shall be considered as his inability to move independently. **Notwithstanding the said, in the event the Insured is unable to move without a**

	wheelchair however can move independently with a wheelchair from place to place during an Insurance Term that ended before July 1, 2017, and during the present Insurance Term the autonomous ability of the Insured changed in such manner that the Insured cannot move independently with his wheelchair, the Insured shall be deemed as incapable of moving independently as of the date in which his autonomous ability changed as aforesaid.
4. Effect of the Policy	
4.1 Existing Insured	An Insured who was insured under the Previous Policy on December 31, 2018 will transfer under insurance continuity without submitting a health declaration and without undergoing repeated underwriting or repeated examination of his Pre-Existing Medical Condition and will be insured under this Policy as of the Effective Date, according to the rights set out in this Policy and according to the age the Insured first joined the long-term care insurance provided to the health fund members, as stated in Section 9.
4.2 New Insureds	A Maccabi Member who joined this insurance as of the Effective Date henceforth, will be insured under this Policy as stated hereunder: 4.2.1 The joining date in accordance with this Policy shall be the date of filing the Joining Application. This date shall constitute the Insurance Commencement Date of the Insured in accordance with the Policy. 4.2.2 A newborn baby or a baby that was added as a Maccabi Member up to the age of 12 months will be added automatically to this insurance. The Insurer will send to the parent and/or to the legal guardian of the newborn baby a letter notifying him about the addition of the newborn to the insurance. The said letter will specify the sections in the Policy relating to the scope of coverage provided to newborn babies and the exclusion set out in Section 15.6 hereunder in this Policy. 4.2.3 In the event the application of a prospective Insured to join the insurance provided under this Policy was rejected by the Insurer, the prospective Insured may appeal the said rejection in 60 days as of the date of receiving the rejection letter. The appeal will be heard by the Appeal Committee for joining members that will be formed and convened from time to time.

	4.2.4 The notice containing the decision of the Insurer regarding the rejection of the prospective insured will be delivered by the Insurer to any prospective insured and to the Policyholder. The same shall also hold true to the decision on the appeal. 4.2.5 A prospective Insured who does not receive an answer to the Joining Application that he filed after he furnished a health declaration and the entire medical and factual materials required by the Insurer to the Insurer as required in 60 days as of the date the said documents were received by the Insurer, shall be insured automatically as of the Insurance Commencement Date, within its meaning in Section 2.14 above, under ordinary conditions and without exclusions. 4.2.6 Transferring Insured – notwithstanding the said, the Insurance Commencement Date of a Transferring Insured shall be the expiration date of the insurance provided by the Previous Health Fund. As of this date, a Transferring Insured can join this insurance without a health declaration, and subject to the provisions set forth in Section 12 of the Regulations.
5. Insurance Term	
5.1	The Insurance Term under this Policy with respect to each Insured shall commence as of January 1, 2019 or as of the joining date of the said Insured to the Policy, whichever is later, and until December 31, 2023.
5.2	The Policyholder and the Insurer shall be entitled to extend the Insurance Term for additional periods and up to 3 (three) additional years in total ("Extension Period"), as agreed between the parties and until a date that shall not fall below 6 (six) months prior to expiration of the Insurance Term. In the event the Policyholder and the Insurer agreed on the extension of the Insurance Term as stated above, the terms set forth in the Policy shall apply during the Extension Period without a change, however the Policyholder shall be entitled to approach the Commissioner in person, or by the Insurer, for the purpose of obtaining approval to perform adjustments in the Insurance Premiums.
5.3	In any event of failure to extend the Policy by the Insurer or the Policyholder, the Insurer shall be obligated to provide coverage under the Policy only with respect to Insured Events that occurred until expiration of the Insurance Term, and in respect of which a claim was filed prior to expiration of the

	limitation period set out in Section 22 hereunder.
6. Right of continuity in individual policies	
6.1	The Insurer will allow a retiring Insured to transfer to a follow-up policy according to the dates set out in Section 6.2, whose terms are as follows: (1) The sums insured and the period of payment of the insurance benefits in the follow-up policy shall not fall below the ones set out for the Insured under this Policy, unless the Insured made the said request, with deduction of periods in which the Insured was entitled to insurance benefits in that policy. (2) The Insurance Premiums in the follow-up policy shall not be greater than the Insurance Premiums that were customary on the transfer date for the New Insureds that joined a similar individual insurance with the Insurer; (3) When transferring to a follow-up policy the Insured will be entitled to insurance continuity without a repeated examination of a Pre-Existing Medical Condition and without a Qualification Period; (4) The Insurance Commencement Date in the follow-up policy shall be retroactive as of the date his registration in the health fund was canceled.
6.2	In 45 days as of the cancellation date for a retiring Insured, the Insurer shall deliver written notice to the Insured and will offer to the Insured to transfer to the follow-up policy in 60 days as of the date of delivering the Insurer's notice.
6.3	Notwithstanding the said in Section 6.2, in respect of an Insured who was entitled to insurance benefits in accordance with the terms set forth in this Policy on the date the long-term care insurance was canceled for the health fund members – the request made by the Insurer to the Insured as stated in that sub-section shall be in 30 days as of the date the entitlement of the Insured to insurance benefits ceased; in such request as aforesaid the Insurer will offer to the Insured to transfer to the follow-up policy in 60 days as of the date the Insurer's notice was sent; such an offer as aforesaid will be made only if the said Insured exercised his full rights to insurance benefits in accordance with the Policy.
6.4 Retiring Insured – for the purpose of this Section	An Insured in the long-term care insurance program for health fund members and who did not yet exercise his full rights in accordance with the Policy and whose long-term care insurance for the health fund members was canceled due to the cancellation of his registration at the health fund in accordance with the National Health Insurance Law 5754-

	1994 and was not registered in another health fund;
6.5 Follow-up policy	An individual long-term care insurance policy for an Insurance Term for life.
7. Group follow-up policy	
7.1	**In the event the long-term care insurance for the health fund members was terminated as a result of failure to extend the Policy for all the Insureds with any Insurer, the Insurer shall add all the Insureds that were insured** under the said Policy to a mutual group long-term care insurance policy and for an Insurance Term for life (hereinafter: the "Follow-up Group Insurance Policy") under the following terms: (1) The Insurance Premiums, the sum insured and the period for payment of the Insurance Premiums (hereinafter in this Section: "Terms of Coverage") in the Follow-up Group Insurance Policy shall comply with the terms set forth in the insurance coverage that were set forth in the long-term care insurance policy for the health fund members shortly before the date in which the Policy was not extended as aforesaid, and on the condition that in the long-term balance between the Insurance Premiums and other income expected to be obtained for the benefits that will be paid, based on the best estimate of the Insurer, is not in a deficit, considering the balance of funds of the Insureds; (2) The terms of insurance coverage are likely to change during the Insurance Term in the follow-up policy according to the best estimate made by the Insurer, approved under Section 40 of the Law, and that will result in a long-term balance that is not in a deficit; in the event such approval was granted as aforesaid, the Insurer shall be obligated to obtain again the approval of the Commissioner pursuant to Section 40 of the Law and only in the event the Insurer requests to change the component that serves as the basis for the calculation of the estimate and that based on which the approval was granted; (3) No settlement values will accumulate in the follow-up policy; (4) When transferring to the follow-up policy the Insurer shall provide insurance continuity without a repeated examination of a Pre-Existing Medical Condition and without a Qualification Period;

	(5) The Insurance Premiums shall be transferred to the fund of the Insureds; insurance benefits and any other expense in respect of the insurance and operation thereof shall be disbursed solely from the fund; the Insurer will not be required to incur the costs of the Follow-up Group Insurance Policy from its own resources; (6) The Insurer shall be entitled to return to a health fund whose members are insured in the Follow-up Group Insurance Policy sums that the health fund paid for the management of the Policy, including in respect of the collection of Insurance Premiums from the Insureds, provided that the reimbursement is not greater than 3% of the amount of the Insurance Premiums that were collected; (7) The Insurer shall be entitled to deduct annual management fees that include reimbursement of expenses to the Insurer and a profit component in respect of which Section 40 of the Law shall apply, for the operation of the Follow-up Group Insurance Policy and the management of the fund for the insureds.
7.2	In the event the balance stated in Section 7.1 on the date the Insureds are added to the Follow-up Group Insurance Policy, based on the best estimate performed by the Insurer, is in deficit, the Insurer shall submit for the approval of the Commissioner possible alternatives for change in the terms of insurance coverage that result in a balance that is not in deficit, based on the best estimate performed by the Insurer.
7.3	The Insurer will notify the Insured regarding its inclusion in the Follow-up Group Insurance Policy and the possibility to cancel his addition in 90 days as of the date of receiving such notice as aforesaid, and will specify the manner in which the Insured is entitled to notify regarding such cancellation as aforesaid.
7.4	In the event the Insured announced his wish to cancel his joining to the Follow-up Group Insurance Policy in accordance with Section 7.3, the Policy shall be canceled with respect to that Insured as of the joining date, and the Insurance Premiums collected from the said Insured shall be returned to him as of the joining date and until the cancellation date as aforesaid, provided that a claim for insurance benefits in accordance with the Policy on the grounds of an Insured Event that occurred during that period was not filed during this period.

7.5	Notwithstanding the said in Section 7.1, the Commissioner shall be entitled to state that in the event the long-term care insurance provided to the health fund members was terminated due to the failure to extend the Policy for all the Insureds with any insurer, the Insurer shall not be obligated to add the Insureds to any Policy, and the remaining fund of the Insureds at the time will be used in favor of the Insureds, upon the occurrence of the following events; (1) The entire long-term care insurance policies for the members of all health funds were not extended with any insurer or are not expected to be extended; (2) The alternatives that the Insurer presented in accordance with Section 7.2 result in terms of insurance coverage that are not reasonable under the circumstances of the case.
8. Amount of insurance benefits	
8.1	The monthly amount of insurance benefits the Insured is entitled to shall be calculated according to the age of the Insured on the date the Insured first joined the long-term care insurance provided to the health fund members, according to the place where the Insured will stay during the period for which the Insured receives the monthly insurance benefits, as stated in the following table:

Place of stay of the Insured	**The age health fund members first join the group long-term care insurance**		
	Up to 49	**50-59**	**60 and above**
Monthly insurance benefits for an Insured staying at home	NIS 5,500	NIS 4,500	NIS 3,500
Limit of monthly insurance benefits for an Insured staying in an institution (indemnity)	NIS 10,000	NIS 6,500	NIS 4,500

8.2	Notwithstanding the said in Section 8.1, the monthly amount of insurance benefits that will be paid to an Insured staying in an institution on the date of entitlement to the monthly insurance benefits will not be greater than a rate of 80% of the amount the Insured actually paid to the institution.
8.3	**Notwithstanding the said in Section 8.1 above, with respect to Existing Insureds as stated hereunder, and that were insured on June 30, 2016 and that continued to be insured under continuity in a long-term care provided to the health fund members thereafter, the age stated by their side shall be read as follows, instead of the age of first joining the long-term care insurance provided to the health fund members as stated in the table in Section 8.1 above:** **8.3.1 An Insured in a group long-term care insurance provided to the Members of Maccabi Health Services:** **8.3.1.1 If the Member joined the "SIUDI ZAHAV" insurance – from ages 49-50;** **8.3.1.2 If the Member joined the "SIUDI KESEF" insurance – from ages 59-60;** **8.3.2 An Insured in a group long-term care insurance to the members of Clalit Health Services "SIUDI MUSHLAM PLUS" who joined the insurance at the age of 60 up to 59-64;** **8.3.3 An insured in a long-term care for members of Meuhedet Health Fund who joined "Meuhedet ZAHAV" insurance at the age of 50 up to 49-65;** **8.3.4 An Insured in a long-term care for members of Leumit Health Fund who joined the "LEUMIT SIUD" insurance at the age of 60, up to 59-64;** In accordance with the provisions set forth in Section 8.3.1 above, Existing Insureds who were insured on June 30, 2016 and who continued to be insured under insurance continuity provided to the health fund members afterwards, shall be entitled to the long-term care insurance benefits as stated hereunder:

Tier in the Policy that expired on June 30, 2016	**The age the Insured first joined the group long-term care insurance**	**Monthly insurance benefits for an Insured staying at home (compensation)**	**Monthly insurance benefits for an Insured staying in an institution (indemnity)**

	in Maccabi		
SIUDI ZAHAV	Any age	NIS 5,500	80% of the amount the Insured actually paid to the institution and an amount not greater than NIS 10,000
SIUDI KESEF	Until the age of 49	NIS 5,500	80% of the amount the Insured actually paid to the institution, and in an amount not greater than NIS 10,000
	Age 50 and above	NIS 4,500	80% of the amount the Insured actually paid to the institution and in an amount not greater than NIS 6,500

9. Calculating the age of an Insured for the purpose of insurance benefits

The age of the Insured for the purpose of calculating the Insurance Premiums and for the purpose of determining the age in which the Insured first joined the insurance will be calculated in whole years according to the full number of years that passed since the month of birth of the Insured.

10 Manner of payment of insurance benefits to an Insured staying in an institution

10.1	Insurance benefits paid in accordance with the provisions of Sections 8.1-8.3 above shall be paid against presentation of receipts by the Insured or his representative together with invoice as required by law, regarding payment of actual hospitalization expenses in the long-term care institution. The Insured may submit source or copy of receipts or invoices as aforesaid. In the event the Insured submitted a copy as aforesaid, the Insured will specify whether the said source or copy of the receipts or the invoices was sent to another entity and will state his identity and the amount he received from that entity.

	In such circumstances as aforesaid, the Insurer shall indemnify the Insured in accordance with the provisions set forth in the Insurance Contract Law 5741-1981, provided that in any event the total amount of indemnity paid to the Insured shall not be greater the amount that is the lower of the following two: **A. The actual amount of the expenses paid by the Insured.** **B. The indemnity amount for the Insured as set out in this Policy.**
10.2	The indemnity shall be paid in any event in which the expenses were actually paid prior to the indemnity date. The indemnity shall be paid to the Insured or to his legal representative.
10.3	The insurance benefits will be paid until the last day of each month for the month that passed, subject to approval of the receipts or the invoices subject matter of the indemnity by the Insurer and subject to the provisions set forth in Section 13.1.
11 Waiting Period	
The Insurer will pay to the Insured insurance benefits the Insured is entitled to in accordance with the provisions set forth in the Policy as of the date in which the Waiting Period expires; only one Waiting Period will be counted, unless more than 12 months as of the date in which the Insured Event ceased to exist with respect to that period; for the purpose of this matter "Waiting Period" – a period commencing on the date in which the Insured Event occurred and that expires 60 days thereafter, and on the condition that the Insured Event is in effect during this entire period.	
12 Entitlement to insurance benefits	
12.1	An Insured shall be entitled to insurance benefits as long as the conditions set forth in Section 3 are fulfilled, subject to the terms set forth in the Policy.
12.2	Notwithstanding the said in Section 12.1, an Insured shall be entitled to insurance benefits for a period of 60 months as of the expiration of the Waiting Period, as stated in Section 11, by virtue of the policy during which the Insured Event occurred and subject to the provisions set forth in Sections 23.1.1 and 23.1.2, with deduction of the periods in which the Insured received insurance benefits by virtue of a long-term care for health fund members.
13 Insurance benefits – General	
13.1	The insurance benefits paid by the Insurer shall be paid to the Insured in 30 days as of the date the Insurer received the information and the documents that are necessary for the purpose of inquiring its liability.
13.2	Insurance benefits paid under this Policy shall be paid in addition to and independently from in any insurance benefits or a long-term care service that was provided or that will provided to the Insured by another entity, including the State,

	in respect of the Insured Event, including by virtue of the National Insurance Institute Law [Consolidated Version] 5755-1995, **except for insurance benefits paid to an Insured that stays in an institution, and in such circumstances the provisions set forth in Section 10.1 above shall come into operation.**
13.3	In any event of entitlement of the Insured to insurance benefits in respect of part of a month, the limit of the insurance benefits shall be the relative part, according to the ratio of that part of the month.
13.4	Entitlement to insurance benefits for indemnity in a long-term care institution may not be accumulated in the event these insurance benefits were not used in a particular month by the Insured, up to the full limit of the insurance benefits, for the purpose of increasing the insurance benefits paid to the Insured in another month. The provisions set forth in this Section shall also apply to parts of a month, *mutatis mutandis*.
13.5	The periods during which the Insured received insurance benefits in accordance with this Policy or in accordance with a long-term care insurance for the health fund members, including any previous policy and including the long-term care fund regulations, are cumulative periods and in any event shall not be greater cumulatively than the limit of the entitlement period for insurance benefits. In addition to the said in Section 12.2, an Insured shall be entitled to insurance benefits with deduction of periods in which the Insured received benefits by virtue of the last entitling policy, within its meaning in Section 1 of the **Regulations**.
13.6	In the event an Insured is entitled to insurance benefits in accordance with this Policy and a guardian was appointed for the Insured by the court, the Insurer shall pay the insurance benefits to the guardian that was appointed as aforesaid.
13.7	The entitlement of the Insured to insurance benefits shall expire on the date the Insured Event ceased to exist or upon reaching the limit of the period of entitlement to insurance benefits or upon the death of the Insured, whichever is earlier. In the event the Insured died during the entitlement period, the insurance benefits shall be paid to his estate, in accordance with the provisions set forth in Section 13.8 hereunder.
13.8 Death of the Insured	In the event the Insured died at the time he was entitled to insurance benefits, and as long as the limit of the entitlement period for insurance benefits is not exhausted, the estate of the Insured shall report about this condition to the Insurer. In the event the Insured died, the full insurance benefits shall be

	paid for the Insured for that month in which he died.
13.9 The Policy is null and void after exhausting the entitlement period to insurance benefits	Upon exhausting the limit of the period of entitlement to full insurance benefits, the Policy with respect to the Insured will be canceled, and the Insured shall not be entitled to any additional amount or service in accordance with this Policy.
13.10	It is agreed that the Insurer shall be obligated to notify the Insured or his representative, immediately upon commencement of payment of the insurance benefits, regarding his release from payment of Insurance Premiums, and shall also report to the Policyholder about the same. **It should be emphasized that the Insured shall be obligated to pay Insurance Premiums also during the Waiting Period**.
13.11	For the avoidance of doubt, in the event the Insurer ceased to pay insurance benefits in respect of the Insured prior to exhausting the limit in the period of entitlement to insurance benefits, the obligation of the Insured to pay Insurance Premiums shall be in effect as of the date his entitlement to insurance benefits expired. The Insurer shall be obligated to report about the renewed payment of Insurance Premiums both to the Insurer and its representative and to the Policyholder.
14 Release from payment of Insurance Premiums	
An Insured who is entitled to insurance benefits in accordance with the terms set forth in the Policy shall be released from payment of Insurance Premiums for the period for which he is entitled to insurance benefits.	
15 Exclusions to coverage	
This Policy does not provide coverage for the following:	
15.1	**The Insured Event occurred as a result of the service of the Insured in the security or police forces, or as a result of an active participation in military, police, war or hostile activities;**
15.2	**The Insured Event occurred as a result of nuclear fission, nuclear fusion or radioactive pollution;**
15.3	**The Insured Event occurred as a result of the use or addiction to drugs, unless the use of drugs was prescribed by a physician and not for the purpose of rehabilitation;**
15.4	**The Insured Event occurred as a result of a Pre-Existing Medical Condition, subject to the provisions set forth in the Control on Insurance Business Regulations (Conditions in Insurance Contracts) (Provisions regarding a Pre-Existing Medical Condition) 5764-2004; for the purpose of this paragraph, an Entitled Insured shall be deemed as an insured under a contract that was replaced with the same insurer or another insurer, in**

	accordance with the provisions set forth in Regulation 6(a)(2) of the said Regulations;
15.5	**An Insured Event that occurred for the first time prior to the commencement of the Insurance Term or after expiration of the Insurance Term, subject to the provisions set forth in Sections 23.1.1 and 23.1.2;**
15.6	**The Insured Event occurred for the first time in the first 36 months in the life of the Insured.**
15.7	**The Insured Event occurred as a result of a road accident, within its meaning in the Road Accident Victims Compensation Law 5735-1975 or an occupational accident, within its meaning in the National Insurance Institute Law [Consolidated Version] 5755-1995 and that was recognized by the National Insurance Institute.**
16 The Claim	
16.1	The Insured shall notify the Insurer regarding the occurrence of the Insured Event as shortly as possible after the date the Insured Event occurred.
16.2	The Insured or his representative shall be solely obligated and entitled to file and substantiate a claim. **It is hereby clarified that the Policyholder is not entitled to file and will not file a claim with the Insurer by virtue of this Policy, following his initiative or on behalf of the Insured**.
16.3	The Insured shall provide to the Insurer all documents demanded by the Insurer, and that are designated for the purpose of inquiring its liability in accordance with the Policy, and will sign a waiver of medical confidentiality that will allow the Insurer to obtain both information regarding the medical condition and the functional condition of the Insured. The Insurer shall be entitled to perform, at its expense and reasonably, and during a reasonable period of time, any action and refer the Insured to a functional and/or medical examination by a physician on its behalf and/or any other medical service provider on its behalf, at its sole discretion. The said obligations are imposed on the Insured both prior to the approval of the claim and during the entire period in which the Insured is entitled to insurance benefits.
16.4	The Insurer shall deliver to the Insured or his representative a written, detailed and reasoned notice regarding the decision that was made in the claim, no later than 60 days after the claim was delivered to the Insurer as stated above, or no later than 90 days as of the said date, if the Insurer delivered notice to the Insured prior to expiration of the said period of 60 days and notified the Insured in advance that it extended

	the response date by 30 additional days, and the reasons for the extension.
16.5	The Insurer or anyone acting on its behalf shall perform a functional evaluation of the Insured, by appointment with the Insured or his representative.
16.6	In the event the condition of the Insured improves and the Insured is no longer in an entitling condition, the Insured shall notify the Insurer about the same forthwith.
16.7	In the event the Insured dies, and in the event no other person is listed by the Insured as entitled to insurance benefits in accordance with the Policy, the Insurer will pay to the estate of the Insured the balance of the insurance benefits that the Insured should have received during the period of his entitlement, and that was not paid to the Insured prior to the date of death.
16.8	In the event long-term care benefits were paid to the Insured and/or his estate in respect of a period for which the Insured was not entitled to benefits, whether as a result of improvement in his condition and/or as a result of his death as aforesaid, the Insurer shall be entitled to receive these sums. The aforesaid sums shall be returned to the Insurer linked to the index, and without interest.
17 Appeal Committees	
17.1	In the event the claim of an Insured for insurance benefits was rejected fully and/or partially, for medical and/or other reasons, the Insured shall receive a reasoned notice by the Insurer, informing the Insured that he is entitled to file an appeal with the Appeal Committee, in 60 days as of the date the Insured received the said notice.
17.2	The Insured shall be entitled to file with the Appeal Committee documents, medical opinions and functional evaluations as the Insured deems fit or as requested by the Committee. In addition, the Committee will allow the Insured and/or his representative to appear before the Committee.
17.3	The Appeal Committee will convene to consider the appeals that were filed with the Committee within a reasonable time from the time the appeal was filed with the Appeal Committee, however no later than 45 days, unless the Insured requested to adjourn the session.
17.4	The Insurer shall deliver to the Appeal Committee all materials relating to the claim and that are in its possession,

	whether delivered to it by the Insured and whether reached its possession not by the Insured.
17.5	The Appeal Committee shall be authorized to consider the claim, accept or reject the claim, in accordance with the terms set forth in the Policy.
17.6	The decisions of the Appeal Committee shall be passed by a majority of votes. In the event the votes are even, the Director of the Insurance Division in Maccabi or whoever is appointed by the Maccabi CEO will have a casting vote, and his decision shall be final and unappealable and shall bind the Insurer. The decision of the Committee shall bind the Insurer and shall be deemed for all intents and purposes as the decision of the Insurer.
17.7	The decision of the Appeal Committee or an appeal filed with the Appeal Committee shall not affect the rights of the Insured to approach the court for the purpose of inquiring his entitlement in accordance with the Policy. For the purpose of this Section "Appeal Committee" shall mean – a committee comprising of three representatives of the Policyholder and three representatives of the Insurer, when four representatives – two from each party, shall constitute a quorum, and its method of operation will be set out in the agreement made between the Policyholder and the Insurer. It is emphasized that at least one of the representatives in the Appeal Committee shall be a physician by training, and at least one additional representative shall be a jurist by training.
Appeal Committee considering joining applications to the insurance	
17.8	In the event the application of a prospective Insured to join the insurance was rejected, the said prospective Insured shall be entitled to approach the Appeal Committee for the purpose of this matter and appeal the rejection in 60 days.
17.9	The said Appeal Committee shall comprise of representatives on behalf of the Policyholder and the representatives on behalf of the Insurer. The prospective Insured shall present to the Committee his entire reasons, both medical and other reasons, and in this regard shall be entitled to submit written opinions on behalf of his physicians.
17.10	The decisions of the Appeal Committee regarding joining applications to the insurance shall be made by a majority of votes. In the event the votes are even with respect to a matter that is not medical, the Director of the Insurance Division in

	Maccabi or whoever is appointed by the CEO of Maccabi shall have a casting vote, and his decision shall be final and unappealable and shall bind the Insurer. In the event the votes in a medical matter are even, the Appeal Committee shall be entitled to add to its members a physician in the relevant field whose identity will be approved by the majority of the Committee members and his decision shall bind the Committee. The decision of the Committee shall bind the Insurer and shall be deemed as the decision of the Insurer, for all intents and purposes.
18 Linkage to the index	
18.1	Linkage differentials, within their meaning in the Adjudication of Interest and Linkage Law, shall be added to the amounts of the monthly insurance benefits specified in Section 8, as of the index that was known on June 30, 2016.
18.2	Linkage differentials, within their meaning in the Adjudication of Interest and Linkage Law, shall be added to the monthly Insurance Premiums, as of the index known on January 1, 2019.
19 Insurance Premiums and their payment	
19.1	Insurance Premiums for each Insured are as stated in the Insurance Premiums table enclosed with this Agreement and shall vary during the Insurance Term according to the age group to which the Insured belongs. The Insurance Premiums shall be calculated according to the age of the Insured on the payment date.
19.2	The Insured will pay the Insurance Premiums once a month as customary with the Policyholder, by an authorization to debit the account or by any other means the Policyholder collects payments from its members.
19.3	Payment of the Insurance Premiums to the Insurer shall be made collectively by the Policyholder or anyone acting on its behalf for all Insureds.
19.4	In the event the Insured did not pay to the Policyholder the Insurance Premiums or any part thereof on time, the Policyholder will deliver to the Insurer the details of the Insured for the purpose of collecting payment or for the purpose of canceling the Policy in connection with the said Insured who failed to pay the Insurance Premiums. The Insurer will transfer, by the Policyholder, and during a period of the first 180 days in which the Insured ceased to pay the Insurance Premiums, two notifications to the said Insured, on

	the dates to be agreed between the Policyholder and the Insurer.
19.5	In the said notifications the Insurer and/or the Policyholder on its behalf will notify the Insured that the Insured failed to pay the Insurance Premiums and the consequences of this failure that might result in an adverse effect on the rights of the Insured in accordance with the Policy.
19.6	In the event the notifications were delivered in accordance with the provisions set forth in Sections 19.4 and 19.5 above, and the Insured did not pay the Insurance Premiums in default to the Insurer, the Insurer shall deliver an additional notice to the Insured in connection with the cancellation of the Policy. After delivery of the said notices as stated above the insurance coverage provided under this Policy shall be canceled by the Insurer, subject to the provisions set forth in the Insurance Contract Law 5741-1981. It is hereby clarified that as long as the Policy is not canceled as stated above, the Policy shall continue to be in effect despite the default in payment of the Insurance Premiums.
19.7	Depositing sums prior to receiving the insurance proposal: 19.7.1 In the event the Insurer received payments on account of the Insurance Premiums before the Insurer agreed to provide insurance coverage for the prospective Insured, payment shall not be deemed as the consent of the Insurer to take out the insurance. 19.7.2 Rejection of the insurance proposal or a request to complete data will be performed in 3 months, at the latest, as of the date the payments on account of the Insurance Premiums were paid, or in the event the Insurer delivered a request to the prospective Insured, as the case may be, to complete the data, in 6 months as of the date of receiving the payments on account of the Insurance Premiums. 19.7.3 In the event the Insurer did not reject the insurance proposal or requested additional information and did not notify the prospective Insured that he was admitted to the insurance during the said period, the prospective Insured shall be deemed to have been added to the insurance under ordinary conditions. 19.7.4 In the event the Insured Event occurred during the period of time stated above, prior to receiving notice regarding the acceptance of the prospective Insured, the prospective Insured shall be entitled to

	insurance benefits if the Insurer had notified the Insured regarding his acceptance to this Policy but for the occurrence of the Insured Event, according to the medical underwriting instructions for the purpose of this Policy for Insureds with similar conditions, to the extent relevant.
20 Settlement and redemption values and Insureds fund	
20.1	No excess sums shall accumulate in favor of an Insured in the Policy for the purpose of obtaining settlement or redemption values.
20.2	Notwithstanding the said in Section 20.1, Insurance Premiums that were paid for all the Insureds in accordance with the group long-term care insurance for the health fund members of a specific health fund, will be used for the purpose of covering the long-term liabilities in respect of the Insureds as aforesaid, with deduction and the addition as ordered by the Commissioner.
21 Option to purchase individual long-term care insurance policies	
21.1	Each Insured shall be entitled to purchase from the Insurer individual long-term care insurance policies "**Individual Policies**") for the entire lifetime of the Insured, in accordance with the long-term care benefits paid under this Policy.
21.2	The Insured shall have the option to purchase two types of Individual Policies: 21.2.1 An Individual Policy for the entire lifetime of the Insured, that pays compensation upon the occurrence of the Insured Event. 21.2.2 An Individual Policy that commences the insurance benefits period after expiration of the period for the payment of insurance benefits in accordance with this Policy, i.e. – transfer to the entitlement period to insurance benefits as customary in accordance with the Policy (after the Insured exhausted his rights in accordance with this Policy for a period of 60 days). The entitlement period in accordance with this Individual Policy shall be for the entire lifetime of the Insured.
21.3	An Insured under this Policy who wishes to purchase an Individual Policy will fill in a joining form that includes a health declaration and will undergo medical underwriting provided by the Insurer in accordance with the customary form in the Insurer in such policies.
21.4	The term of insurance in accordance with the Individual

	Policies shall be in compliance with the form of the Individual Policies customary in the Insurer at the time of purchase.
21.5	The Insurance Premiums that the Insurer will collect from the Insured for the Individual Policy shall be collected with a 15% discount as a minimum compared to the lower Insurance Premiums as approved by the Commissioner and that will be customary in the Insurer at the time in respect of Individual Policies that are equivalent to the program that was selected by the Insured, for an Insured in a similar age and health condition. The said discount shall be in effect during the entire lifetime of the Insured.
21.6	An Insured who joined the insurance and who wishes to purchase the Individual Policy will fill in a joining form and will be required to submit a health declaration and will undergo medical underwriting process in accordance with the customary form in the Insurer in this type of policies. In the event of an Insured who is 65 years of age or older, the Insurer shall be entitled to demand from this Insured to undergo an examination by a physician on its behalf. For the avoidance of doubt, the aforesaid shall also apply to whoever was insured under the Previous Policy, and transferred under insurance continuity to be insured under this Policy, if he wishes to purchase the Individual Policies as aforesaid.
21.7	The Insured will pay the Insurance Premiums in respect of the Individual Policies directly to the Insurer and without the involvement of the Policyholder.
22 Limitation	
The limitation period of a claim for payment of insurance benefits in accordance with this Policy is three years as of the date of occurrence of the Insured Event.	
23 transitional provisions	
23.1	The following provisions shall apply to a Transferring Insured: 23.1.1 The Insurer of the members of a Previous Health Fund in a long-term care period shall incur payment of the insurance benefits of a Transferring Insured, upon fulfillment of the following conditions: 23.1.1.1 The Insured experienced an Insured Event during the previous insurance term that entitles to payment of insurance benefits; 23.1.1.2 The Insured filed an additional claim for insurance benefits during a period that is not greater than 12 months since the Insured ceased to be in a condition that entitles him as stated in Section 23.1.1.1 above.

	23.1.2 In the event the previous Insurer incurred payment of the insurance benefits as stated in Section 23.1.1 – 23.1.2.1 The previous Insurer shall be entitled to offset from the Insurance Premiums that it paid the Insurance Premiums for the period during which the Insurance Premiums were not paid to the Insurer as aforesaid. 23.1.2.2. The new Insurer will return to the Insured the Insurance Premiums that were paid for the period until the occurrence of the Insured Event as aforesaid. 23.1.3 An Insured that experienced an Insured Event shortly before he reiterated from the Previous Health Fund shall be entitled to join this Policy, while maintaining insurance continuity without a repeated examination of his medical condition, in 90 days as of the date in which the Insured Event is no longer valid for him, and provided that the said Insured did not yet realize his full rights to insurance benefits under a long-term care insurance policy for the health fund members; the period during which an Insured under this Policy shall be entitled to insurance benefits shall include deduction of the periods in which he received insurance benefits by virtue of a long-term care insurance policy provided to the health fund members. 23.1.4 In the event the Insurer proved that the Insured Event that occurred to a Transferring Insured occurred for the first time prior to the Insurance Commencement Date, and continued uninterruptedly with respect to the Insured until the Insured joined this Policy, the Insured shall not be entitled to any insurance coverage, and the insurance applicable as of the date the Insured joined this Policy will be canceled, and the Insured will receive reimbursement of the Insurance Premiums charged from him.
23.2	Transitional provisions regarding recuperating Insureds: 23.2.1 A member of Maccabi MAGEN who was defined as requiring for long-term care in accordance with the regulations of the long-term care fund on the Effective Date (hereinafter: "**Member Requiring Long-Term Care**") will continue to receive long-term care services in accordance with the long-term

		care fund regulations, whether or not he receives long-term care benefits and/or received long-term care benefits. It is clarified that a Member Requiring Long-Term Care as aforesaid shall not be entitled to insurance and insurance benefits in accordance with this Policy. Notwithstanding the aforesaid, in the event the Member Requiring Long-Term Care is no longer considered as a Member Requiring Long-Term Care in accordance with the long-term care fund regulations as a result of an improvement in his functional condition, the said member shall become (however not before the Effective Date or three years retroactively, whichever is later) an Insured under this Policy and as of this date henceforth the said member shall pay Insurance Premiums in accordance with the provisions set forth in the Policy, and all on the condition that after the improvement in his functional condition as aforesaid he does not meet the definition of the Insured Event in accordance with the Policy. The provisions set forth in Section 8.3 shall apply to a recuperating Insured, *mutatis mutandis* and in accordance with the insurance tier in which he was insured in accordance with the long-term care fund regulations.
	23.2.2	Whoever is entitled to insurance benefits in accordance with the Previous Policy or any policy that preceded the said policy for group long-term care insurance provided to the members of Maccabi Health Services (hereinafter in this Section respectively: "Long-Term Care Insured" and the "Previous Policy") shall not be entitled to insurance and insurance benefits in accordance with the Policy and the provisions set forth in the Previous Policy shall apply to the said Insured. Notwithstanding the said, in the event the entitlement of a Long-Term Care Insured to insurance benefits ceased under the Previous Policy as a result of an improvement in his functional condition, the said Insured shall become, as of this date (however not before the Effective Date) an Insured under this Policy and as of this date henceforth the Insured will pay Insurance Premiums to the Insurer in accordance with the provisions set forth in the Policy, and all on the condition that after the improvement in his functional condition as aforesaid he no longer meets the definitions of the Insured Event in accordance with the Policy.

	23.2.3 In the event an Insured Event, within its meaning in the Policy, occurs to a recuperating Insured, as stated in sub-sections 23.2.1 and 23.2.2, the said Insured shall be entitled to insurance benefits for the remaining period of entitlement to benefits, i.e., for the maximum period and up to the limit of entitlement to benefits in accordance with the Policy, with deduction of the number of months in which the said Insured was entitled to benefits in accordance with the Previous Policy, and with respect to whoever is a Member Requiring Long-Term Care – with deduction of the number of months in which he received indemnity (whether payment of indemnity and whether long-term care services) in respect of long-term care hospitalization or long-term care provided at home in accordance with the long-term care fund regulations.
23.3	With respect to an Entitled Insured – in the event the Insurer proved that the Insured Event that occurred to an Entitled Insured occurred for the first time prior to the Insurance Commencement Date, and continued uninterruptedly until he joined this Policy, the Insured shall not be entitled to any insurance coverage, the insurance for this Insured shall be canceled as of the date the Insured joined the Policy and the Insurance Premiums collected from the said Insured shall be returned to him.
24 Taxes and levies	
The Insured shall be obligated to pay all government and other taxes applicable to this Policy or that are charged from the Insurance Premiums and the insurance benefits and all other payments the Insurer is obligated to pay in accordance with the Policy, whether the said taxes exist on the date the Policy comes into operation and whether imposed on a later date. It is clarified that the Insurance Premiums on the Effective Date include the full taxes and levies applicable on this from.	
25 Conditions pursuant to the Control on Financial Services (Insurance) (Group Health Insurance) Regulations, 5769-2009	
25.1	The Policyholder declares and undertakes that as a Policyholder it acts faithfully and diligently solely in favor of the Insureds and it does not and will not have any benefit in light of the fact that it is the Policyholder;
25.2	An Insured under long-term care group insurance is obligated to pay on the Insurance Commencement Date Insurance Premiums or any part thereof, including in the event their collection started after the said date, and the Insurer shall not add the Insured to the insurance in the event the Insured

	granted its prior and express approval that is documented, and in the event the Insured is the child or the partner of a member in the group of Insureds – the Insurer shall be entitled to add him after the said member consented to add his child or partner.
25.3	Section 25.2 shall not apply to a group long-term care insurance policy that will be extended for an additional period with the same Insurer or with another Insurer, if the following hold true: (1) The group policy was in effect with respect to the group of Insureds at least three years prior to the date of its extension; (2) The group policy was extended, whether under the same terms and whether under different terms, while maintaining insurance continuity with respect to insurance coverage that was in effect until the extension date and that was included in the group policy after the said date; "maintaining insurance continuity" for the purpose of this matter – maintaining the continuity without reconsidering a Pre-Existing Medical Condition and without a qualification period.
25.4	**Upon commencement of the Insurance Term the Insurer shall provide to each of the members of the group of Insureds, whether joining for the first time and whether on the date of extension of the insurance for an additional period, a copy of the Policy, a Due Disclosure Form in accordance with the instructions set forth by the Commissioner, the Schedule** and additional documents as instructed by the Commissioner;
25.5	Notwithstanding the said in Section 25.4 above, in the event the group insurance was extended for an additional period with the same Insurer, or the insurance was extended for a period that is not greater than three months, during which the Policyholder and the Insurer engaged in negotiations regarding the extension of the Policy for an additional period, without changing the Insurance Premiums and the other terms of insurance coverage, the Insurer shall deliver to each member of the group of Insureds notice regarding extension of the insurance only and will state the following: 25.5.1 That the Insurance Term was extended and that the insurance coverage was not changed. 25.5.2 The entitlement of the Insured to receive a copy of the Policy documents.

	25.5.3 The entitlement of the Insured to inspect the Policy documents, with details as to where the Insured can inspect the Policy.
25.6	In the event the Insured is obligated to pay Insurance Premiums or any part thereof, the Insurer shall deliver to the Insured, upon its demand, a copy of the contract made between the Insurer and the Policyholder, in 30 days as of the date of receiving the demand of the Insured to that effect.
25.7	In the event of a change in the Insurance Premiums or the terms of insurance coverage on the extension date of the group long-term care insurance or during the Insurance Term (in this sub-Regulation – Change Commencement Date) the Insurer shall deliver to each members of the group of Insureds in which he was insured shortly before the commencement of the change, and up to 60 days prior to the Change Commencement Date, a written notice that includes information regarding the said change.
25.8	In the event a policy was extended for a group of Insureds with another Insurer that did not provide insurance coverage for the group shortly before the extension – the other Insurer shall deliver to each of the members of the group of Insureds written notice regarding the said extension, no later than 30 days as of the insurance extension date.
25.9	In the event the relationship between the Insured and Policyholder was terminated, the Insurer shall deliver to each of the members in the group of Insureds, in 30 days as of the date it learned about the termination of the relationship as aforesaid, or in 90 days at the latest as of the date the said relationship was terminated, a written notice regarding termination of the insurance, with information regarding the rights of the Insured under the group policy.
25.10	In the event an Insured is obligated to pay Insurance Premiums on the date of joining the group long-term care insurance policy and that, in accordance with the terms of the Policy, their collection will commence after the said date, the Insurer shall deliver to whoever pays the Insurance Premiums other than the Policyholder written notice regarding the date in which the collection of the Insurance Premiums will commence; such notice as aforesaid will be delivered to whoever pays the Insurance Premiums in the three months that preceded the said collection date.
25.11	In the event the insurance was extended or its terms were modified during the Insurance Term and no express approval

	of the Insured was required, as stated in Sections 25.2 and 25.3, and the Insured notified the Insurer or the Policyholder, during the period of 60 days after extension of the insurance or the date of the change, as the case may be, that the insurance with respect to the said Insured was canceled, the insurance with respect to the said Insured will be canceled as of the insurance extension date or on the date of the change, as the case may be, provided that no claim for exercising the rights under the Policy was filed as a result of an insured event that occurred during the said period of 60 days.
25.12	A group long-term care insurance policy will not expire with respect to an Insured prior to expiration of the Insurance Term and the entire coverage provided thereunder shall be in effect until expiration of the Insurance Term, on the condition that the Insurer received Insurance Premiums for the Insured for these coverages.
25.13	The Insurer shall be held liable towards the Insured, severally, for the payment of the full insurance benefits up to the amount of the limit set out in the group policy. Even if the Insured is entitled to reimbursement of expenses that are paid for an insured event also according to another group long-term care insurance policy, whether provided by the same Insurer and whether by another Insurer.
25.14	In policies whose insurance benefits are paid according to the rate of damage that was caused, the Insurers shall incur the payment among themselves, according to the ratio between the limits of the insurance benefits relating to the insured events as set forth in the insurance policies.
26 Cancellation of insurance	
This Policy shall be canceled in accordance with the provisions set forth in the Insurance Contract Law and the Regulations.	
27 Control Regulations	
This Policy is subject to the provisions set forth in the Control on Financial Services Regulations (Insurance) (Group Insurance for Health Fund Members) 5776-2015 (the "**Regulations**").	
28 Amending the Policy terms and conditions	
In the event the Regulations are amended during the Insurance Term, the terms and conditions of the Policy will change accordingly, and the Insurer shall be entitled to change the Insurance Premiums in accordance with an agreement between the health fund whose members are insured under the Policy as aforesaid and the Insurer, or cancel the Policy, and all subject to the approval of the Commissioner.	
29 General	
29.1	It is clarified that in accordance with the agreement made

	between the Policyholder and the Insurer, in the event the Regulations are amended as aforesaid and the terms and conditions of the Policy are amended accordingly, it is possible to change the Insurance Premiums according to the changes in the terms and conditions of the Policy, with the approval of the Commissioner. A request to change the Insurance Premiums as aforesaid shall be made at the sole discretion of the Policyholder, whether by himself or by the Insurer.
29.2	It is clarified that in accordance with the agreement made between the Policyholder and the Insurer, the amounts as stated in Section 20.2 above shall be managed by the Insurer in accordance with the Regulations or the approval of the Commissioner.
29.3	If payment under this Policy is made by way of a wire transfer, the payment date shall be the date in which the payments are actually transferred to the Insurer or the Insured.
29.4	The addresses of the parties for the purpose of delivery of notices in connection with this Policy are: **The Policyholder**: Maccabi Health Services, 27 HaMered St. Tel Aviv. **The Insurer: Phoenix Insurance Co. Ltd.**, 53 Derech Hashalom Rd., Givatayim. **The Insured**: the last address of the Insured, as provided to the Policyholder. Any notice delivered in registered mail to the aforesaid registered addresses shall be deemed to have reached its recipient 72 hours from the time the letter containing the notice is delivered from the post office, and for the purpose of proving delivery it suffices to prove to the letter was deposited in the post office. An information booklet, drafted by the Insurer and the Policyholder, containing information regarding the claims procedure and service procedures will be enclosed with the Policy.

Maccabi SIUDI

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Contact details:
53 Derech Hashalom Rd., Givatayim 5345433; Tel.: 1-801-22-7788;
Speed dial: *3057; Email: Sm@fnx.co.il; Fax: 03-7337757