"Siudi Mushlam Plus"

The best long-term nursing care coverage for the whole family

January 2019 Edition

HAREL
Insurance & Finance

כללית מעל 100 שנה
הכי טובה למשפחה

Due Disclosure

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Summary of the terms of insurance - "Siudi Mushlam Plus"

Edition 01/2019

Summary of the policy details	
Insurance name	"Siudi Mushlam Plus" - long-term care insurance
Insurance type	Long-term care
Insurance period	Commencing on 1.1.2019 and until 31.12.2023
Insurance description	If the Insured requires long-term care, the Insured will be entitled to monthly insurance benefits as specified in the insurance details sheet. A long-term care situation in this policy is defined as the Insured's inability to independently perform a majority of at at least 3 of the following actions: getting up and lying down, dressing and undressing, bathing, eating and drinking, continence, mobility or is suffering from dementia.
The policy does not cover the Insured under the following circumstances (exceptions in the policy)[1]	In the circumstances specified in Section 9 of the policy. You can contact the Company to obtain detailed information about this matter.
After what period of time from the occurrence of the insurance event I will be eligible to benefits (waiting period)	As specified in Section 7of the policy - 60 days
The number of months insurance benefits will be paid	Up to 60 months.

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Summary of the policy details

The insurance amount that I will receive at home and in an institution

The amount of monthly insurance benefit to which the Insured is eligible will be calculated based on the Insured's age on the date of first enrollment in long-term insurance for HMO members, based on the the location of the Insured's stay during the period for which the Insured is being paid the monthly insurance benefit, as specified below:

Place of the Insured's residence	Age at first enrollment		
	Up to 49	50 to 59	60 and above
Monthly insurance benefit for Insured staying at home (compensation)	NIS 5,500	NIS 4,500	NIS 3,500
*Monthly insurance benefit for Insured residing in an institution (indemnity)	NIS 10,000	NIS 6,500	NIS 4,500

*For an Insured staying in an institution - the amount of the monthly insurance benefit to be paid to an Insured staying in an Institution on the date of eligibility for the monthly insurance benefit will not exceed 80% of the amount actually paid by the Insured to the Institution.
Amounts of the monthly benefits are linked to the Index, with the base index being the one published on 15.06.2016.

[1]Waiting period - the period that begins upon occurrence of the insurance event during which the Insured is not eligible for compensation or indemnity of any kind but only after it has ended.

Summary of the description of coverages in the policy		
Name of the coverage	Description of the coverage	Maximum coverage granted to the claimant (coverage limit)
Long-term care status - Insured staying at home (compensation)	**As stipulated in Sections 3 and 4 of the policy:** Monthly benefit for an Insured staying at home who requires long-term care at the end of the waiting period, and as long as the Insured is in an eligible situation, based on the age at first enrollment, and for the benefit period of up to 60 months, and waiver of payment of the premium for this policy during the eligibility period.	
Long-term care status - Insured staying in an institution (indemnity)	**As stipulated in Sections 3 and 4 of the policy:** Monthly benefit for an Insured staying in an institution who requires long-term care at the end of the waiting period, and as long as the Insured is in an eligible situation, based on the age at first enrollment, and for the benefit period of up to 60 months, and waiver of payment of the premium for this policy during the eligibility period.	Up to 80% of the monthly amount that the Insured actually paid to the Institution and up to the limit set forth in the policy (based on the age at first enrollment) linked to the Index published on 15.6.2016.

Complete and binding terms are the terms specified in the policy

Comments:

1. For your information, the Company website displays the rules, examinations and functional assessment form.
   www.harel-group.co.il/t/CG2JZR
2. For an Insured staying in an institution (indemnity) - the insurance company will pay the actual expenses up to the limit set forth in the policy. Note, if you have the same coverage in a different policy, you will not be eligible for double reimbursement for the amount of actual expenses and subject to the terms of the policy.

"Siudi Mushlam Plus" premiums

Age	Monthly premium In NIS commencing on date 1.1.2019	Monthly premium In NIS commencing on date 1.9.2019	Monthly premium In NIS commencing on date 1.9.2020	Monthly premium In NIS commencing on date 1.9.2021	Monthly premium In NIS commencing on date 1.9.2022
0-18	0.00	0.00	0.00	0.00	0.00
19-25	10.28	10.28	10.28	10.79	11.29
26-30	10.48	10.79	10.99	11.79	12.60
31-35	27.22	27.72	28.33	28.83	29.43
36-40	38.20	39.51	40.82	42.24	43.65
41-45	46.37	47.38	48.38	49.39	51.41
46-50	76.51	80.34	83.26	87.40	91.83
51-55	94.45	99.79	105.34	111.29	117.54
56-60	104.33	111.39	118.85	126.91	135.48
61-65	126.10	134.27	143.04	152.31	162.19
66-70	156.85	165.82	175.29	186.18	196.77
71-75	185.27	194.95	205.13	215.72	227.01
76-80	196.97	206.95	219.85	230.94	242.43
81+	205.94	215.62	225.80	238.40	249.48

Projected premiums for future periods (if any)*

Age	Monthly premium In NIS commencing on date 1.9.2023	Monthly premium In NIS commencing on date 1.9.2024	Monthly premium In NIS commencing on date 1.9.2025	Monthly premium In NIS commencing on date 1.9.2026	Monthly premium In NIS commencing on date 1.9.2027
0-18	0.00	0.00	0.00	0.00	0.00
19-25	11.79	11.79	11.79	11.79	11.79
26-30	13.41	13.71	14.01	14.31	14.62
31-35	30.04	30.64	31.25	31.85	32.56
36-40	45.16	46.67	48.28	49.90	51.61
41-45	53.43	55.44	57.46	59.47	63.51
46-50	93.34	98.18	103.22	108.56	117.23
51-55	124.09	131.04	138.40	146.16	154.33
56-60	144.65	154.43	164.81	175.90	187.79
61-65	172.77	183.96	195.96	208.76	222.27
66-70	207.85	219.55	230.94	244.04	264.71
71-75	238.80	251.20	264.30	278.01	292.53
76-80	254.63	267.33	280.73	294.85	307.14
81+	261.18	273.37	285.07	297.47	311.38

Age	Monthly premium In NIS commencing on date 1.9.2029	Monthly premium In NIS commencing on date 1.9.2030	Monthly premium In NIS commencing on date 1.9.2031
0-18	0.00	0.00	0.00
19-25	11.79	11.79	11.79
26-30	15.32	15.62	16.03
31-35	33.87	34.47	35.18
36-40	55.24	57.05	59.07
41-45	67.84	70.16	72.58
46-50	129.23	135.68	142.43
51-55	172.07	181.75	191.93
56-60	214.00	228.52	243.94
61-65	252.11	268.54	285.98
66-70	295.15	311.68	329.12
71-75	323.67	340.51	358.25
76-80	339.00	356.23	374.28
81+	341.42	357.44	374.28

*Amounts of the premium are linked to the Index, with the base index being the one published on **15.06.2017.**

*The premiums for future periods specified in this Appendix are not final and may change from time to time (including on dates that are different than those specified above) in accordance with the agreements between the Insurance Company and Clalit and subject to approval of the Commissioner of Insurance. Furthermore, the presentation of premiums for later periods than the insurance period set forth in the policy does not constitute any undertaking by the Insurer and/or Clalit of the Insurer continuing to serve as the Insurer in this policy after the end of the insurance period set forth in the policy and/or for the extension of the insurance period for additional insurance periods beyond the insurance period set forth in the policy.

Group Policy for Long-term Care Insurance "Siudi Mushlam Plus" through Harel Insurance Company Ltd.

1. Introduction

1.1. This policy indicates that in consideration for payment of the premium as specified in the insurance details sheet and subject to the terms, provisions and exclusions specified below, the Insurer will pay the Insured insurance benefits for an insurance event as specified in this policy.

2. Definitions

In this policy, the following phrases will be assigned the definitions appearing alongside them:

2.1. "Clalit" or "Policyholder" - Clalit Health Services.

2.2. "The Insurer" - Harel Insurance Company Ltd.

2.3. "Health Insurance Law" - The National Health Insurance Law 5754-1994.

2.4. "Clalit member" - an individual who is a Clalit member in accordance with the rules set forth in the Health Insurance Law including a Clalit member whose registration in Clalit was canceled in accordance with the Health Insurance Law, and is not registered with any other HMO, with the exception of a member whose registration in Clalit was canceled due to cancellation of his residency in the State of Israel.

2.5. "HMO" - as defined in Section 2 of the Health Insurance Law.

2.6. "Start Date" - 1 January 2019.

2.7. "Insured" - Clalit member who joined this policy and pays the long-term care insurance premium in accordance with the provisions of the Insurance Contract Law, and subject to the specified in Section 15 of the Insurance Contract Law. In addition, a baby born to the Insured or who was added as a Clalit member by the age of 12 months (Hereinafter: "The Baby") will be automatically added to this insurance with the exception of a baby for whom an application to add the baby was submitted and rejected by the Insurer. The Insurer will send via Clalit to the parent and/or legal guardian of the Baby a letter informing said party of the addition of the Baby to the insurance. This letter will specify the sections in the policy pertaining to the scope of the Baby's coverage and exclusion specified in Section 9.6 of this policy below.

2.8. "Clalit Mashlim" - supplementary insurance policy (including long-term care coverage) proposed to members of Clalit Health Services by Dikla Insurance Company Ltd. ("Dikla") in 1995-1998.

2.9. "The First Policy" - group long-term care insurance policy offered to Clalit Health Services members by Dikla between 1998-2004.

2.10. "The Second Policy" - group long-term care insurance policy offered to Clalit Health Services members by Dikla commencing in 6/2004 and until 07/2010.

2.11. "The Third Policy" - group long-term care insurance policy offered to Clalit Health Services members by Dikla commencing in 07/2010 and until 31.12.2014.

2.12. "The Fourth Policy" - group long-term care insurance policy offered to Clalit Health Services members by Dikla commencing in 1.1.2015 and until 30.6.2016.

2.13. "The Fifth Policy" - group long-term care insurance policy offered to Clalit Health Services members by Dikla commencing in 1.7.2016 and until 30.6.2017.

2.14. "The Sixth Policy" - group long-term care insurance policy offered to Clalit Health Services members by Dikla commencing in 1.7.2017 and until Date.

2.15. "Previous Policy" - The first policy and/or second policy and/or third policy and/or the fourth policy and/or the fifth policy and/or the sixth policy.

2.16. "Institution" - The Long-term Care Department or Nursing Ward in Old Age Homes, hospitals or in any other institution that primarily 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 Public Ordinance 1940 or by the Ministry of Welfare and Social Services, or any other institution approved by the Insurer.

2.17. "Long-term care insurance for HMO members" - Group long - term care insurance arranged for HMO members of one policy in which one or more of the HMOs is policyholder for its members;

2.18. "The Regulations" - the provisions of the Control of Financial Services (Insurance) (Group Long-term Care Insurance for HMO members) 5776-2015.

2.19. "First-time membership" - membership of an Insured to long - term care insurance for members of any HMO under which the member is continuously insured, including continuity that is maintained when switching HMOs in accordance with Regulation 12 of the Regulations.

2.20. "Existing Insured" - any member who had been an insured in long-term care insurance for HMO members on the start date and remained an Insured continuously in said insurance afterwards.

2.21. "Preexisting Medical Condition" - A set of medical circumstances that were diagnosed in the Insured prior to the date of first enrollment in the insurance, as defined above, including due to disease or accident; for these purposes, "Diagnosed in the Insured" by way of documented medical diagnosis, or during the course of a documented medical diagnosis that was performed in the six months preceding the date of enrollment in the insurance.

2.22. "Exclusion for a preexisting condition" - a general exclusion in the insurance contract that exempts the company from its liability, or reduces the Company's liability or scope of coverage for the insurance incident that was a natural course of a preexisting medical condition and that occurred to the Insured during the qualification period.

2.23. "The Index" - The Consumer Price Index including fruits and vegetables that is published by the Central Bureau of Statistics or in the absence of said publication, the Index published by any other official entity that comes in lieu of the CBS.

2.24. "Appeals Committee" - a committee composed of a representative of the policyholder and a representative of the Insured with requisite qualification as the case may be in the case.

2.25. The Commissioner - The Commissioner of Capital Markets, Insurance and Savings.

3. Insurance Event - Entitling Situation (as specified in Section 3.1 or 3.2)

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

3.1. Dementia established by a specialist physician in the field; for this purpose: "Dementia" - impaired cognitive ability of the Insured and diminished intellectual capacity that includes impaired insight and judgment, diminished long-term or short-term memory and lack of spatial and temporal orientation who requires supervision for most hours of the day in accordance with the cancellation by the specialist physician in the field, that is attributed to Alzheimer's or various forms of dementia.

3.2. State of health and diminished function of the Insured as a result of disease, accident or health condition due to which the Insured is unable to independently perform a majority (at least 50% of the action) of at least 3 of the following actions:

3.2.1. Getting up and lying down - independent ability of the Insured to transition from supine to sitting position and from sitting to standing including from a wheelchair or bed;

3.2.2. Getting dressed and undressed - independent ability of the Insured to get dressed in any type of clothing and to undress including buttons or wearing a medical belt or prosthetic device;

3.2.3. Bathing - independent ability of the Insured to bathe in a tub, shower or wash in any other manner, including entering or exiting a bathtub or shower;

3.2.4. Eating or drinking - independent ability of the Insured to feed himself in any manner or means with the exception of eating with a straw, including drinking with a straw, after the food was prepared and served to the Insured;

3.2.5. Incontinence - independent ability of the Insured to control bowel movements or urination; inability to control any of these actions, which means , for example, regular use of a stoma, urinary catheter, diapers or pads, will be considered incontinent;

3.2.6. Mobility - independent ability of the Insured to move from one location to another, without the assistance of another party; reliance on crutches, cane and walker or any other aide including mechanical, motor or electronic aid that allows the Insured to move independently will not be considered an impairment in the Insured's independent ability to move; it will be emphasized that the Insured's inability to move without a wheelchair will be considered inability to independently move; however, if the Insured is unable to move without a wheelchair but can move independently with a wheelchair form site to site during the insurance period that ended before 7th Tamuz 5777 (1 July 2017) and during the current insurance period, the independent ability of the Insured changed so that the Insured is unable to independently move with a wheelchair, the Insured will be considered as being not independently mobile commencing from the date on which the Insured's ability to move independently changed.

4. Amount of insurance benefits

4.1. The amount of monthly insurance benefit to which the Insured is entitled will be calculated based on the Insured's age on the date of first enrollment in long-term insurance for HMO members, based on the the location of the Insured's stay during the period for which the Insured is being paid the monthly

insurance benefit, as specified in the table below:

The Insured's location	Age of first enrollment in group long-term insurance for HMO members		
	Up to 49	50 to 59	60 and above
Monthly insurance benefit for Insured residing at home (compensation)	NIS 5,500	NIS 4,500	NIS 3,500
Monthly insurance benefit for Insured residing in an institution (compensation)	NIS 10,000	NIS 6,500	NIS 4,500

Amounts of the benefit are linked to the Index, with the base index being the one published on 15.06.2016.

4.2. Despite the specified in Section 4.1above regarding the types of Existing Insureds specified below, Insureds who will be insured on 30 June 2016 and who remained Insured continuously in long-term care insurance for HMO members - instead of the age of first enrollment in long-term care insurance for HMO members specified in Section 4.1the age appearing alongside them will be hereinafter known:

4.2.1. An insured in group long-term care insurance for members of Clalit Health Services "Siudit Mushlam Plus" who joined the insurance between the ages of 60-64-59;

4.2.2. An insured in group long-term care insurance for members of Maccabi Healthcare Services -

a. If the Insured joined 'Gold Nursing Care" between the ages of 49-50;

b. If the Insured joined 'Silver Shield Nursing Care" between the ages of 59-60;

4.2.3. An Insured long-term care insurance for members of Meuhedet HMO long-term care insurance who joined the Meuhedet Gold plan between the ages of 50-65-49;

4.2.4. An insured in long-term care insurance for members of Leumit HMO who joined the insurance between the ages of 59-60 to 64;

The provisions of sections 4.2.2-above, apply to the Existing Insureds who joined this policy as a result of the transition to Clalit from another HMO after 1 January 2017.

4.3. Despite the specified in Section4.1above the amount of the monthly insurance benefit to be paid to an Insured staying in an Institution on the date of eligibility for the monthly insurance benefit will not exceed 80% of the amount actually paid by the Insured to the Institution.

5. Disposal values and surrender of the Insureds' fund

5.1. No surplus will be accrued in the Insured's policy for the purpose of receiving the disposal or surrender values.

5.2. Despite the specified in the Section5.1above, the premium paid for all Insured members in accordance with the group long-term insurance for members of a certain HMO may be used to cover long-term liabilities for the Insureds as specified with the withholdings and increments as to be instructed by the Commissioner.

6. Duty of disclosure, violation of said duty and consequences

6.1. The insurance applicant in accordance with this policy is subject to a duty to disclose full and honest responses to questions presented to the applicant upon entering the insurance contract, and the Parties do hereby agree that solely on the basis of said questions and answers did the Insurer agree to accept the applicant as member of the insurance in accordance with this policy.

6.2. With regards to the relationship between the Insured and the Insurer during the engagement in the insurance contract, including the scope of duty of disclosure that applies to the Insured, the remedies available to the Insurer for breach of said duty and the qualifications for their existence, the provisions of the Insurance Contract Law 5741-1981 pertaining to the matter will apply in full.

7. The waiting period

7.1. The Insurer will pay the Insured insurance benefits to which the Insured is entitled in accordance with the terms of the policy commencing on the date on which the waiting period ends; not more than one waiting period will be granted unless more than 12 months have elapsed since the date on which the insurance event ceased to exist;

For the purpose of this section, "the waiting period" - the period that commences on the date on which the insurance event occurred and ends 60 days afterwards, provided that the Insured has an insurance event during the period.

8. Eligibility for insurance benefits

8.1. An Insured is entitled to receive insurance benefits pursuant to satisfaction of the terms specified in section3above and subject to the terms of the policy.

8.2. Despite the specified in Section 8.1 above, an Insured will be eligible for insurance periods for 60 months commencing from the end of the waiting period as specified in Section7 by virtue of the policy during which period an insurance event

occurred and subject to the specified in Regulation 13 of the Regulations, less the periods in which the Insured received insurance benefits by virtue of the long-term care insurance policy for HMO members.

9. Exceptions from coverage

This policy does not include coverage under the following circumstances:

9.1. An insurance event that occurred following the Insured's service in a defense or policy entity, or due to participation in a military, police, combat action, or hostile action

9.2. An insurance event caused by nuclear fission, nuclear fusion or radioactive contamination.

9.3. An insurance event caused by use or addiction to drugs, with the exception of drugs used under a physician's instructions not for the purpose of withdrawal;

9.4. An insurance event caused by a preexisting medical condition, subject to the provisions of the Control of Insurance Business Regulations (Terms in Insurance Contracts) (provisions regarding Preexisting Medical Conditions) 5764-2004; for the purpose of this paragraph, an eligible Insured will be considered an Insured in contract that was replaced by said Insurer or another Insurer as specified in Regulation 6(a)(2) of said Regulations;

9.5. An insurance event that first occurred before the start of the insurance period or after the end of the insurance period subject to the specified in Regulation 13 of the Regulations;

9.6. An insurance event that first occurred in the first 36 months of the Insured's life;

9.7. An insurance event that was caused by a traffic accident, as defined in the Compensation for Victims of Road Accidents Law 5735-1975, or work accidents as defined in the National Insurance Law [Consolidated Version] 5755-1995 that were recognized by the National Insurance Institute.

10. Payment of insurance benefits

10.1. The Insurer will be entitled, at its discretion, to pay insurance benefits directly to any party that provided the Insured with medical service, or pay the Insured.

10.2. With regards to an Insured who is residing in an institution - the insurance benefits will be paid subject to presentation of a copy of a tax invoice or receipts.

10.3. If the Insured is eligible for insurance benefits in accordance with this policy, but due to his medical condition is unable to handle his affairs, the Insurer will pay the insurance benefits to a guardian to be appointed for this purpose by the court.

10.4. Upon the death of the Insured, the estate is required to report the death to the Insurer.

10.5. Death of the Insured - if the Insured died during a period in which it was eligible for insurance benefits, the eligibility for insurance benefits will cease from the date of the Insured's death, and the Insurer's liability in accordance with this policy to the Insured will cease from said date.

10.6. If an Insured died without listing another beneficiary, the Insurer will pay the balance of the insurance benefits that were not paid prior to the date of death to anyone it undertook to pay and in the absence of said undertaking to the Institution or if a balance remains after payment is made in accordance with said undertaking, the balance will be paid to the estate of the Insured.

11. General conditions for Insurer liability

11.1. If an insurance event occurred, the Insured must inform the Insurer immediately upon learning of the event, of the occurrence of the event and of its eligibility for insurance benefits.

11.2. Once the Insurer is issued notice of the occurrence of an insurance event and a written claim for payment of insurance benefits, the Insurer must immediately follow the requirements to investigate its liability.

11.3. The Insured must provide the Insurer, within reasonable time after said demand is made, the information and documents required to investigate the liability, and if this is not in its possession, must assist the Insurer, to the extent of its ability, to obtain them.

11.4. If said requirement was not satisfied as specified in Section11.1or in accordance with Section11.3 on time, and said compliance would have allowed the Insurer to reduce its liability, it is not required to pay insurance benefits that it would have been required to pay had the requirement been satisfied; this provision will not apply to any of the following:

11.4.1. The requirement was not satisfied or was satisfied at a delay for justifiable reasons;

11.4.2. Failed or delayed satisfaction did not prevent the Insurer from investigating its liability and did not hinder the investigation.

11.5. If the Insured intentionally acted to prevent the Insurer from investigating its liability or impeded it, the Insurer is not required to pay insurance benefits that it would have been required to pay had said action not been taken.

11.6. The Insurer will be entitled to manage at its expense any medical or other examination or investigation to clarify its liability in accordance with the policy, at the Insurer's discretion, in a reasonable manner under the circumstances and pursuant to the examination not hindering treatment, the delay of which might endanger the Insured or his health. The Insurer's right to conduct investigations and examinations will not be affected by the death of the Insured.

If the Insured lives overseas, the Insurer may, if necessary, under the circumstances, demand that the Insured undergo a medical and/or other examination in Israel in order to clarify its liability in accordance with the policy.

It is hereby clarified that this does not derogate from the Insured's right to demand at any time to exercise the rights afforded to it by virtue of the policy in court.

12. The Insurance period

12.1. The insurance period commences from the start date and ends on 31.12.2023.

13. Right of continuity for the individual policy

13.1. The Insurer will allow the departing Insured to switch to a continuation policy based on the dates specified in Section13.2, the conditions of which are listed below:

13.1.1. The amount of the insurance and the period of payment of the insurance benefits in the continuation policy will not be less than those set forth for the Insured in the long-term care policy for members of the HMO, unless the Insured otherwise requested, less periods during which the member was entitled to receive insurance benefits in said policy;

13.1.2. The insurance premium in the continuation policy will not be higher than the insurance premium that would have been in effect on the transition date for new members in an individual long-term care insurance policy with the Insurer;

13.1.3. The transition to the continuation policy will provide insurance continuity without a repeated review of preexisting medical conditions and without a qualification period.

13.1.4. The insurance period in the continuation policies will commence retroactively from the date of cancellation of its registration in the HMO.

13.2. Within 45 days from the date of cancellation of the insurance of the departing Insured, the Insurer will contact the Insured in writing to offer a transition to a continuation policy within 60 days from the date of delivery of said notice of the Insurer;

13.3. Despite the specified in Section13.2 with regards to the Insured who had been eligible to receive insurance benefits in accordance with the terms of the long-term care insurance policy for HMO members on the date on which the long-term care insurance policy was canceled for HMO members - the Insurer's offer to the Insured as specified in said subsection will be made within 30 days from the date on which the eligibility of the Insured to insurance benefits ceased; in said offer, the Insurer will offer to the Insured to switch to a continuation policy within 60 days from the date on which the Insurer's notice was sent; said offer will only be issued if said Insured has not yet exercised his rights to receive insurance benefits in accordance with the policy.

13.4. In this Section 13 -

"Departing Insured" - Insured in a long-term care insurance for HMO members who has yet to exercise all of tis rights in accordance with the policy and whose long-term care insurance for HMO members was terminated due to cancellation of his record in the HMO in accordance with the Health Insurance Law and was not registered with another HMO;

"**Continuation Policy"** - individual policy for long-term care insurance for the insurance period for the entire life.

14. Right to group continuation policy

14.1. If the long-term insurance for HMO members was terminated due to non-renewal of the policy for all insureds with any Insurer, the Insurer will attach all insureds who were insured in said policy to a mutual group long-term care insurance policy for the lifelong insurance period (Hereinafter - The Group Continuation Policy), whose terms are listed below:

14.1.1. Insurance premiums, amount of insurance and the period of payment of insurance benefits (Hereinafter in this section - Terms of insurance coverage) in the group continuation policy will be in accordance with the insurance coverage terms set forth in the long-term health care insurance for HMO members prior to the non-renewal of the policy as specified subject to the long-term balance balance sheet between insurance premiums and other revenue expected to be received for all Insureds in the policy and all expected costs of due to benefits that must be paid, based on the Insurer's best estimate, is not in deficit taking into account the balance of the Insureds' fund.

14.1.2. The terms of insurance coverage may change during the insurance period in the continuation policy based on the optimal estimate of the insured, which was approved in accordance with Section 40 of the Law, which introduces a long-term balance sheet that is not in deficit; once said approval has been issued, the Insurer will be required to accept the Commissioner's approval in accordance with Section 40 of the Law only in cases in which it is asked to change a component used to calculate the estimate and that serves as the basis for issuing said approval.

14.1.3. The disposal values in the continuation policy will not accrue.

14.1.4. The transition to the continuation policy will provide insurance continuity without a repeated review of preexisting medical conditions and without a qualification period.

14.1.5. The insurance premium will be transferred to the Insureds' fund; insurance benefits and any other expense attributed to insurance and its operation will be paid from the fund only; the Insure will not be required to assume the costs of the group continuation policy from its sources;

14.1.6. The insurer will be entitled to reimburse the HMO whose members are insured in the group continuation policy amounts incurred by the HMO for management of the policy, including for collection of premiums from the Insureds, and pursuant to the reimbursement not exceeding 3% of the amount of the premium collected.

14.1.7. For operating the group continuation policy and management of the Insureds' fund, the Insurer is entitled to deduct the annual management fee that includes reimbursement of Insurer expenses and the profit item that is subject to Section 40 of the Law.

14.2. If said balance sheet in Section14.1, on the date of enrollment of the Insureds in the group continuation policy, based on the Insurer's best estimate, is in deficit, the Insurer will submit to the Commissioner for possible options for a change in the terms of insurance coverage that results in a balance sheet that is not in deficit, based on the Insurer's best estimate.

14.3. The Insurer will inform the Insured of its addition to the group continuation policy and of the possibility of terminating its membership within 90 days from the date of receipt of said notice, while specifying the manner in which the Insured may issue notice of said cancellation.

14.4. If the Insured announces its desire to terminate its membership in the group continuation policy, in accordance with Section14.3, the policy will be terminated commencing from the date of the enrollment and the premium collected from the Insured from the date of enrollment and until the date of cancellation will be reimbursed, pursuant to no claim having been filed during this period to exercise rights to receive insurance benefits in accordance with the policy due to the occurrence of an insurance event in said period.

14.5. Despite the specified in Section14.1, the Commissioner may determine that if the long-term care insurance for HMO members was terminated due to non-renewal of the policy for all Insureds with any insurer, the insurer will not be required to enroll the Insureds in any policy, and the balance of the Insureds' fund on said date will be used on behalf of the insureds, under the following circumstances:

14.5.1. All long-term care insurance policies for members of all HMOs were not renewed or is not expected to be renewed with any Insurer;

14.5.2. The alternatives submitted by the Insurer, in accordance with Section14.2 results in terms of insurance coverage that are not reasonable under the circumstances.

15. Limitation

The statute of limitations of a claim for payment of insurance benefits in accordance with this policy is three years from the date of occurrence of the insurance event.

16. Transitional instructions

16.1. If the insurance event occurred **for the first time** during the insurance period of the previous policy and is still continuous, and/or was discontinued and reinstated in the 12 months since the date on which it was discontinued, said insurance event will not be subject to the provisions of this policy butto the provisions of the previous - relevant policy, during whose insurance period the insurance incident first occurred including with regards to the qualificationperiod, insurance amounts, period of payment of insurance benefits.

16.2. If the insurance event occurred for the first time during the insurance period of the previous policy, was discontinued and reinstated in the insurance period of this policy after more than 12 months passed since the date on which it was discontinued, the insurance event will be subject to the provisions of this policy that was reinstated. Commencing in the period of eligibility to receive insurance benefits by virtue of this policy, the periods of payment of insurance benefits received by the Insured by virtue of the previous policy in a manner that in any case the

total insurance benefits to which the Insured will be entitled by virtue of this policy accrued with the benefits period received under the previous policy will not exceed the maximum benefits period under this policy - 60 months.

17. Clarification of medical disagreements

17.1. If a claim of an Insured for payment of insurance benefits is denied for medical and/or other reasons, a detailed notice will be issued by the Insurer that directs the Insured's attention to its right to file an appeal before the Appeals Committee within 60 days from the date of delivery of the notice...

17.2. The Insured will be entitled to be represented in the Appeals Committee hearings by a representative (medical or other) on its behalf and file medical documents and opinions as it deems necessary or as will be requested by the Committee.

17.3. The Appeals Committee will convene no later than 45 days from the date of receipt of the appeal, and its decision will be unanimous.

17.4. If differences of opinion arise among members of the Appeals Committee, a certified party in the relevant field to be appointed by the policyholder will be added to the Committee for the purpose of the discussion in dispute, by the policyholder, the expanded Appeals Committee as specified will again discuss the subject of dispute and reach a majority opinion. The specified in this section does not prevent the Insured from contacting other parties available to it in accordance with the law.

18. Clarification of disputes regarding enrollment in the insurance

18.1. If the application of an insurance applicant to join the insurance is denied, the applicant will be entitled to contact the Appeals Committee within 60 days from the date on which it was notified and file an appeal of this denial.

18.2. The Appeals Committee for this purpose will be composed of a representative of the policy holder and a representative of the Insurer. The insurance applicant will present to the Committee its written explanations and can attach the opinions of his physicians.

18.3. If differences of opinion arise among members of the Appeals Committee, a certified party in the relevant field to be appointed by the policyholder will be added to the Committee for the purpose of the discussion in dispute, by the policyholder, the expanded Appeals Committee as specified will again discuss the subject of dispute and reach a majority opinion.

19. Applicability of the laws

19.1. This policy is subject to regulations.

19.2. Provisions of the Insurance Contract Law 5741-1981 will apply to this policy.

20. Notices

All notices designated for the Insurer and all documents that must be delivered will be delivered to the Insurer in writing. Notices for the policyholder (Clalit Health Services) will be delivered in writing to the address of the Head Office. Notices designated for the Insured regarding its claim will be delivered in writing to the contact of the Insured as specified in the claims form.

21. The Premium

21.1. Premiums will be paid on the first of every month in accordance with the date on which payments were set forth by the Insurer.

21.2. Any premiums that are not paid on time will have linkage differentials and interest added in accordance with that set forth in the Interest and Linkage Payments Ruling Law 5721-1961 commencing on the date of occurrence of the arrears and until actual redemption of the premium to the Insurer.

21.3. The premium (amount of premium) - in accordance with the specified in "Due Disclosure".

21.4. The age of the Insured for the purpose of determining the premium and for the purpose of determining the age of first enrollment will be calculated in whole years based on the number of whole years that passed from the month of the Insured's birth.

22. Waiver of payment of premium

An Insured who is entitled to receive insurance benefits in accordance with the terms of the policy will be exempt from payment of premiums for the period for which it is entitled to receive insurance benefits.

23. Index-linked

23.1. The monthly insurance benefits specified in Section4 will be subject to linkage differentials as these are defined in the Interest and Linkage Law, from the Index known on 15.6.2016.

23.2. The monthly premiums specified will be subject to linkage differentials as these are defined in the Interest and Linkage Law, from the Index known on 15.6.2017.

24. Change in the terms of the policy

If the Regulations are amended during the insurance period, the terms of the policy will be amended accordingly, and the Insurer will be entitled to change the premium, in accordance with the

agreement between the HMO whose members are insured in said policy and the Insurer or to terminate the policy, subject to the Commissioner's approval.

25. Change in premium

In addition to the specified in Section 24 above:

25.1. The Insurer will be entitled to change the premium subject to Commissioner approval but not before the end of the year in which the insurance period commences.

25.2. Clalit will be entitled to contact the Commissioner in conjunction with the Insurer with a request to change the premiums. Change in premium will be made subject to Commissioner's approval.

26. Cancellation of policy by the Insured

26.1. By written notice to the Company at any time.

26.2. If the insurance was renewed or its conditions changed during the insurance period and no explicit consent of the Insured was required and the Insured informed the Company or Policyholder within 60 days following the renewal of the insurance or the date of the change, as the case may be, of the cancellation of insurance in which he is insured, the insurance will be canceled commencing on the date of renewal of insurance or on the date of the change, as the case may be, pursuant to no claim having filed to exercise rights under the policy due to an insurance incident that occurred during the said 60-day period.

27. Cancellation of policy by the Insurer

27.1. If the policyholder and/or insured are failing to pay or did not regularly pay the premium. The cancellation will be carried out in accordance with the Insurance Contract Law 5741-1981 ("Insurance Contract Law").

27.2. If the Insured and/or policyholder concealed from the Company material fact the knowledge of which would have resulted in the Company not accepting the Insured into the insurance (in accordance with the Insurance Contract Law).

27.3. If the Insured's registration in Clalit is cancelled due to cancellation of his residency in Israel.

27.4. An Insured who exercised all of its rights in accordance with the policy.

27.5. With regards to a baby who was automatically added to this insurance - the policy will automatically be canceled on the first date on which payment of the premium begins in accordance with the terms of the policy, unless the parent and/or legal guardian of the baby granted consent to pay the premium and a method of payment was granted for this purpose, before the first date of mandatory payment of said premium.

28. The provisions in accordance with the Control of Financial Services Regulations (Insurance) (Group Health Insurance) 5769-2009.

28.1. Addition of an Insured:

a. The Insured must, in accordance with the terms of the group health insurance policy, satisfy one of the following:

(1) To pay, on the insurance period start date, the premium, or any part thereof, including if collection occurs after said date, with the exception of withholding of the medical insurance premium from the salary in accordance with section 1d(c) of the Foreign Workers Law;

(2) To pay tax or any other payment for the group insurance policy; The Insurer will not enroll said applicant in the insurance without the expressed consent of the applicant, which will be documented and if the Insured is the child or partner of a member in the group of Insureds - the Insurer may enroll him after consent was given by said member to enroll his children or partner.

b. Subsection (a) above will not apply to a group health insurance policy that will be renewed for another period with the same Insurer or with another Insurer, pursuant to satisfaction of the following conditions:

(1) The group policy will be valid for the group of Insureds for a minimum of three years prior to the date of renewal;

(2) The group policy will be renewed either under the same conditions or under different conditions, while maintaining insurance continuity for insurance coverage that will be valid up to the date of the renewal and that was included in the group policy after said date; for this purpose "maintenance of insurance continuity" - maintaining continuity regardless of recurrence of a preexisting medical condition and without a qualification period.

c. If the number of insureds in a group drops below 50, the group policy will not be renewed on the expiration date or at the end of the insurance period, whichever is earlier.

28.2. Double Insurance

a. The Company will be liable, severally, to the Insured for the full amount of the insurance benefit up to the cap set forth in the Group Policy, even if the Insured is entitled to coverage of expenses paid for an insurance incident even according to another health insurance policy either with said Insurer or with another Insurer.

b. In policies for which insurance benefits are paid according to the rate of damage caused, the Insurers will bear the burden of the liability among themselves, based on the ratio between the insurance benefits cap pertaining to the insurance incident as set forth in the insurance policies.

28.3. Issuing of documents to the Insured

a. An Insurer will provide at the start of the insurance period, to every individual in the group of Insured, whether enrolled for the first time or on the date of renewal of the insurance for another period, a copy of the policy, the due disclosure form in accordance with the Commissioner's directives, an insurance details sheet, and other documents so ordered by the Commissioner;

(a1) Despite the specified in Section a above, if the group insurance is renewed for an additional period with said Insurer or if the insurance was extended for a period that does not exceed three months, during which negotiations are conducted between the Policyholder and the Insurer regarding renewal of insurance for another period, with no change in premium and other terms of insurance coverage, the Insurer will provide every member of the group of Insureds notice of insurance renewal only and will note-

(1) That the insurance period was extended and that no changes were made to the terms of insurance coverage;

(2) The possibility of the Insured receiving a copy of the policy documents;

(3) The Insured's option to review the policy documents while providing details on where this can be done.

b. If the Insured is required to pay the premium or any part thereof, the Insurer will send the Insured, upon demand, a copy of the contract between the Insurer and the Policyholder within 30 days from the date of receipt of the Insured's request.

c. If the Policyholder is required to pay the entire premium, the Insurer will send the Insured, upon demand, a copy of the contract between the Insurer and the Policyholder within 30 days from the date of receipt of the Insured's request, and yet the Insurer is entitled to not send the Insured provisions in said contract with regards to the amount of the premium, adjustment of the premium and profit sharing.

28.4. Issuing of notices to the Insured

a. If a change is made to the premium or terms of insurance coverage on the date of renewal of the group health insurance or during the insurance period (in this section - date of the start of the change), the Insurer will deliver to each member of the insured group who was insured there on the eve of the date of the change, up to 60 days before the date of the change, written notice that includes the details of said change.

(a1) If the policy ended and was not renewed, either with the same Insurer or with another Insurer, for all or some of the Insured, the Insurer will issue to each member in the

group of insureds whose policy ended or was not renewed, as specified, no later than 30 days after the end of the insurance period, written notice regarding the cancellation of the insurance , and will specify the individual's right to continuity in an individual health insurance policy and the individual's right to reduced premiums, to the extent that each of these rights is relevant, and will specify in said notice any additional rights of the individual arising from the cancellation of the policy.

(a2) If the affiliation between the Insured and the Policyholder is terminated as specified in Section 28.5 (b) below the Insurer will issue to each member of the group of Insureds within 30 days from the day on which he is informed of such cancellation or no later than 90 days after the cancellation of the said affiliation , a written notice regarding the cancellation of the insurance that includes details of the rights of the Insured according to the group policy.

b. Commencing on the date of enrollment in the group health insurance, the Insured must pay premiums, the collection of which, according to the conditions of the policy, will occur after the said date, the Insurer will issue to the party paying the premium who is not the policyholder; written notice regarding the date on which collection of the premium commences; said notice will be issued to the party paying the premium during the three months that preceded said collection.

28.5. Cancellation of insurance for a certain Insured

a. If the insurance was renewed or its conditions changed during the insurance period and no explicit consent of the Insured was required and the Insured informed the Company or Policyholder within 60 days following the renewal of the insurance or the date of the change, as the case may be, of the cancellation of insurance in which he is insured, the insurance will be canceled commencing on the date of renewal of insurance or on the date of the change, as the case may be, pursuant to no claim having filed to exercise rights under the policy due to an insurance event that occurred during the said 60-day period.

b. Despite the specified in Section 28.6 below, if the association between the Insured and the Policyholder is terminated as specified in Regulation 2, for which it engaged in a group health insurance policy, the insurance for said Insured will be canceled within 90 days from the date of cancellation of the association.

28.6. **The Insurance period**

The Group Health Insurance Policy will not expire for the Insured before the end of the insurance period, and all insurance coverages will apply until the end of the insurance period, if the Company received payment of premium for the Insured for said coverage.

28.7. **Policyholder Declaration**

The policyholder hereby declares and undertakes that as a policyholder in the "Siudi Mushlam" policy for members of Clalit and their families, it will acts faithfully and diligently for the benefit of the policyholders only, and that it does not and will not have any benefit from being the policyholder.

Guidelines for submitting a claim for long - term care benefit

Documents that must be issued to the Insurer during the claim:

1. Claim submission form and documents required thereof. The form can be downloaded from the Insurer's website, at www.harel-group.co.il at the nurses station at Clalit branches.
2. Medical documents relevant to the claim as well as any other document that may indicate your functional and/or cognitive state (such as decision from the National Insurance Institute). If the Insured is staying in an institution for a fee, we want to provide the insurance company with a copy of the first receipt for this payment that also specifies the date of payment (day month and year).
3. In order for us to handle the claim in an efficient and speedy manner, the Insured must send the Insurer all complete documents, in accordance with the aforementioned list.
4. The claim will only be approved if it is in compliance with the provisions of the policy.
5. All said documents mentioned above must be sent to:
   Dikla Insurance Company Ltd.
   Long-term Care Claims Department, BSR-2 Tower, 1 Ben Gurion Street, POB 903 Bnai Brak 5110802
   or Fax: 03-7348597, or to email: tvsiud@dikla.co.il
   Telephone for inquiries: 1-800-551122

Claim management process:

1. Upon receipt of the documents, the Insurer will review the long-term care coverage in accordance with the terms of the policy.
2. Whenever necessary, at the Insurer's discretion, the Insurer will order medical material and information from the National Insurance Institute.
3. The Insured may be asked to undergo a functional / cognitive examination. The examination will be scheduled in advance.
4. When additional material is necessary, the Insurer will issue a request for the issuing of these documents.
5. Upon completion of the claims management process, written notice will be sent specifying the Insurer's decision.

For additional information and details:

dial *2700

from any telephone

clalit.co.il/siudi

b14307/24156

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Insurance & Finance

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