Contents

Dear Insured,

I am pleased to inform you that as of January 1, 2020 the company that will insure the Meuchedet [Health Care Fund] insureds under the “Meuchedet Frail Care” policy is Menorah Insurers Insurance Ltd. (“Menorah”), after Menorah won the tender to select a new insurer.

Menorah Mivtachim Insurance is one of the five largest insurance companies in Israel and has many years of experience in the health care sector in general and in the field of frail care and provides you with a dedicated range of professionals and experts in the field.

“Meuchedet Frail Care” – The group long term frail care insurance for Meuchedet insureds, provides a solution to the frail care insured and his / her family members and provides a suitable solution to the needs of the frail care insured. The terms of this insurance are set in accordance with the Financial Services Supervision Regulations (Insurance) (Group Frail Care Insurance for Health Care Fund Members) 5776 - 2015, which were proclaimed by the Minister of Finance. The regulations stipulate that all Health Care Funds will offer their insureds a uniform policy, the terms of which are stipulated in the regulations.

As you are aware, caring for a frail care patient involves many hardships and is a heavy financial burden on the patient and on his or her family. We at Meuchedet take care of your health at any age, however, if heaven forbid you and / or your loved ones

are in need of frail care, you will be entitled to receive financial assistance from the insurance company, which will enable you to receive dedicated and appropriate care.

The process of providing the service by Menorah is pre-determined in the terms of the tender and Meuchedet will take care to monitor its implementation.

Alongside your personal and human contact, Menorah will provide you with a variety of digital means to update all stages of the claim, as appropriate, and will even provide a personal area for Meuchedet insureds on its website.

Frail Care insurance is part of the range of services offered to Meuchedet customers, out of a concept of commitment to our insureds at every stage of their lives. We are making great efforts to offer additional health care and other services that will address any age and any medical condition.

We wish you good health and longevity.

Wishing you good health,

Sigal Regev Rosenberg

CEO

Dear Insured

We applaud the cooperation with the Meuchedet Health Care Fund and the choice of Menorah Mivtachim to insure the members of the Health Care Fund under the “Meuchedet Frail Care” Policy.

The insurance will take effect as of January 1, 2020. As a leading company in the insurance market in Israel, we at Menorah Mivtachim understand the importance of an available and personalized service system that provides professional, prompt and optimal solutions in the moments of truth, when you need us.

Menorah Mivtachim Insurance has insured tens of thousands of policy holders in health care and frail care insurance for many years and we have flown the banner of providing efficient, personal, compassionate and uncompromising service. Therefore, we undertake to provide a quality and reliable service, with a personal vision that takes into account the needs and well - being of each insured in order to fulfill his rights.

We provide you with the size, experience and resilience of the Menorah Mivtachim Group and we will make sure to accompany you, to materialize and protect your rights when it comes to frail care cover. We do this, inter alia, through a dedicated team of professionals and experts in the field.

Menorah Mivtachim Insurance is one of the five largest insurance companies in Israel and the biggest dealing in general insurance and auto insurance and is part of the Menorah Mivtachim Group, which manages the largest pension

fund in Israel – “Menorah Mivtachim Pension” and with decades of experience in health care in general and in frail care in particular.

Like 2 million customers of the company, you too can be safe with Menorah Mivtachim. The attached booklet contains comprehensive information on your long-term frail care insurance.

Wishing you a solid health,

Orit Kramer

Deputy CEO, Health Care Insurance Domain Manager

Company Website: www.menoramivt.co.il	**Postal Address:** C / O Health Care Domain P. O. Box 927, Tel Aviv 6100802	**Email Address of the Company:** meuhedet@menora.co.il	**Meuchedet Frail Care Customer Service Hotline**: 1-700-722-233 Fax: (03) 710-7788

Summary of insurance terms – Group Frail Care insurance policy for members of the Meuchedet Health Care Fund	
Summary of Details of the Policy	
Name of the Insurance	Meuchedet Frail Care – A policy for frail care insurance for members of a Meuchedet Health Care Fund
Type of Insurance	Frail Care
Insurance Period	January 1, 2020 – December 31, 2024 plus an option to renew the policy for an additional three year period, with the consent of both parties.
Description of the Insurance	Compensation for the insured being in a frail care situation at his home or indemnity for expenses expended at a frail care institution.
The policy does not cover the insured in the following cases (Policy exceptions)	As specified in Section 11 of the Policy. You may contact the company for detailed information on this matter.
How long after the beginning of the insurance, can I claim and receive compensation (qualification) [1]	There is no qualification period
How long after the occurrence of an insurance event can I claim and receive compensation (Waiting Period) [2]	60 days as detailed in section 6 of the policy
Deductible Amount	For an insured who resides in an institution – up to 20% of

[1] Qualification Period – A period commencing upon the date of the commencement of the insurance. Upon the occurrence of an insurance event, during the course of this period, the insured (or beneficiary) will not be eligible for insurance benefits.

[2] Qualification Period – A period commencing upon the date of the occurrence of an insurance event for which the insured is not eligible for any compensation or indemnity whatsoever, but rather only at the end thereof.

<table>
<tr><td></td><td>the amount the insured actually paid to the institution, in accordance with the provisions of section 7 (c) of the policy.</td></tr>
<tr><td>For how many months / years will the insurance benefits be paid</td><td>Up to 60 months cumulative ceiling for the entire insurance periods.</td></tr>
<tr><td>The Insurance Amount that I will Receive at Home and in an Institution</td><td>The amount of the monthly insurance benefit to which the insured is entitled will be calculated according to his age at the date of first signing up for the frail care insurance for Health Care Fund members (for details of “special” ages, see section 7 (b) of the policy), and according to the place of residence of the insured during the period for which the monthly insurance payment is paid, as specified in the table below:

<table>
<tr><td rowspan="2">Place of Residence of the Insured</td><td colspan="3">Age of First Sign up for Group Frail Care Insurance for Health Care Fund Members</td></tr>
<tr><td>Up to 49</td><td>50 to 59</td><td>60 and Over</td></tr>
<tr><td>Monthly Insurance Benefit for an Insured Staying at Home (Compensation)</td><td>Nis 5,500</td><td>NIS 4,500</td><td>NIS 3,500</td></tr>
<tr><td>Monthly Insurance Benefit for an insured Staying in an Institution (Indemnity)</td><td>NIS 10,000</td><td>NIS 6,500</td><td>NIS 4,500</td></tr>
</table>
The amounts in the table above are linked to the CPI published on June 15, 2016.
The age of first sign up will be as stipulated in the regulations, including that stipulated, the 2019 amendment made on the matter.</td></tr>
</table>

Cost of the Insurance	As specified in the premium variability table on pages ___ below.
Remarks	Regarding receiving indemnity insurance benefits for Frail Care Institution stay expenses: The insurance company will pay the actual expenses up to the ceiling set in the policy. Please note that if you have the same coverage under another policy, you will not be eligible for additional reimbursement beyond the actual expense level and subject to the terms of the insurance plan. Please note that the Company's website presents the rules, tests and functional evaluation form.

Description of the Cover in the Policy					
Name of the Cover	**Description of the Cover**	**What is the maximum amount that can be claimed**	**How long after the commencement of the insurance can I claim and receive compensation (qualification)**	**How long after the insurance event will happen will I be entitled to compensation (waiting)**	**Deductible Amount**
Monthly remuneration due to frail care status	As specified in Section 3 of the Policy. Monthly compensation or indemnity based on the insured's stay for up to 60 months for an insured in poor health and degraded functioning as a result of illness, accident or health impairment for which	Up to the ceiling set in the policy (depending on the age of first sign up for frail care insurance), and for an insured who resides in an institution – no more than 80% of the amount the insured	None	60 days	For an insured who resides in an institution – up to 20% of the amount the insured actually paid to the institution, in accordance with the provisions of section 7 (c) of the policy.

	he is unable to perform a substantial part (at least 50% of the operations) of at least 3 of the 6 daily operations listed in the definition of the insurance case, or "mental exhaustion" (as defined in the insurance event definition) determined by a specialist in the field.	actually paid to the institution .			
Remarks	**<u>Regarding an insured staying in an institution (indemnity):</u>** The insurance company will pay the actual expenses up to the limit set in the policy. Please note, if you have the same coverage in another policy, you will not be entitled to double reimbursement beyond the actual expense level and subject to the terms of the policy.				

Please note that the full and binding terms are the terms set forth in the policy.

Information on the eligibility rules for obtaining frail care benefits under this policy, the tests for defining frail care status and a functional assessment form can be found on the Meuchedet Frail Care website at www.meuhedet.co.il and also on the insurer's website www.menoramivt.co.il. Furthermore, a copy of the Guide for the Insurance Buyer, published by the Commissioner of Insurance, may be requested from the insurer.

Full Disclosure Appendix (Insurance Cost):

The following are the premiums for additional insurance periods between 2020 and 2032:

Monthly Insurance Premiums (in NIS) for the first period *:

The age of the insured at the time of payment of the premium	The Amount of the Monthly Premium in Shekels							
	From January to July 2020	From August 2020 to July 2021	From August 2021 to July 2022	From August 2022 to July 2023	From August 2023 to July 2024	From August 2024 to July 2025	From August 2025 to July 2026	From August 2026 to July 2027
0-17	-	-	-	-	-	-	-	-
18-20	7.16	7.16	7.16	7.16	7.16	7.16	7.16	7.16
21-25	13.10	13.10	13.10	13.10	13.10	13.10	13.10	13.10
26-30	17.64	17.64	17.64	17.64	17.64	17.64	17.64	17.64
31-35	36.99	36.99	36.99	36.99	36.99	36.99	36.99	36.99
36-40	55.94	55.94	55.94	55.94	55.94	55.94	55.94	55.94
41-45	63.20	63.60	64.01	64.41	64.81	65.21	65.62	66.02
46-50	107.85	109.67	111.58	113.50	115.41	117.43	119.44	121.46
51-55	127.00	130.23	133.55	136.88	140.31	143.84	147.46	151.19
56-60	148.17	152.60	157.24	161.98	166.82	171.86	177.00	182.34
61-65	169.64	175.79	182.14	188.69	195.54	202.60	209.96	217.52
66-70	203.51	209.55	215.70	222.05	228.60	235.36	242.31	249.47
71-75	226.19	233.34	240.80	248.46	256.32	264.49	272.85	281.52
76-80	237.47	245.34	253.40	261.77	270.43	279.41	288.68	298.25
81 and Over	242.31	249.87	257.73	265.79	274.16	282.73	291.60	300.77

Monthly Insurance Premiums (in NIS) for the additional period *:

The age of the insured at the time of payment of the premium	From August 2027 to July 2028	From August 2028 to July 2029	From August 2029 to July 2030	From August 2030 to July 2031	From August 2031 to July 2032
0-17		-	-	-	-
18-20	7.16	7.16	7.16	7.16	7.16
21-25	13.10	13.10	13.10	13.10	13.10
26-30	17.64	17.64	17.64	17.64	17.64
31-35	36.99	36.99	36.99	36.99	36.99
36-40	55.94	55.94	55.94	55.94	55.94
41-45	66.42	66.93	67.43	67.94	68.44
46-50	123.58	125.69	127.81	130.03	132.24
51-55	155.02	158.95	162.99	167.12	171.35
56-60	187.78	193.43	199.27	205.32	211.47
61-65	225.38	233.54	242.01	250.78	259.85
66-70	256.83	264.39	272.15	280.11	288.38
71-75	290.49	299.77	309.34	319.22	329.40
76-80	308.13	318.31	328.79	339.68	350.87
81 and Over	310.15	319.82	329.80	340.18	350.87

* The premiums are linked to the Consumer Price Index published on June 15, 2017.

Note!

The insurance price varies during the insurance period according to the age group to which the insured belongs, and

is linked to the Consumer Price Index published on June 15, 2017.

You can compare insurance prices and specify the various insurers' service index in the Health Insurance Calculator website at the Capital Market Authority – to Access the Calculator

The insurance price and service index scores for this product are correct as of the date of publication.

Meuchedet Frail Care – the Group Frail Care Insurance Policy for Members of the Meuchedet Health Care Fund

Introduction
Against the payment of a premium and subject to the terms, instructions and exceptions set forth below, the Company will provide the Insured with insurance benefits for an insurance event that occurred during the insurance period, in accordance with this policy and its terms.

Definitions
Policy Holder – Meuchedet Health Care Fund ("**Meuchedet**")
The Previous Policy – Group Frail Care Insurance for Meuchedet Members named "Meuchedet Gold", which expires on December 31, 2019.
The Insurer / the Company – Menorah Mivtachim Insurance Ltd.
Effective Date – January 1, 2020

Commissioner – The Commissioner of Capital Markets, Insurance and Savings.

The Policy – Group frail care insurance for health care fund members, the terms of which, including their exceptions and qualifications, are detailed in this document. The proposal form and the insurance details page will be considered an integral part of the policy.
First Time Sign Up – Signing up on the part of an insured for frail care insurance for any Health Care Fund members, from which he is insured continuously, including a continuum which is maintained in the transition from one health care fund to another, including all amendments made in the matter, including the 2019 amendment.

Health Care Insurance Law – State Health Care Insurance Law, 5754 - 1994.
Meuchedet Member – Anyone who is registered and eligible to receive Medical Services from Meuchedet under the Health Care Insurance Law.
Insured – One who fulfills all of the following conditions (1 - 2):

1. The insured is one of the following:
   (a) A Meuchedet member and / or his children registered

with him at Meuchedet, who was / were insured under the previous policy on the eve of the effective date and / or a former Meuchedet member whose membership in Meuchedet had been cancelled under the State Health Care Insurance Law and who has not signed up for another health care insurance fund (except for the person whose residence [in the country] has been revoked) after the effective date;

(b) A Meuchedet member and / or his children registered with him at Meuchedet, who was / were not insured under the previous policy on the eve of the effective date and / or a former Meuchedet member who membership in Meuchedet had been cancelled under the State Health Care Insurance Law and who has not signed up for another health care insurance fund, and applied to the company to sign up for the insurance, in a procedure that involves examining a pre-existing medical condition, and the company has agreed to their insurance ("**Sign Up Application**");

(b)(1) Notwithstanding the provisions of subsection (b) above, a Meuchedet member who is a prior insured shall be entitled to sign up while maintaining an insurance continuum and without re-examining his medical condition, unless the insurance case is met and subject to the provisions of section 13 of the policy.

(b)(3) An insured whose membership in the health care fund was cancelled under the Health Care Insurance Law because he ceased being a resident [of the country] according to the definitions of the stated law, will not be allowed to sign up for the policy as stated.

(c) In the event that a Meuchedet member submitted an insurance offer to the Company and advance payments were made to the Company for the insurance premium for the relevant insurance coverage, before the Company announced its consent for the insurance (if and insofar as it announced or was due to give notice under the underwriting rules regarding the policy), the following provisions will

apply:

(1)(c) The Company will send to a Meuchedet member, who is an insurance candidate, within 90 days of receiving the insurance premium for the first time or 90 days from the date of application, at the earliest of the above dates, a rejection notice stating that the insured is not accepted for insurance and has no insurance coverage in effect ("**Rejection of the Proposal**") or will submit a counter proposal to him (the "**Counter Proposal**") or will get back to him with a request to supplement the data ("**Request for Data Supplementation**") (hereinafter: "**Response Date**" respectively).

(2)(c) Should the Company not send to a Meuchedet member who is an insurance candidate by the time allocated for the provision of a response of the rejection of the proposal, or a request to supplement data or a counter proposal, the insurance candidate will be deemed to have signed up for the insurance under normal conditions in accordance with the insurance proposal, the insurance details page and the terms of this policy. The date of commencement of insurance and the determining date for payment of premiums in this case shall be the day marked as the date of commencement of insurance as stated in the application for membership provided to the Company, provided that this date does not precede the date of application for membership.

(3)(c) In the event that the Company sent a Meuchedet member, who is a candidate insurance, an inquiry to supplement data or a counter proposal by the response date, and the insurance candidate provided the Company with the requested data or his reference to the counter proposal, the Company will send the insurance candidate, within 90 days from the date of such referral,

a decision regarding accepting the candidate for insurance or rejecting the proposal. Should the Company not send the applicant a notice of acceptance or rejection of the proposal within this time, the insurance candidate will be deemed to have signed up for the insurance under normal conditions in accordance with the terms of the application for membership on the insurance details page and under this policy. The date of commencement of insurance and the date of payment of the premiums in this case will be the date specified in the application for membership, provided that this date does not precede the date of application.

(4)(c) Should an insurance event occur after an advance payment has been made to the company for the insurance premium for the relevant insurance coverage and before the Company announced its consent to insurance as described in this section, a Meuchedet member will be eligible for insurance benefits, provided that under the Company's underwriting rules in force at the time in the matter of the policy, the policy terms and conditions and the relevant cover, a Meuchedet member would have been eligible to be admitted to the relevant insurance coverage, had the insurance event not occurred

The insurer has the right to make sure that there is no change in the terms and answers which the insurance applicant declared in the application for membership, including the accompanying health declaration, when signing up for the insurance and before the insurer informed the insured of his acceptance for the insurance. "**Change**" for the purposes of this section – a change in the state of health, physical condition, profession and occupation of the candidate to be insured that would have affected the insurer's consent

or conditions for the application for membership, should the insurer have known about them.

2. If the insurer has been paid the insurance premium or if the insurer has been given a form of payment for the insurance premium that can be collected from him.

A Former Insured – an insured in frail care insurance for health care fund members who transitioned from another health care fund, was insured in frail care insurance for health care fund members.
The Index - the Consumer Price Index (including fruits and vegetables) set by the Central Bureau of Statistics, including any other official index to replace it, even if it is published by any other government institution that replaces it.
Institution – a frail care or mentally fatigued person's ward in a nursing home, hospital or other institution whose primary occupation is the hospitalization of frail care patients and is approved as a frail care institution by the Ministry of Health under the Public Health or Social Welfare Ordinance or other institution approved by the insurer;

1. **Supervision Regulations** – This policy is governed by the Financial Services Supervision Regulations (Insurance) (Group Frail Care Insurance for Members of Health Care Funds), 5775 - 2015 (in this policy – "**The Regulations**").

2. **Change of Terms and Conditions of the Policy** – In the event that the **regulations** change during the insurance period, the terms and conditions of the policy will change accordingly and the insurer will be at liberty to change the insurance premiums, according to an agreement between the health care fund whose members are insured in such policy and the insurer, or to cancel the policy, all subject to the approval of the Commissioner. Without derogating from the above stated, the insurer will be at liberty to change the terms of the policy and / or the insurance premiums by written notice 60 days in advance to the insureds, subject to the approval of the Commissioner.

3. **The Insurance Event** – The insurance event is one or more of the following occurrences:

(a) **Mental fatigue** diagnosed by a specialist in the field;
In this regard: "**Mental Fatigue**" – impairment of the insured's cognitive activity and a reduction in his

intellectual capacity, which includes impairment of insight and judgment, decreased long term or short term memory and lack of orientation of place and time, requiring supervision during most of the day, according to a specialist in the field, the reason for is a state of health such as: Alzheimer's or in various forms of dementia.

(b) The state of health and poor functioning of the insured as a result of illness, accident or health impairment, due to which the insured is not capable of performing a substantial part (at least 50%) of the action, of at least 3 of the following actions:

1. **Stand up and lie down** – The independent capability on the part of the insured to move from a supine to a sitting position and to stand up from a chair, including a wheelchair or bed;

2. **Dressing and undressing** – The independent capability on the part of the insured to put on clothing items of any kind and the removal thereof, including attaching or assembling a medical belt or artificial limb;

3. **Bathing** – The independent capability on the part of the insured to bathe in the bath, take a shower or any other acceptable manner, including entering or exiting the bath or shower;

4. **Eating and Drinking** – The independent capability on the part of the insured to feed himself in any way or means, except eating through a straw, and including drinking through a straw, after the food has been prepared for him and served to him;

5. **Control of Sphincters** – The independent capability on the part of the insured to control bowel movements or urinary tract function; failure to control one of these functions, which means, for example, regular use of a stoma, bladder catheter, diaper, or various absorbents, will be considered as having no control over sphincters;

6. **Mobility** – The independent capability on the part of

the insured to move from place to place, without the help of others;

Use of crutches, a stick, a walker or any other accessory, including mechanical, motor or electronic accessory, which allows the insured to move independently, will not be considered as impairing the insured's independent ability to move.

It would be prudent to emphasize that the insured's inability to move without a wheelchair would be considered his inability to move independently; However, should an insured with no ability to move without a wheelchair, but with an independent ability to move with the wheelchair from one place to another in the insurance period that ended before the 7th of Tammuz, 5777 (July 1, 2017), and during the current insurance period, his ability to move independently changed so that he is unable to move independently with the wheelchair, he will be deemed as an insured who is unable to move independently, from the date when his independent capability, as stated, has changed.

4. Calculation of the insured's age for insurance premiums – The age of the insured for the purpose of determining insurance premiums and for determining the age of first signing up will be calculated for whole years according to the full number of years elapsed from the month of birth of the insured.

5. Eligibility for Insurance Benefits

(a) An insured is eligible to receive insurance benefits as long as the conditions specified in section 3 are fulfilled, subject to the terms of the policy.

(b) Notwithstanding the provisions of subsection (a), an insured will be entitled to receive insurance benefits for 60 months from the end of the waiting period as specified in section 6, by virtue of the policy during the period of which the insurance event occurred and subject to the provisions of section 14 of the policy, less periods in which the insured received insurance benefits under the power of a frail care insurance policy for health care fund members

6. Waiting period

An insurer will pay the insured insurance benefits to which he is entitled under the terms of the policy as of the date the waiting period ends; no more than one waiting period shall be tallied unless more than 12 months have elapsed since the date that the insurance event ceased to be valid with respect to the insured.

For the purposes of this section: "**Waiting Period**" – a period beginning on the date on which the insurance event occurred and ending 60 days thereafter, provided that during the entire period the insurance event is valid vis-à-vis the insured.

7. Insurance Benefits Amount

(a) The amount of the monthly insurance benefit to which the insured is entitled shall be calculated according to his age at the date of first joining the health insurance members, according to the place of residence of the insured during the period in which the monthly insurance is paid, as detailed in the table below:

Residence of the Insured	**Age of First Sign up for Group Frail Care Insurance for Health Care Fund Members**		
	Up to 49	**50 to 59**	**60 and Over**
Monthly Insurance Benefit for an insured Staying at Home (Compensation)	Nis 5,500	NIS 4,500	NIS 3,500
Monthly Insurance Benefit for an insured Staying in an Institution (Indemnity)	NIS 10,000	NIS 6,500	NIS 4,500

(b) Notwithstanding that stipulated in subsection (a) regarding types of existing insureds (Health care fund members who were insured for frail care on June 30, 2016), listed below, instead of the age of first signing up for frail care insurance for health care fund members, stipulated in regulation (a),

the **age** written alongside them will be read:

			The age of first joining group frail care insurance for members of a health care fund
1.	Insured with group frail care insurance for health care fund members of Clalit Health Services "Clalit Supplementary Frail Care Plus", who signed up for the insurance aged 60 to 64;		59
2.	An insured with group frail care insurance for Maccabi Health Care Fund members -		
	a.	If he signed up for "Gold Frail Care" insurance from the age of 50	49
	b.	If he signed up for "Silver Frail Care" insurance from the age of 60	59
3.	a) An insured with frail care insurance for members of Meuchedet Health Care Fund: If he signed up for the "Meuchedet Gold" insurance aged 50 to 65 b) Notwithstanding subsection (a), an insured who was of a calculated age of 66 and over, as defined in the same insurance prior to the 25th day of the month of Sivan in the year 5776 (July 1, 2016)		49

		50
4.	An insured with general frail care insurance for members of the Leumit Health Care Fund, who signed up for "Leumit Frail Care" insurance aged 60 to 64.	59

(c) Notwithstanding subsection (a), the amount of the monthly insurance payable to the insured residing at an institution at the time of eligibility for the monthly insurance shall not exceed 80% of the amount actually paid by the insured to the institution.

8. Linkage to the Index

(a) The monthly insurance benefits specified in section 7 will be supplemented by linkage discrepancies as referred to in the Interest Ruling Law, from the index known on June 15, 2016.

(b) The monthly insurance premiums will be added to linkage discrepancies as referred to in the Interest Ruling Law from the index that was known at the time of the commencement of the policy.

9. Exemption from the payment of insurance premiums – An insured who is entitled to receive insurance benefits under the terms of the policy, will be exempt from the payment of insurance premiums for the period for which he is entitled to receive insurance benefits.

10. Settlement and Cashing In Values and the Insureds Fund

(a) Surpluses will not accrue for an insured in a policy for the purpose of obtaining settlement or cashing in values.

(b) Notwithstanding paragraph (a), insurance premiums paid for all insureds insured under group frail care insurance for members of a particular health care fund will be used to cover the long term liabilities for the insureds as stated, with the deduction and additions, as instructed by the Commissioner.

11. Exceptions to coverage - This policy does not include coverage in the following cases:

1) An insurance event that occurred as a result of service on the part of an insured in a security or police outfit or because of active participation in military, police, war, hostilities actions;

2) An insurance event that occurred due to nuclear fission, nuclear fusion or radioactive contamination;

3) An insurance event that occurred due to drug use or addiction to narcotics, except if the drug was used as directed by a doctor, not for rehabilitation purposes;

4) An insurance event that occurred due to a pre-existing medical condition, subject to the provisions of the Insurance Business Supervision Regulations (Conditions in Insurance Contracts) (Directives Regarding Pre-existing Medical Condition), 5764 - 2004; in the matter of this paragraph, an eligible insured will be considered as being insured under a contract exchanged with the same insurer or other insurer as specified in Regulation 6 (a) (2) of the stated regulations.

5) An insurance event that occurred for the first time before the beginning of the insurance period or after the end of the insurance period subject to the provisions of section 14 below;

6) An insurance event that occurred for the first time during the first 36 months of an insured's life;

7) An insurance event that occurred as a result of a road accident, as defined in the Compensation Law for Victims of Road Accidents, 5735 - 1975, or a work accident, within the meaning of the National Insurance Law [Combined Version], 5755 - 1995, recognized by the National Insurance Institute.

12. Continuity Right

12.1 The insurer will allow a leaving insured to transfer to a

continuation policy according to the dates specified in section 12.2, under the following conditions:

12.1.1 The amount of insurance and the period of payment of the insurance benefits in the continuation policy will not be less than those prescribed for the insured in a frail care insurance policy, unless the insured so requests, less periods during which he was entitled to receive insurance benefits under that policy;

12.1.2 The insurance premiums in the continuation policy will not be higher than the insurance premiums customary at the date of transition for new members in a similar individual policy with the insurer;

12.1.3 In the transition to the continuation policy, an insurance continuum will be given without re-examining a pre-existing medical condition and without a qualifying period.

12.1.4 The beginning of the insurance period in the continuation policy will be retroactive from the date of the cancellation of his registration at the health care fund.

12.2 Within 45 days from the date of cancellation of the insurance for a leaving insured, the insurer will contact the insured in writing and propose to him to transition to a continuation policy within 60 days from the date of submission of the insurer's notice.

12.3 Notwithstanding that stipulated in section 12.2, with respect to an insured who was entitled to receive insurance benefits under the terms of the frail care insurance policy for members of a health care fund, upon the date of cancellation of the frail care insurance for health care fund members – The insurer's request to the insured as stated in that subsection will be within 30 days from the date the insured's entitlement to the insurance benefits has expired; in such a request, the insurer will propose to the insured to transition to a continuation policy within 60 days from the date the insurer's notice was dispatched; such a proposal will only be granted if the insured has not yet exercised his full rights to receive insurance benefits under the policy.

12.4 In this Section 12 -

"**Leaving Insured**" – An insured who has not yet exercised his full rights under the policy and whose frail care insurance for members of a health care fund has been cancelled due to the cancellation of his registration with Meuchedet pursuant

to the Health Care Insurance Law, and he is not enrolled in another health care fund.

"**Continuation Policy**" – A individual policy for frail care insurance for the insurance period for life.

12.5 In the event that the frail care insurance for health care fund members is terminated due to the non-renewal of the policy for all insureds by any particular insurer, the insurer will enroll all insureds who were insured under the stated policy for a mutual group frail care insurance policy for life (hereinafter - a group continuation policy), the following terms will apply:

12.5.1 The insurance premiums, the amount of insurance and the period of payment of the insurance benefits (hereinafter in this section – the terms and conditions of the insurance cover) in the group continuation policy, will be according to the terms and conditions of the insurance cover that were laid out in the frail care insurance policy for health care fund members, on the eve of the non-renewal of the said policy, subject to the long-term balance between the insurance premiums and other income expected to be received for all insureds in the policy and all expected costs due to the benefits to be paid for them, based on the insurer's best estimate, is not a deficit given the balance of the insureds' fund.

12.5.2 The terms and conditions of insurance cover may change during the insurance period in the continuation policy according to the insurer's best estimate, approved in accordance with section 40 of the Law, which results in a long-term balance that is not in deficit; if such approval is granted, the insurer shall be required to reapply for the authorization of the Commissioner under section 40 of the Law only in the event that the insurer wishes to change an element based on which the estimate is calculated on the basis of which the approval was granted;

12.5.3 Settlement values will not accrue in the continuation policy.

12.5.4 In the transition to the continuation policy, an insurance continuum will be given without reexamining a pre-existing medical condition and without a qualifying period.

12.5.5 The insurance premiums will be transferred to the

insureds' fund; the insurance benefits and any other expenses due to the insurance and the operation thereof will be paid out of the fund only; the insurer will not be required to bear. from its own sources. the costs of the Group Continuation Policy;

12.5.6 An insurer may reimburse, to the health care fund whose members are insured under the group continuation policy, the sums taken out by the fund for the purpose of managing the policy, including for the collection of the insurance premiums, provided that the reimbursement does not exceed 3% of the insurance premiums collected.

12.5.7 For the operation of the Group Continuation Policy and the management of the Insureds' Fund, the Insurer is entitled to deduct annual management fees which include reimbursement of expenses to the Insurer as well as a profit component for which Section 40 of the Law applies.

12.6 If the balance referred to in section 12.5 at the time of the insureds' enrollment to the group continuation policy, based on the insurer's best estimate, is in deficit, the insurer shall submit, for the Commissioner's authorization, possible alternatives for change to the insurance cover terms and conditions that result in a non-deficit balance, based on the insurer's best estimate.

12.7 An insurer shall notify the insured of his enrollment in the group continuation policy as well as the possibility of opting out within 90 days from the date of receipt of such notice, detailing how the insured may inform of such cancellation.

12.8 Should the insured notify the insurer, his desire to opt out of the Group Continuation Policy under section 12.7, the policy shall be canceled from the date of the enrollment and the insurance premiums collected from him from the date of such cancellation will be refunded, provided that during this period a claim for the exercise of insurance benefits under the terms and conditions of the policy was not filed during the insurance period, due to an insurance event that occurred during that same period.

12.9 Notwithstanding the provisions of section 12.5, the Commissioner is at liberty to determine that in the event that the frail care insurance for health care fund members was terminated due to non-renewal of the policy for all insureds by any particular insurer, the insurer will not be obliged to

enroll the insured for any policy, and the balance of the insureds' fund will be used for the benefit of the insured in following cases:

12.9.1 All frail care insurance policies for members of all health care funds have not been renewed by any particular insurer or are not expected to be renewed.

12.9.2 The alternatives submitted by the insurer under section 12.5 results in terms and conditions of insurance cover that are not reasonable under the circumstances of the matter.

13. Transition of insureds between insurance plans, due to transition between health care funds (Regulation 12 of the regulations)

(a) The insurer will enroll, in the health care fund's frail care insurance, an insured with regard to whom information that was transmitted from a health care fund indicates that it is "a transitioning insured" or at the request of a transferee within 90 days of the transfer date; such enrollment shall be in keeping with the insurance continuum and without re-examination of his medical condition, unless an insurance event case exists.

(b) For the purpose of this section: "**Previous Health Care Fund**" – a health insurance fund in which a transitioning insured was enrolled, on the eve of transitioning to another health insurance fund;

"**Receiving Health Care Fund**" – a health care fund in which an insured person is enrolled, after transitioning from a previous fund.

"**Basic Insurance Authorization**" – An authorization from the insurer in the previous health care fund that the insured is a transitioning insured.

"**Extended Insurance Authorization**" – an authorization that includes the following information in relation to the same insured:

(1) Basic Insurance Authorization;

(2) First name and surname;

(3) Age upon signing up for the insurance, pursuant to section 7;

(4) Exceptions to the insurance cover, insofar as such

exist;

(5) Declaration whether the insured is an eligible insured;

(6) Dates of commencement and termination of the insurance period during which the insured was insured in the previous health care fund

(7) The scope of the monthly insurance benefits received by the insured, if such were received.

"**An Eligible Insured**" – an insured for who all the following conditions are upheld:

(1) He was insured in the last entitling policy on the date at the end of the insurance period in which he was not insured in frail care insurance for members of the health care funds at the time of filing a sign up application under section 3 (b) of the regulations;

(2) He has reached the age of 55 or older at the commencement date, or at the end of the term of insurance in the last entitling policy in which he was insured, the chronologically later of the two;

(3) There is no insurance event with respect to him at the time of his application to sign up for group insurance for members of a health care fund;

(4) The insured did not exercise his full rights under a the last entitling policy in which he was insured.

(c) Should an insured have been enrolled as stipulated in subsection (a), the insurer is at liberty to demand of the insured to produce a basic insurance authorization; should the insured not produce such authorization within 180 days of the date the demand was dispatched to him, the insurance will be canceled from the date of enrolling in the frail care insurance at the receiving health care fund, provided that an alert is dispatched to the insured within 30 days of the demand and another notification is dispatched within 60 days of that date.

(d) An insurer at the receiving fund will notify the insured of his or her enrollment in the insurance as well as the possibility of canceling his enrollment within 90 days from the date of receipt of such notice, detailing the manner in which the insured may notify such cancellation.

(e) Should an insured notify his wish to cancel his enrollment in the insurance under subsection (d), his insurance will be canceled from the date of enrollment in the receiving health care fund's frail care insurance and will be reimbursed with insurance premiums from the date of signing up for the receiving fund's frail care insurance until such cancellation, provided that during this period, no claim to exercise rights to receive insurance benefits under the policy was filed due to an insurance case that occurred during that period.

(f) The commencement of the insurance period for insurance of the receiving health care fund will be from the date of termination of the insurance in the insurance of the previous fund and the insured will be required to pay insurance premiums starting on that date.

(g) The insurance benefits to which the insured is entitled will be calculated according to the insured's age at the date of first enrollment.

(h) An insured for whom an insurance event exists on the eve of leaving the previous health care fund, will be entitled to sign up for the receiving health care fund's frail care insurance, while maintaining an insurance continuum without re-examination of his medical condition, within 90 days from the date the insurance event ceased to exist, provided that the insured has not yet realized his full rights to receive insurance benefits under the policy; the period of insurance benefits to which the insured will be entitled under a frail care insurance policy for health care fund members of the receiving health care fund, will be less periods during which he received insurance benefits under a frail care insurance policy for health care fund members.

(i) An insurer in frail care insurance at the previous health care fund will contact the transitioning insured and notify him of his right to sign up for the receiving health care fund's frail care insurance, under the terms and conditions of this regulation, within 14 days from the date the insurer received

the insured's information from the previous health care fund or the date of receipt of the insured's notice of leaving the health care fund, the chronologically earlier of the two; the insurer's notice will also include the extended insurance authorization for the same insured.

(j) The insurer in frail care insurance at the receiving health care fund will contact the transitioning insured and provide him with an insurance details sheet within the meaning of Regulation 6 of the Financial Services Supervision Regulations (Insurance) (Group Health Insurance), 5769 - 2009, within 14 days from the date the insurer received an extended insurance authorization; should all the required information not be included in the extended authorization, the insurer will provide the insured with an insurance details page on the basis of the information in possession of the insurer regarding that insured and will inform the insured that he has the right to transfer the rest of the required information, as stated.

14. Insurer's liability (in relation to the transitioning insured) (Regulation 13 of the regulations)

(a) An insurer during a frail care insurance period for previous health care fund members, will pay the insurance premiums of a transitioning insured, subject to the following conditions:

1) The insured incurred an insurance event during the previous insurance period that qualifies for the payment of insurance benefits;
2) The insured filed another claim for insurance benefits within a period not exceeding 12 months since the insured ceased to be in the qualifying state as stated in paragraph (1).

(b) Should the previous insurer have paid the insurance benefits as stated in sub-regulation (a):

1) The previous insurer will be at liberty to offset from the insurance benefits he paid, the insurance premiums for the period during which the insurance premiums were not paid to such insurer;

2) The new insurer will refund, to the insured, the insurance premiums paid for the period up to the time

of the insurance event as stated in the same sub-regulation.

15. The Insurance Period

(a) The insurance period will commence from the effective date until December 31, 2024 at midnight. With the consent of the insurer and the policy holder, the insurance period can be extended for another 3 years.

(b) The Company will only be obligated to cover under the policy, for insurance cases that occurred up to the end of the insurance period, for which a claim has been filed before the statute of limitations set out in section 16 below.

(c) The insurance period is subject to the insured's right to cancel the policy pursuant to the provisions of the law and the company's right to cancel the insurance for a specific insured for breach of a material disclosure obligation according to the provisions of the Insurance Contract Law and its reservations in this case, in the event of non-payment of premium (section 19 below) or in case of termination of the insurance when the insurance benefits amount is exhausted pursuant to section 5 (b) above.

16. Statute of Limitations -

The statute of limitations for payment of insurance benefits shall be after the passage of three years from the occurrence of the insurance event pursuant to section 31 of the Insurance Contract Law, or a change in any section of this law or any legislative provision that supersedes this matter.

17. The filing of a claim for insurance benefits

(a) The insured or his representative will notify the Company of the occurrence of the insurance event as close as possible to the date on which it occurred.

(b) The obligation and the right to file and establish a claim apply only to the insured or his representative, and to them only. It is hereby clarified that the policy holder is not entitled to file nor will he submit a claim to the insurance company under this policy, at his own initiative or on behalf of the insured.

(c) The insured or his representative will provide the company with the documents indicating the insurance event and which are intended to clarify its liability under the policy. The

insurer or its representative will sign a waiver of confidentiality vis-à-vis the Company for the purpose of ascertaining the liability to a third party. The Company will be at liberty to conduct, at its expense and reasonably and for a reasonable period of time, any medical or other examination or investigation for the purpose of ascertaining its liability under the policy, and to have the insured examined by a physician acting on its behalf or other medical service provider acting on its behalf, at its sole discretion, provided that the examination is reasonable under the circumstances and at the insurer's expense (**it would be prudent to clarify that the insured may at any time seek to exercise his rights conferred on him by virtue of the policy, in a court of law**). These liabilities are borne by the insured both before the claim is approved and during the period in which he is entitled to insurance benefits.

(d) A functional assessment for the insured will be conducted by the company after coordination with the insured or with his representative.

(e) **Indemnity type insurance benefits (for an insured residing in an institution)**

(1) The indemnity will be paid against the presentation of original receipts proving the existence of the frail care benefit expenses, if paid, or alternatively – against the presentation of original transaction invoices by the aforementioned frail care assistance provider.

(2) Notwithstanding the foregoing, the insured is at liberty to file a copy of the receipt, invoice or transaction invoice and attach a certificate from the party to whom he submitted the original document, insofar as he submitted such, regarding the amount claimed from the other entity.

In such a case, the Company will indemnify the insured in accordance with the provisions of the policy, provided that the total amount of indemnity for the insured does not, in any case, exceed his actual expenses.

(3) The indemnity will only be paid to one of the following:

(a) In any case where the expenses were actually expended prior to the date of indemnity, the indemnity will be paid to the insured or to his legal representative.

(b) In the event that the indemnity expenses have not yet been expended at the time of the indemnity payment, the Company is at liberty to pay the indemnity directly to the frail care services provider eligible for receiving the expenses for the frail care services, provided that it is a frail care institution.

(c) The indemnity payment shall be paid by the 15th day of each month, for the preceding month, subject to the authorization of receipts or tax invoices or transaction invoices that are the subject of the indemnification by the Company, subject to the provisions of section 17 (g) (1) below.

(f) **Insurance Benefits that are Compensation (for an insured Residing at Home)**

The insurance benefits that are compensation under the policy will also be provided in addition to and independently of any other frail care benefits or for a frail care service provided or which will be provided to the insured by the State for the insurance event, including by virtue of the National Insurance Law [Integrated Version], 5755 - 1995.

(g) **Claims – General Instructions**

1 The insured who is entitled to receive insurance benefits will be entitled to receive the insurance benefits from the company within 30 days from the date the company was in possession of the information and documents required to clarify its liability.

2 In each case of the insured's entitlement to insurance benefits for part of a month, the amount of insurance benefits will be the pro rata share, as the ratio of that part to the month.

3 Eligibility for insurance benefits that are indemnified under the policy that was not utilized by a insured for a

full month may not accrue to the full amount of monthly insurance benefits in order to increase the amount of monthly insurance benefits for the insured in another month. The provisions of this section shall also apply to parts of a month, mutatis mutandis.

4 The insured's eligibility for insurance benefits will cease on the date the insurance event ceased to exist or at the end of the eligibility period for insurance benefits or upon the death of the insured, whichever is earlier.

5 The insurer shall examine the insured's eligibility in accordance with his notice, provided that the examination is reasonable under the circumstances of the matter and is at the insurer's expense and subject to the Commissioner's circular on the clarification and settlement of claims and handling of public inquiries and on reconsideration of the eligibility and subject to changes to his circular or any other regulatory provision in this matter.
(It would be prudent to clarify that the insured may at any time seek to exercise his rights conferred on him by virtue of the policy in a court of law).

6 A notice of a renewed examination of eligibility and manner of execution will be provided as part of an letter of eligibility approval.

7 If a renewed examination of eligibility was carried out as per the letter of authorization of eligibility and it was decided to terminate or reduce the eligibility, the claimant will be sent a reasoned letter, which includes the reasons for canceling or reducing the eligibility in accordance with the relevant policy and / or the relevant provisions of the law. A change notice will be sent at least 30 days prior to the date of termination or reduction of payments.

8 In the event that for the purpose of cessation or reduction of entitlement, the insurer uses expert considered opinion, the considered opinion will be attached to the change notice.

9 The insurer has the right to demand the repayment of amounts that have been paid in excess prior to the reduction or termination of payments.

10 In the event of the death of the insured and, to the extent that a beneficiary is not indicated, the company shall pay to the estate of the insured, the balance of the nursing allowance which was to be paid to the insured during the period in which he was entitled to receive it and which was not paid for before the death.

(h) **Appeals Committee for the Rejection of a Claim**

(1) If the insurer rejects a claim filed by the insured, in whole or in part, for functional and / or medical and / or other reasons, he shall be given a written reasoning by the insurer regarding the rejection (hereinafter - a rejection notice).

The rejection notice shall specify the grounds for rejection which shall also include reference to the terms of the policy or the charter, stipulation or reservation set at the date of enrollment or the date of renewal of the insurance cover, or the provisions of the law, due to which the claim is rejected (insofar as the rejection is reliant upon them).

(2) In addition, the rejection notice shall also include a section directing the insured's attention to his right to appeal to an appeals committee, within 60 days of the date the notice was issued to him.

(3) The insured will be entitled to submit documents and medical and functional opinions to the Appeals Committee as he deems fitting or as requested by the Committee. In addition, following the submission of the appeal, the Committee will allow the insured and / or his representative to appear before it.

(4) The Appeals Committee will convene to discuss appeals filed within a reasonable time from the day the appeal was filed, but not later than 45 days, unless the insured has requested to postpone the hearing.

(5) The insurer shall submit, to the committee, all material relating to the claim which is in his possession, whether submitted to him by the insured or has come into its possession not through the insured.

(6) The Appeals Committee will be empowered to discuss, accept or reject the claim in accordance with the terms of the policy.

(7) The decisions of the Appeals Committee will be taken by a majority vote. In the case of a tie, an entity appointed on behalf of Meuchedet shall have the right of decision, and its decision shall be final and irrefutable. The committee's decision will bind the insurer and will be considered, to all intents and purposes, as being the insurer's decision.

(8) It would be prudent to clarify that the decision of the Appeals Committee is not to prejudice the insured's rights to apply to a court of law for clarification of his eligibility under the policy.

(9) **Appeals Committee for Rejection of Acceptance for Insurance –**

Should an application for a candidate for signing up for insurance is rejected, he will be entitled to apply to an Appeals Committee within 60 days and submit an appeal regarding his rejection.

Appeals Committee decisions on signing up for insurance will be taken by majority vote. In the case of a tie, an entity appointed on behalf of Meuchedet shall have the right of decision, and its decision shall be final and irrefutable. The committee's decision will bind the insurer and will be considered, to all intents and purposes, as being the insurer's decision.

The committee's decision will bind the insurer and will be considered, to all intents and purposes, as being the insurer's decision.

For the purpose of this section, "**Appeals Committee**" - means a committee consisting of at least a representative of the policy holder and a representative of the insurer, whose mode of action is regulated by an agreement between the insured and the insurer.

18. Cancellation of insurance on the part of the insured – The insured may cancel the insurance under this policy at any time by means of a written instruction. The cancellation will take effect within 3 days from the written cancellation notice being submitted to the Company.

19. The Premium and How it is Paid

(a) The premium for each insured is as detailed in the premium table set out in the disclosure statement attached to this policy, and it varies during the insurance period according to the age group to which the insured belongs.

(b) The insured will pay the premium once a month.

(c) Payment of premiums to the company will be made in bulk by the policy holder for all insureds.

(d) Should the premium, or part thereof, not be paid to the insured on time, and neither paid within 15 days of the insured being required to pay in writing, the Company, through the policy holder, is at liberty to notify the insured in writing that the policy will be canceled 21 days later if the amount of arrears plus legal linkage discrepancies and interest is not paid prior to that.

(e) In the event of a premium payment arrears, the insured shall legally pay legal linkage to the index and interest without derogating from the Company's right to cancel the policy pursuant to the provisions of the law.

(f) In addition, and without derogating from the foregoing, the Company is at liberty, with the consent of the policy holder, to change the premium for this policy, in addition to the increase in the index, in accordance with the provisions of section 2 above.
To the extent that such premium increase is not approved for any reason, the Company is at liberty to notify of the cancellation of the agreement and the adjustment of the policy, by means of a 60 day written notice to the policy holder and the insureds.

20. Taxes and Levies – The insured is obligated to pay all government and other taxes applicable to this policy or to the premiums and insurance benefits and any other payments that the company is obligated to pay under the policy, whether or not these taxes are in effect on the day of the policy coming into effect or whether imposed at a later date. It would be prudent to clarify that the premium at the determining date includes the full taxes and levies applicable at that date.

21. Various Instructions – Group Health Care Insurance

(a) **Obligations of the Policy Holder** – The policy holder declares and undertakes that in the matter of it being a policy holder, it acts faithfully and diligently for the benefit of insureds only and that it does not have nor will it have any benefit from being the policy holder.

(b) **Signing Up an insured (For the First Time)**

a) An insured is liable under the terms of the policy, for one of the following: (1) to pay, at the date of commencement of the insurance, insurance premiums, or part thereof, including if the collection thereof applies after that date; (2) to pay tax or other payment due to the group insurance policy; The insurer will not enroll the insured in the same insurance, except with the express prior consent of the insured which has been documented, and if the insured is the child or spouse of a member of the insureds group – the insurer is at liberty to enroll him, after the consent of that member to the enrollment of his child or spouse.

b) Subsection (a) will not apply to the policy, if renewed for an additional period with the insurer or another insurer, if the following conditions were met: (1) the policy was valid for the group of insureds for at least 3 years before the date of renewal; (2) the policy is renewed, under the same conditions or under different conditions, while maintaining the insurance continuum of insurance cover that was in effect until the renewal date and which is included in the policy after that date;

In this matter, "**maintaining an insurance continuum**" – means maintaining the continuum without re-

examining a pre-existing medical condition and without a qualifying period.

c) If the number of insureds in the group decreases to below 50, the policy will not be renewed at the expiry date or at the end of the insurance period, whichever is earlier.

(c) **Providing Documents to the Insured**

a) At the beginning of the insurance period, the insurer will provide, for each insured, whether he signed up for the first time or at the date of renewal of the insurance for another period, a copy of the policy, a proper disclosure form according to the Commissioner's instructions, an insurance details page, and other documents that the Commissioner will order:

Notwithstanding the above, should the policy be renewed for an additional period by the same insurer or the policy was extended for a period not exceeding 3 months, during which period, negotiations between the policy holder and the insurer regarding the renewal of the policy for a further period are conducted, without changing the insurance premiums and other insurance cover terms, the insurer will give every insured a notice upon the renewal of insurance only and will state -

(1) That the insurance period was extended and no changes were made to the terms and conditions of the insurance cover.

(2) The possibility for the insured to obtain a copy of the policy documents.

(3) The option of the insured to review the policy documents, giving details, where possible.

b) If an insured is obliged to pay insurance premiums or part thereof, the insurer will send the insured, at his request, a copy of the contract between the insurer and the policy holder, within 30 days from the date the insured's request was received.

c) Should it be determined that the policy holder will pay the insurance premium in full, the insurer will send to the insured, at his request, a copy of the contract between the insurer and the policy holder, within 30 days from the date the insured's request was received, but the insurer is at liberty to not send the insured,

instructions in the contract, in respect of the amount of the insurance premium, the adjustment of insurance premiums and profit participation.

(d) **Providing Notices to the Insured**

a) If there is a change in the insurance premiums or the terms of the insurance cover, at the date of the policy renewal or during the insurance period (in this section – "**the date of the commencement of the change**"), the insurer shall provide each insured, before the date of the change, up to 60 days before the date of the change, a written notice detailing the same change.
The express consent of an insured, as stated in this policy, a paragraph regarding the express consent of the insured and the absence of the meaning of the absence of the insurance continuum, is required to be included in the said notice.

If the said insured's unequivocal consent is not received by the date of the change, the insurer shall give the policy, holder within 21 days, and no later than 45 days before the date of the change, a second notice regarding the need for the insured's unequivocal consent. A second message will be delivered by other means than by regular mail, including registered mail or a telephone call.

b) Should the policy have been renewed by another insurer, who did not insure the group on the renewal date – the other insurer will give each insured written notice of such renewal, no later than 30 days from the date of renewal of the insurance.

c) Should the policy terminate and has not been renewed, whether with the same insurer or with another insurer, for all or part of the insureds, the insurer will give any insured whose policy has been terminated or not renewed, no later than 30 days from the end of the insurance period, written notice of termination of the insurance and stating the insured's right of continuity to an individual frail care policy and the insured's right to a discount in the insurance premium, insofar as each of these rights is concerned, and will specify in any

such notice any additional right of the insured arising from the termination of the policy.

d) The affinity clause between the insured and the policy holder (the absence of membership in Meuchedet), the insured will notify each insured, within 30 days of being informed of the termination of such affiliation or at least within 90 days of the said affiliation cessation, written notice of termination of the insurance, which includes details of the insured's rights according to the policy.

e) Should an insured, at the time of signing up for the policy, be obliged to pay insurance premiums, which according to the terms and conditions of the policy will begin to be collected after the said date, the company will give written notice of the date on which the insurance premium will begin to be paid to those who pay the premium who is not the policy holder, a written notice regarding the date on which collections of insurance premiums will commence; such notice will be given to those who pay the insurance premium during the three months preceding the said collection date.

(e) **Cancellation of the Insurance with Respect to a Particular Insured**

a) Should the insurance have been renewed or its terms have been changed during the insurance period and no unequivocal consent on the part of the insured is not required as stated in this policy above, and the insured informed the company or the policy holder, within 60 days after the renewal of the insurance or the date of change, as the case may be, about the cancellation of the insurance for that insured, the insurance will be canceled for him as of the date of the renewal of the insurance or the date of the change, as applicable, provided that no claim for the exercise of rights under the policy has been filed due to an insurance event that occurred during the 60 day period as stated.

b) Should the insurance have been renewed or its terms have been changed during the insurance period and

the unequivocal consent of the insured is required as stated in this policy above, and no such agreement was received by the date of renewal of the insurance, the insurance will be canceled as of the date of renewal of the insurance or the date of change, as applicable; Should the insurance have been cancelled as stated and the insured contacted the insurer to be re-admitted to the policy, within 45 days of the date of the second notification, and gave his unequivocal consent to renew the insurance or the change, as the case may be, the insured will be enrolled in the policy while maintaining the insurance continuum as stated in section 21 b above;

For the purposes of this section, "**no consent has been obtained**" – with the exception of the insured's unequivocal refusal to renew the insurance or the change in its terms and including the insured to whom the second notice was given by telephone call and during which the insured did not express his consent.

c) Notwithstanding subparagraph (b), the affinity clause between the insured and the policy holder (membership in Meuchedet), for which it signed up for the policy, the insurance for that insured shall be canceled at most within 90 days of the cancellation date.

(f) **The Insurance Period –**

The policy will not expire with respect to an insured before the end of the insurance period as stated in section 15 above, and all insurance cover under such will apply until the end of the insurance period, if the insurer received insurance premiums for the insured for these coverages.

(g) **Duplicate Insurance (under Indemnity)**

a) The Company will be liable, separately, to the insured for the full amount of the insurance benefits up to the ceiling set in the policy, even if the insured was entitled to cover for the expenses paid for an insurance case also under another frail care insurance policy (or health care policy covering this event) whether at the same insurer or at another insurer.

b) The insurers will bear the burden of billing amongst themselves, according to the ratio between the insurance benefits ceilings relating to the insurance event as such are fixed in the insurance policies.

23. Jurisdiction

The competent courts in the City of Tel Aviv will have a unique jurisdiction to hear any matter relating to violation of or compliance with the terms of the policy.
The addresses of the parties for notification in connection with the provisions of this policy are:

Messages

Policy Holder: Meuchedet Health Care Fund, 124 Ibn Gvirol St., Tel Aviv.

Company: Menorah Mivtachim Insurance Ltd., 23 Jabotinsky St., Ramat Gan.

Insured: The insured's last address as it appears at the policy holder.

Guidelines for Filing a Claim

Dear Insured,

There is a set of documents available for filing a claim for frail care benefits, according to cover in the frail care policy and the terms and conditions of the insurance policy. For convenience, the kit is formulated in the masculine but is intended for both women and men.

In order to allow us to handle your claim in an orderly and prompt manner, we will ask you to fill out the claim form and attach the relevant documents as set out in the attached appendices.

For your information – You can claim insurance benefits for a period prior to the date of filing, subject to proof of eligibility in accordance with the policy and the statute of limitations. Please attach any supporting medical document.

Please note that our company operates a service that allows you to file a claim through the website at www.menoramivt.co.il

In addition, the service allows you to receive text messages via SMS / email at each of the stages of the claim, to view the status of the handling thereof, to upload omitted documents and more.

In order for us to be able to update you at all stages of the claim process, we will ask you to fill in your e-mail address and mobile phone number or the contact person acting on your behalf who is handling the claim.

Please submit the required claim form and documents in one of the following ways:

- By email to: Meuhedet-siud@madanes.com
- By fax: 03-6380011

- By snail mail to: PO Box 927, Tel Aviv 6100802.
- Via the website: www.menoramivt.co.il

Please note, receipt of the claim form with the insurer does not constitute the consent and / or commitment and / or approval of the insurer in connection with the claim filed.
We will be happy to answer any questions you may have on the phone: 1-700-72-2233

Sincerely,
Health Claims Department
Menorah Insurers Insurance Ltd.