

**Rules of Voluntary Medical Insurance of citizens
(typical (uniform))**

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No. 152

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1. THE SUBJECTS OF INSURANCE

1.1. In accordance with the legislation of the Russian Federation and by virtue of these Rules, Rosgosstrakh System Insurance Company (PAO IC Rosgosstrakh) (hereinafter referred to as the Insurer) shall enter into contractual relations of voluntary medical insurance of citizens (hereinafter referred to as the Insurance Policy), within the framework of which it shall organize the provision and payment of medical and other services to the Insured in accordance with the List of Medical and Other Services attached to these Rules (Supplement No. 1). These Rules are intended to determine the content of Insurance Policies and regulate the relations arising between the Subjects of Insurance.

1.2. The Subjects of Insurance are the Insurer, the Policyholder and the Insured.

1.3. The Insurer is a legal entity established in accordance with the legislation of the Russian Federation for the implementation of insurance and reinsurance and having a license for the right to carry out insurance activities on Voluntary Medical Insurance.

1.4. The Policyholder enters into an Insurance Policy with the Insurer for its own benefit or for the benefit of third parties (hereinafter referred to as the Insured). Policyholders may be:

- Russian or foreign legal entities of any legal form registered and operating in accordance with the legislation of the Russian Federation;
- individuals – citizens of the Russian Federation, foreign citizens and stateless persons with civil capacity.

1.5. Under the terms of these Rules, Insurance Policies shall be concluded in favor of the Insureds – citizens of the Russian Federation, foreign citizens entering or staying in the territory of the Russian Federation and stateless persons.

1.6. The beneficiary under the Insurance Policy shall not be appointed.

2. THE OBJECT OF INSURANCE

2.1. The Object of Voluntary Medical Insurance is the material interest of the Insured not going into contrary to the legislation of the Russian Federation related to the payment for organization and provision of medical and medicine aid (medical services) and other services due to health disorder or status of the Insured, requiring the organization and provision of such services, as well as for preventive measures, reducing the degree of threat to the life or health of the Insured and (or) eliminating them.

3. INSURED ACCIDENTS AND INSURANCE RISKS

3.1. The Insurance Risk is an expected event, in case of occurrence of which the insurance is executed. The event, considered as the Insurance Risk, should have signs of probability and randomness of its occurrence.

3.2. The Insured Accident is a documented appeal of the Insured in accordance with the terms of the Insurance Policy and during its validity to a medical institution or a pharmacy, service company and/or other institution, from among those provided by the Insurance Policy or agreed with the Insurer, for medical and/or other services¹ regarding a health disorder or deterioration of the Insured as a result of acute illness, exacerbation of chronic disease, injury, poisoning and other conditions requiring medical care, as well as for preventive measures, reducing the degree of threat to the life or health of the Insured and (or) eliminating them that are provided to the Insured in accordance with the Insurance Policy or additional agreement with the Insurer by providing consultative, treatment, diagnostic, preventive, rehabilitation, spa, medical, emergency medical and other assistance.

3.2.1. The Insured's request for medical and other services shall not be recognized as the Insured Accident, unless otherwise provided by the Insurance Policy:

3.2.1.1 in connection with acute conditions and injuries arising from or sustained in the state of or as the result of alcoholic, narcotic or toxic intoxication;

3.2.1.2 in connection with traumatic damage or emergence of other pathological condition which has come as a result of illegal actions executed by the Insured that shall be confirmed by decisions of the relevant authorities;

3.2.1.3. if the Insured intentionally harmed his health, in connection with suicidal attempts and other intentional actions of the Insured aimed at the occurrence of the Insured Accident, except for cases when the Insured was brought to such state by illegal actions of third parties, which must be confirmed by the decisions of the relevant authorities;

¹ Other services include but not limited by: medical support services, medical transportation services and repatriation services provided to the Insured in accordance with the Insurance Policy subject to the state of health of the Insured.

3.2.1.4. caused by effects of a nuclear explosion, radiation, radioactive contamination, chemical or biological attacks and their consequences;

3.2.1.5. caused by military actions, as well as maneuvers or other military measures, civil war, terrorist acts, civil unrest of all kinds or strikes, natural disasters, natural or man-made emergencies, environmental disasters.

4. PROCEDURE FOR DETERMINING THE INSURANCE COVERAGE

4.1. The Insurance Coverage is amount determined in the manner prescribed in the Insurance Policy at its conclusion, and upon which the Insurance Premium (Insurance Installment) and the maximum possible amount of Insurance Benefit upon occurrence of the Insured Accident shall be set.

4.2. The Insurance Coverage shall be established by agreement between the Policyholder and the Insurer on the basis of the list of medical and other services provided by the Insurance Policy and shall be specified in the Insurance Policy.

4.3. The amount of Insurance Benefits under the Insurance Policy concluded according to the terms of these Rules may not exceed the amount of the Insurance Coverage established by such policy, unless otherwise provided by the Insurance Policy.

5. INSURANCE PERIOD

5.1. The Insurance Policy is concluded for a period of one year, unless otherwise provided by the terms of the Insurance Policy. The start and end dates of the Policy shall be specified in the Insurance Policy.

5.2. The Insurance Policy, unless otherwise provided in it, shall enter into force upon payment of the Insurance Premium (first Insurance Installment).

Unless otherwise provided in the Insurance Policy, the date of payment of the insurance premium shall be deemed:

a) for Insurance Policies concluded with legal entities – the date of receipt of the Insurance Premium (Insurance Installment) on the current account of the Insurer or payment of the Insurance Premium (Insurance Installment) in cash to the Insurer/representative of the Insurer;

b) for Insurance Policies concluded with individuals – in accordance with article 37 of Law “On consumer rights protection”.

5.3. The Insurance provided due to the Insurance Policy concluded on the terms of these Rules shall be valid from 00 hours 00 minutes of the day following the date of entry into force of the Policy, unless the Policy provides a different period of the insurance commencement.

6. THE PROCEDURE FOR DETERMINING THE INSURANCE RATE, INSURANCE PREMIUM, INSURANCE INSTALLMENT

6.1. The Insurance Premium is an insurance fee, which the Policyholder is obliged to pay to the Insurer in such manner and within such terms as specified in the Insurance Policy. The Insurance Installment is a part of the Insurance Premium when it is paid in parts (installments).

6.2. **The Insurance Rate** is a rate of the Insurance Premium per unit of the Insurance Coverage, taking into account the object of insurance and the nature of the Insurance Risk, as well as other conditions of insurance, including whether a deductible is present and its size in accordance with the terms of the insurance. The Insurance Rate for each Insurance Policy shall be determined by an agreement of the parties.

6.3. When determining the amount of the Insurance Premium payable by the Policyholder on the Insurance Policy deposits, the Insurer shall apply the developed by itself insurance rates that determine the Premium, levied from unit of the Insurance Coverage taking into account the Object of Insurance and character of the Insurance Risk.

6.4. Insurance Rates for the List of Medical and Other Services within the framework of Voluntary Medical Insurance are provided in Supplement No. 3 hereto. At the conclusion of the Insurance Policy, the Insurer has the right to use referential factors in addition to base insurance rates based on a set of and level of medical and other services, medical institutions, service companies and other institutions, coverage areas, region of stay, nature of work, age and health status (presence of chronic diseases, pre-existing diseases, etc.) of the Insured, as well as the information specified by the Insured (the Policyholder) in a questionnaire, the results of the preliminary medical examination, periodicity of payment of the insurance premium and other conditions stipulated by the Insurance Policy.

6.5. At the conclusion of the Insurance Policy in order to determine the size of the Insurance Premium (Insurance Installment) payable, the Insurer may offer the Insured (the Policyholder) to fill in a questionnaire. The Insurer has the right to direct the Insured for undergoing a preliminary medical examination to the extent necessary to determine the terms of the Insurance Policy. Unless otherwise agreed by the Parties, the payment for the preliminary medical examination shall be made at the Policyholder's expense. The preliminary medical examination shall be carried out in a medical institution having the appropriate license, at the choice of the Insurer.

6.6. If the Insured refuses to fill in the questionnaire and/or undergo a preliminary medical examination, the Insurer shall have the right to refuse to conclude an Insurance Policy with such Insured.

6.7. The Insurance Premium under the Insurance Policy may be paid by the Policyholder in total (one-time payment for the entire term of the Insurance Policy) or in parts (installments). The procedure for payment the Insurance Installments when paying the insurance premium in parts shall be determined in the Insurance Policy. The Policyholder may pay the Insurance Premium (Insurance Installments) in cash to the Insurer (its representative) or transferred to the account of the Insurer (its representative) on a cashless basis.

The day of receipt of the Insurance Premium (Insurance Installment) to the current account of the Insurer shall be deemed as the date of payment of the Insurance Premium (Insurance Installment) on a cashless basis, unless otherwise is provided by the Insurance Policy.

The date of payment of the Insurance Premium (Insurance Installment) to the authorized representative of the Insurer shall be deemed as the date of payment of the Insurance Premium (Insurance Installment) in cash, unless otherwise is provided by the Insurance Policy.

6.8. The Policyholder and the Insurer shall hereunder agree and recognize that if the Policyholder fails to pay the Insurance Policy (Insurance Installment) or such payment is lesser than needed under the Insurance Policy within the period established by the Insurance Policy, such shall undoubtedly mean the Policyholder's / Insured's will (volition) to withdraw from the Insurance Policy (terminate the Insurance Policy) from 00: 00 of the date following the date specified in the Insurance Policy as date of payment of the Insurance Premium (appropriate Insurance Installment).

That said, in case of such refusal of the Insured / the Policyholder to follow the Insurance Policy on the basis of nonpayment of the Insurance Premium (Insurance Installment) within the period specified by the valid Insurance Policy or payment in amount lesser than needed due to the Insurance Policy, the Insurer may send the Policyholder a written notice on its agreement on such early termination of the Insurance Policy at the initiative of the Policyholder (the Insured) starting from 00 hours 00 minutes of the date following the date of payment of the Insurance Premium (corresponding Insurance Installment), or to suspend the Insurance (Insurance Policy) for a period of up to 14 calendar days by sending a written notice to the Insured on the suspension of the Insurance in connection with non-payment of the Insurance Premium (Insurance Installment) or payment in a lesser amount. If the Insurer notifies the Policyholder of the suspension of the Insurance, the Insurance Policy shall be deemed terminated starting from 00 hours 00 minutes of the date following the date specified in the notification as the deadline for payment of the Insurance Premium (corresponding Insurance Installment), thus the Insurer shall reserve the right to recover the amount of the Insurance Premium arrears for the period of such default of the Insurance Premium (Insurance Installment) till the termination of the Insurance Policy.

7. THE INSURANCE POLICY - THE PROCEDURE FOR ITS CONCLUSION, FULFILLMENT, TERMINATION, ENTERING AMENDMENTS AND ADDITIONS

7.1. At the conclusion of the Insurance Policy due to the terms of these Rules, these conditions shall become an integral part of the Insurance Policy and be binding for the Subjects of Insurance. In accordance with the legislation of the Russian Federation, the Insurance Policy

may include amendments and additions to these Rules and / or exceptions to them. If the provisions of these Rules differ from the provisions of the Insurance Policy, the relevant provisions of the Insurance Policy shall apply, unless it contradicts the legislation of the Russian Federation.

7.2. In order to conclude the Insurance Policy, the Policyholder may apply to the Insurer in order to declare the intention to conclude the Insurance Policy either with a written application in the form established by the Insurer, reporting the data necessary for concluding the Insurance Policy, or in another accessible way (oral application, fax, etc.).

7.2.1. The following documents may be requested by the Insurer in order to confirm the accuracy of the information provided by the Policyholder, as well as to identify an Insured - legal entity and possible Insured - Individuals:

- a) for individuals:
 - documents recognized as identity documents in accordance with the legislation of the Russian Federation;
 - a migration card;
 - a document confirming the right of a foreign citizen or a stateless person to stay in the Russian Federation;
 - a certificate of registration of an individual by a territorial body of the Federal Tax Service of Russia.
- b) for legal entities – residents of the Russian Federation:
 - a registration certificate;
 - a certificate of tax registration
 - an extract from the Unified State Register of Legal Entities;
 - a certificate of registration by a tax authority;
- c) for non-resident legal entities:
 - a certificate of registration issued in the country of registration;
 - and a certificate of assignment of a foreign organization code issued in the country of registration.
- d) for individual entrepreneurs:
 - documents listed in subclause a);
 - a certificate of registration of an individual as individual entrepreneur.

7.2.2. All documents submitted to the Insurer must be current and valid at the time of conclusion of the Insurance Policy or acceptance of the Insured for insurance.

7.2.3. If the submitted documents do not contain the information provided in clause 7.7. hereof, the Insurer shall have the right to request additional documents necessary for the conclusion of the Insurance Policy, as well as to conduct an examination of the submitted documents in agreement with the Policyholder.

7.2.4. If the Policyholder refuses to provide the requested documents and data, the Insurer shall have the right to refuse the Policyholder to enter into an Insurance Policy or to accept a person, in respect of whom the documents requested by the Insurer have not been submitted for insurance.

7.3. If it is established that the Policyholder has provided obviously false data on the circumstances having essential value for definition of a probability for the Insured Accident's approach and amounts of possible losses resulting from such approach (the Insurance Risk) after the conclusion of the Insurance Policy, the Insurer shall be entitled to demand the termination of the Policy and application of the consequences provided in paragraph 2, article 179 of the Civil Code.

7.4. The fact of conclusion of the Insurance Policy shall be certified by signing of one document – the Insurance Policy and/or by issuance of a duly executed Certificate of Insurance signed by the Insurer to the Policyholder, accompanied by the scope, conditions and order of rendering medical and other services from the List of Medical and Other Services agreed by the Parties.

7.5. The conditions specified by these Rules and not included in the text of the Insurance Policy (Certificate of Insurance) shall be mandatory for the Policyholder, if the Insurance Policy (Certificate of Insurance) expressly specifies the application of these Rules and the Rules themselves are set out in the same document with the Insurance Policy (Certificate of Insurance) or on its reverse side or attached thereto. In the latter case, the fact of delivery of these Rules to the Policyholder at the conclusion of the Insurance Policy shall be certified by a record in the Insurance Policy.

7.6. The Insurance Policy shall be formed at the choice of the Policyholder, agreed with the Insurer.

7.6.1. The Insurance Policy may contain sets of medical and other services from among the services provided by the List of Medical and Other Services in Supplement No. 1 hereto. The Set of Medical and Other Services under each Insurance Policy may be defined in the insurance program, which shall be drawn up on the basis of these Rules and Supplements hereto and may have an original name. The Insurance Policy may provide the provision of services under several specified insurance programs.

7.6.2. At the conclusion of the Insurance Policy, the Insurer and the Policyholder may agree on the scope of the Insurance Coverage by determining a set of diseases (conditions) from the List of Diseases and Conditions (Supplement No. 2), the treatment of which will become an Insured Accident under the relevant Insurance Policy, as well as by determining an exhaustive list of medicines, medical devices, medical and other services, including the entering of applications for services for diseases/conditions listed in paragraph 3.2.1. into the scope of the Insurance Coverage.

7.7. The Insurance Policy must contain: for Policyholders – legal entities (Supplement No. 4 hereto) – name, location address and banking details of the Insurer and the Policyholder, the Insured's full name, date of birth, address of residence (registration) and phone number; for Policyholders – individuals (Supplement No. 5 hereto) – number of the Certificate of Insurance, name, address of residence (registration), passport data and phone number of the Policyholder, the Insured's name, address of residence (registration), date of birth, gender, passport details and phone number; for all Insurance Policies – validity period of the Insurance Policy, the Object of Insurance, volume, conditions and procedure for the provision of medical and other services agreed by the Parties, list of medical and other institutions, the Insurance Coverage, the Insurance Premium (Insurance Installments) payable under the Insurance Policy, the terms and procedure of its payment, terms and conditions of entering of the Insurance Policy into force and its termination, liability of the Parties and other conditions not contradicting the legislation of the Russian Federation.

7.8. The Insurance Policy may establish a conditional or unconditional deductible.

When establishing the conditional deductible, the Insurer shall be released from payment of costs associated with the provision of medical and other services to the Insured, if their volume does not exceed the deductible, however, reimburse them in full if the loss exceeds the deductible.

When establishing the unconditional deductible in the Insurance Policy, the Insurer's obligations shall be determined by the volume of expenses incurred to provide the Insured with medical and/or other services provided by the Policy, minus the deductible.

The deductible shall be determined by the Parties as a percentage of the Insurance Coverage or in the absolute value.

The Insurance Policy may also establish other types of deductibles, including temporary deductibles – the period of time starting from the date of the Insurance Policy conclusion, during which the Insurance Benefits shall not be made in the event of an Insured Accident or in relation to specified diseases (conditions, injuries, damages).

7.9. Simultaneously with the Certificate of Insurance (or with the Insurance Policy), the Policyholder (the Insured) may be provided with an insurance card (plastic, etc.) and, if necessary, a pass to a medical or other institution. The insurance card is a personal document and contains reference information (series and number of the Certificate of Insurance (insurance card), the period of the Insurance Policy, reference phones of medical and other institutions, contact telephone numbers of the Insurer).

7.10 The Policyholder (the Insured) is prohibited to give the Certificate of Insurance (insurance card) to another person for the purpose of receiving services under the Insurance Policy. The Insurer shall not reimburse the costs of rendering services to persons not specified as the Insured within the context of the Insurance Policy.

7.11. If the Policyholder (the Insured) lost the Certificate of Insurance and/or the insurance card, the Insurer shall issue a duplicate of the Certificate of Insurance upon written application of the Policyholder (the Insured). The duplicate will have a corresponding record. The lost Certificate of Insurance (insurance card) shall be considered invalid starting from the date of filing the application for loss and cannot be the basis for receiving services under the Insurance Policy.

7.12. In case of early termination of the Insurance Policy, the Certificate of Insurance (insurance card) shall be returned to the Insurer within 3 business days.

7.13. The Insurance Policy shall be terminated and the Insured shall lose the right to receive services under the Insurance Policy:

7.13.1. at the expiration of the Insurance Policy;

7.13.2. in case of death of the Insured (except for payment for services provided in relation with the death of the Insured) – in respect of the deceased, if the Policy have been concluded in respect of more than one Insured;

7.13.3. if the Insurer fulfills its obligations to the Policyholder (the Insured) under the Insurance Policy in full – in respect of the respective Insured, if the Policy have been concluded in respect of more than one Insured;

7.13.4. in case of liquidation of the Policyholder – legal entity, from the moment of entry of the relevant decision into force;

7.13.5. anytime upon request of the Policyholder, if the possibility of occurrence of the Insured Accident has not disappeared due to circumstances other than the Insured Accident at the time of such request;

7.13.6. by agreement of the Parties;

7.13.7. if the Policyholder failed to pay the Insurance Premium or the Insurance Installment in full under the Insurance Policy that has entered into force within the term established by the Insurance Policy (in accordance with clause 6.8. hereof);

7.13.8. in other cases, provided by the legislation of the Russian Federation or these Rules.

7.14. If the possibility of occurrence of the Insured Accident disappeared and the existence of insurance risk stopped on circumstances other than the Insured Accident, the Insurance Policy shall be prematurely terminated, the Insurer shall have the right on the part of the Insurance Premium proportional to the time during which the insurance remained valid.

7.15. The paid Insurance Premium (Insurance Installment) shall not be refundable:

7.15.1. upon expiry of the Insurance Policy;

7.15.2. upon termination of the Insurance Policy at the initiative of the Policyholder – legal entity, unless otherwise provided by the Insurance Policy.

7.15.3. upon termination of the Insurance Policy at the initiative of the Policyholder – individual after the deadline set by Russian Central Bank Directive No. 3854-Y as of 20.11.2015 “On minimum (standard) requirements to conditions and procedures for the implementation of certain types of voluntary insurance” calculated from the date of its conclusion, unless the Insurance Policy stipulates otherwise.

7.16. In case of early termination of the Insurance Policy, the Insurance Premium (Insurance Installment) shall be refunded in accordance with the terms of the Insurance Policy, these Rules and the legislation of the Russian Federation.

7.16.1. In case of refusal of the Policyholder – individual (with the exception of foreign citizens and individuals without citizenship residing on the territory of the Russian Federation for work) to fulfill the Insurance Policy within the term established by Russian Central Bank Directive No. 3854-Y as of 20.11.2015 “On minimum (standard) requirements to conditions and procedures for the implementation of certain types of voluntary insurance” calculated from the date of its conclusion in the absence of events that have signs of an Insured Accident, the paid insurance premium shall be returned to the Policyholder within 10 business days starting from the date of receipt of the written application of the Policyholder:

- in full – if the Policyholder cancelled the Policy before the start date of the Insurance;

- with deduction of a part of the Insurance Premium in proportion to the term of the insurance validity – in case of refusal from the Policy after the start date of the Insurance.

7.16.2. The Insurance Policy shall be terminated at 23:59 (11:59 PM) on the date when the Insurer received the Policyholder’s written notice of withdrawal.

7.17. The Insurer that was notified on the circumstances entailing increase of the Insured risk, may require changes in the terms of the Insurance Policy or payment of additional Insurance Premium in proportion to the increased risk that shall be made in an additional agreement to the Insurance Policy. If the Policyholder is opposed to a change in the terms of the Insurance Policy or an additional payment of the insurance premium, the Insurer shall have the right to demand the termination of the Insurance Policy.

7.18. The Insurer shall not be entitled to demand termination of the Insurance Policy if the circumstances entailing an increase in the insurance risk have already disappeared.

7.19. Changes in terms and conditions of the Insurance Policy shall be made by mutual consent of the Policyholder and the Insurer on the basis of an application from one of the Parties and shall be certified by an additional agreement, which shall become an integral part of the Insurance Policy. If any of the Parties does not agree to amendments to the Insurance Policy, the Parties shall decide on the validity of the Insurance Policy on the old terms or on its termination.

7.20. If any law was adopted establishing mandatory rules for the Parties other than those that were valid upon conclusion of the Insurance Policy after conclusion of the Insurance Policy, the terms of the Policy shall remain valid, except in cases when the law stipulates that it applies to relations arising out of the Insurance Policy.

8. RIGHTS AND OBLIGATIONS OF THE PARTIES UNDER THE INSURANCE POLICY

8.1. The Policyholder shall have the right to:

8.1.1. choose services from the List of Medical and Other Services in any combination and completeness if such is provided by the Insurance Policy, as well as medical and other institutions rendering services under the Insurance Policy from among offered by the Insurer and in coordination with it;

8.1.2. in coordination with the Insurer – change the list of insurance risks, medical and other institutions, to change a set of medical and other services, size of the Insurance Coverage subject to the conclusion of an additional agreement and payment of the additional insurance premium, if necessary;

8.1.3. make changes to the list of the Insureds by signing an additional agreement to the Insurance Policy with provision of the necessary information to the Insurer;

8.1.4. get a duplicate of the Certificate of Insurance (insurance card) in case of its loss;

8.1.5. on the basis of a written application to the Insurer – cancel the Insurance Policy at any time, if the possibility of occurrence of the Insured Accident has not disappeared due to circumstances other than the Insured Accident at the time of such refusal.

8.2. The Policyholder is obliged to:

8.2.1. when concluding the Insurance Policy and during its validity – provide the Insurer with all information on activities related to the conclusion and execution of the Insurance Policy, as well as having significant significance for determining the probability of occurrence of the Insured Accident and volume of possible losses from its occurrence (the Insurance Risk);

- 8.2.2. bring information on the terms of the Insurance Policy, the Rules and the procedure for providing medical and other services to the attention of the Insured;
- 8.2.3. pay the Insurance Premium (Insurance Installments) in such amount and within such terms as established by the Insurance Policy;
- 8.2.4. ensure the safety of documents under the Insurance Policy;
- 8.2.5. within the limits of its liability and competence – take measures aimed at elimination of circumstances affecting the Insurance Risk increase;
- 8.2.6. ensure confidentiality in relations with the Insurer;
- 8.2.7. obtain from the Insured and provide the Insurer and/or its representative upon first request with the written consent of the Insured to use and provide its personal data and their health status to medical and/or other institutions for the purpose of fulfilling the obligations of the Insurer under the Insurance Policy.

8.3. The Insurer shall have the right to:

- 8.3.1. check the information provided by the Policyholder (the Insured), as well as the compliance of the Policyholder (the Insured) with the requirements and conditions of these Rules and the Insurance Policy, and refuse to conclude or demand for the invalidity of the Insurance Policy, if the Policyholder has provided false information;
- 8.3.2. when concluding the Insurance Policy – demand the Insured (the Policyholder) to fill in a questionnaire and / or conduct a preliminary medical examination;
- 8.3.3. if there is no possibility to render medical and other services to the Insured in the medical and other establishments defined by the Insurance Policy – organize the provision of necessary services corresponding to the Insured in terms of completeness and quality via other establishments of the corresponding profile defined at discretion of the Insurer;
- 8.3.4. transfer the information received from the Policyholder and/or the Insured on the personal data and state of their health to medical and / or other institutions in order to fulfill their obligations under the Insurance Policy.

8.4. The Insurer is obliged to:

- 8.4.1. make the Policyholder familiar with these Insurance Rules;
- 8.4.2. issue Certificates of Insurance (insurance cards, passes to medical and other institutions) to the Insured (directly or through the Policyholder) at the conclusion of the Insurance Policy;
- 8.4.3. organize the provision of medical and other services to the Insured in accordance with the Insurance Policy;
- 8.4.4. control the volume, timing and quality of services provided to the Insured in accordance with terms and conditions of the Insurance Policy;
- 8.4.5. pay for services rendered under the terms of the concluded Insurance Policy in the event of the Insured Accident in accordance with the established procedure;
- 8.4.6. observe the confidentiality of insurance.

8.5. The Insured shall have the right to:

- 8.5.1. receive services in accordance with the Insurance Policy;
- 8.5.2. receive explanations under these Rules and terms and conditions of the Insurance Policy on the procedure for providing medical and other services;
- 8.5.3. choose any medical and other institution from among those specified in the Insurance Policy;
- 8.5.4. inform the Insurer on cases of non-provision, incomplete or poor-quality provision of services under the Insurance Policy;
- 8.5.5. get a duplicate of the Certificate of Insurance (insurance card) in case of its loss.

8.6. The Insured is obliged to:

- 8.6.1. keep their health safe, fulfill the recommendations of their attending physician received during the services under the Insurance Policy, follow the regime and routines established by medical and other institutions;
- 8.6.2. keep the insurance documents safe and not transfer them to other parties in order for them to receive medical and other services;
- 8.6.3. timely notify the Insurer on changes in their surname, other passport data or place of residence (registration);
- 8.6.4. provide the Insurer and / or its representative with the right to review medical documentation from any medical and other institutions in order to resolve issues related to the execution of the Insurance Policy;
- 8.6.5. ensure confidentiality in relations with the Insurer.

8.7. All rights and obligations of Insureds under 18 years old under the Insurance Policy, except for the right to provide services in accordance with the Insurance Policy, shall be exercised by their legal representatives on behalf and in interests of such minors in accordance with the legislation of the Russian Federation.

8.8. The Insurance Policy may include other rights and obligations of the Parties that do not contradict the legislation of the Russian Federation.

8.9. Rights and obligations of the Parties on operation with personal data

The Policyholder has concluded the Insurance Policy with the Insurer on the terms and conditions of the Insurance, hereby gives its consent to the Insurer to process the following personal data of the Insured in order to obtain insurance under the Insurance Policy, inter alia to verify the quality of insurance services rendered and settle claims under the Agreement, to administer the Policy and to inform the Insured on other products and services of the Insurer.

The personal data of the Policyholder include: surname, given name, patronymic, year, month, day and place of birth, personal data, address of residence, other data specified in the Insurance Policy concluded with the Insurer (including its integral parts – application for the insurance, supplements, etc.), which may be deemed as personal data in accordance with the legislation of the Russian Federation.

The Policyholder shall grant the Insurer the right to perform all actions (operations) with personal data including collection, systematization, accumulation, storage, clarification (update, change), use, depersonalization, blocking, destruction. The Insurer shall have the right to process personal data by including them in the Insurer's electronic databases.

The Insurer shall have the right to transfer the personal data of the Policyholder to third parties during the fulfillment of its obligations under the Insurance Policy, provided that the Insurer has concluded an agreement with such third parties that ensures the security of personal data during their processing and prevents the disclosure of personal data.

By confirming the receipt of these Insurance Rules, the Policyholder gives its consent to processing of personal data of the Policyholder from the very moment of conclusion of the Insurance Policy (if the conclusion of the Insurance Policy was preceded by the Insurer's application for insurance, the consent is valid from the date specified in the application for insurance). The Policyholder's consent to processing of the Policyholder's personal data shall remain valid for 10 years (unless otherwise provided by the Insurance Policy).

The policyholder shall have the right to withdraw its consent by drawing up an appropriate written document, which shall be sent to the Insurer by registered mail with a notice of delivery or delivered personally on signature to the authorized representative of the Insurer. If the Insurer receives a written application from the Policyholder to revoke the consent to processing of personal data, the consent shall be deemed withdrawn from the date of receipt of the said application by the Insurer. Upon expiry of the Insurance Policy (including its termination) or

withdrawal of consent to processing of personal data, the Insurer shall undertake to stop processing personal data and then destroy the personal data of the Policyholder within a period not exceeding 10 years from the date of expiry of the Insurance Policy / withdrawal of consent to processing of personal data.

The aforementioned provisions of this paragraph of the Insurance Rules shall also apply to the Insured in the event that they sign a consent to processing of personal data by the Insurer.

9. THE ORDER AND CONDITIONS OF RENDERING SERVICES TO THE INSURED AND PAYMENT OF INSURANCE BENEFITS.

9.1. In order to receive services under the Insurance Policy, the Insured shall apply to the medical and/or other institution specified in the Insurance Policy, or firstly to the Insurer by phone numbers specified. If necessary and in accordance with the procedure provided in the Insurance Policy, before applying to a medical institution (pharmaceutical or other organization²), the Insured may apply to an assistance company cooperating with the Insurer, or to another legal entity provided for in the Insurance Policy in order to obtain medical care (medical and other services, medicines or medical devices).

The Insurer shall organize and / or pay for medical care provided to the Insured in medical institutions located both in the territory of the Russian Federation and in the territory of foreign states in the amount determined by the Insurance Policy.

When organizing and/or paying for medical services, the Insurer shall have the right to request all the necessary medical documentation and materials from the Insured for the purpose of carrying out the appropriate examination and confirmation of the Insured Accident.

9.2. The provision of services to the Insured shall be carried out upon presentation of Certificate of Insurance (insurance card) and a document confirming the identity of the Insured, and a pass to a medical or other institution, if necessary.

9.3. In order to fulfill its obligations to organize the provision of services to the Insured in accordance with the terms of the Insurance Policy, the Insurer shall conclude agreements for the provision of medical care and other services to the Insured with public, private medical and other institutions located on the territory of the Russian Federation (residents or non-residents) and abroad, including foreign insurance companies, service companies, research institutes, laboratories, medical centers and clinics (including foreign), pharmacies, private practitioners and other organizations of various forms of incorporation, provided that this does not contradict the legislation of the Russian Federation.

9.4. Medical institutions, service companies and other institutions, in accordance with the agreement concluded with the Insurer, shall provide services to the Insured under the Insurance Policy, including medical transport services and repatriation services.

9.5. The payment under the Insurance Policy shall be carried out by the Insurer by paying the cost of medical care (medical and other services, as well as medicines or medical products) provided to the Insured directly (or through an attorney, agent, commission agent) to a medical institution and to a pharmacy (or other) organization on their accounts. The Insurer may arrange and pay for sanatorium-resort treatment of the Insured by either payment for a ticket for such sanatorium-resort treatment directly to such resort or association or to a resort agency.

The payment for medical care (medical and other services, medicines or medical devices) may be made on the basis of an agreement concluded in writing in accordance with paragraph 2 of article 434 of the Civil Code of the Russian Federation.

The terms and procedure for making a decision on the Insurance Benefit and terms of payment of the Insurance Benefit under the Insurance Policy for medical care or other services provided to the Insured, as well as payment for medicines or medical products shall be determined by terms and conditions of agreements with medical and/or other institutions, pharmacies or other organizations.

9.6. The Insurance Policy may provide the reimbursement of expenses incurred by the Policyholder (the Insured) for payment for medical and/or other services provided as agreed with the Insurer and in accordance with terms and conditions of the Insurance Policy directly to the Insured in cash or by transfer to their account. The terms and procedure of such payments shall be determined in accordance with clause 9.7.5. hereof. In this case, the costs shall be recognized by the Insurer as reasonable on the basis of the documents listed in paragraph 9.7. hereof, confirming the need for incurred costs and the fact of such payment.

9.7. In order to make payments according to clause 9.6., the Insured must provide the Insurer with an application attached by the original of the paid invoice indicating the medical or other institution, the list of services rendered and their cost, a receipt or cash slip, a referral for treatment, an extract from the medical card of an outpatient or inpatient patient or other document confirming the fact and grounds for receiving the service.

9.7.1. In addition to the above documents, one shall also submit the documents from the competent authorities indicating the events that occurred, in case of which the Insured was insured, if such is specified in the Insurance Policy.

9.7.2. If medical or other services were received by the Insured outside the Russian Federation, the Insurer shall be provided with medical documents that allow to establish the fact of occurrence of the Insured Accident, prognosis, terms of treatment, medical and diagnostic measures and services provided with their cost. Documents in a foreign language shall be provided together with a notarized translation. The costs of collecting these documents and their translations shall be paid by the Policyholder (the Insured).

9.7.3. If the submitted documents do not contain information covered by the above terms and conditions of insurance required for the decision on insurance benefit or determination of its size, but also contain contradictory information, the Insurer shall have the right to request additional documents necessary for making an informed final decision (in agreement with the Policyholder (the Insured), and conduct the verifying examination of the documents or to investigate the cause and circumstances of the insurance event on their own.

9.7.4. In case of refusal of the Policyholder (the Insured) to provide the requested documents, the Insurer shall have the right to pay only the uncontested part of the Insurance Benefit, confirmed by the documents provided at the time of payment, or to refuse to pay the insurance benefit.

9.7.5. The Insurance Benefit shall be paid to the Insured on the basis of the insurance act, technical expertise of the Insured Accident (insurance act) approved by the Insurer.

The Insurer shall draw up and approve the insurance act within 20 business days upon receipt of all documents necessary and sufficient to establish the fact, causes, circumstances of the Insured Accident and the amount of loss.

The Insurance Benefit shall be paid to the Insured within 15 business days after approval of the Insured Accident by the Insurer.

9.8. The Insurer shall verify the correspondence of services provided to the Insured with the volume and terms specified in the Insurance Policy as well as fulfillment of other provisions thereof and conducting the examination of quality of services provided at its discretion or at the written request of the Policyholder (the Insured).

9.9. The Insurer shall not pay for the expenses incurred by the Policyholder (the Insured) in connection with events occurring after the expiry of the Insurance Policy; that said, the Insurer shall pay for the expenses related to the Insured Accident that occurred during the term of the Insurance Policy and incurred before the elimination of threat to life of the Insured, unless otherwise provided by the Insurance Policy.

9.10. Planned hospitalization shall be carried out at least 14 days before the end of the Insurance Policy. The services at a planned hospitalization under the Insurance Policy provided to the Insured shall be payable prior to the expiry of the Insurance Policy, unless otherwise provided in the Insurance Policy; any further – payable on the Policyholder's (the Insured's) expense.

9.11. When establishing the insurance deductible in the Insurance Policy, the part of costs of services rendered to the Insured equal to the deductible established in the Insurance Policy, shall be paid by the Policyholder (the Insured) upon receipt (provision) of services directly to the

² Other organization is an organization with the right to sell medicines and / or medical devices both by wholesale and retail

institution that provides the service, either to the Insurer within 30 (thirty) days upon recognition of the event as the Insured Accident and receipt of the notice from the Insurer on payment of the last services rendered.

9.12. In case of foreign currency insurance, the amount of Insurance Benefits for all the Insured Accidents occurring during the validity of the Policy may not be greater than the rouble equivalent of such amount calculated according to rates of the Russian Central Bank for the chosen currency for payment of the Insurance Premium (Insurance Installment) subject to the exchange rate as on the date of the Insurance Benefit does not exceed the max rate for the chosen currency.

If the rate of foreign currency established by the Central Bank of the Russian Federation on the date of the Insurance Benefit exceeds the maximum rate of foreign currency, the Insurance Benefit shall be calculated at the maximum rate of foreign currency agreed when concluding the Policy.

The maximum rate of a foreign currency means the foreign exchange rate set by the Central Bank of the Russian Federation on the date of payment (write off) of the Insurance Premium (first Insurance Installment), increased by a percent for each month (including incomplete) agreed by the Parties, last since the payment of the Insurance Premium (first Installment of the Insurance Premium).

10. EXCEPTIONS TO THE PAYMENT OF BENEFITS

10.1. The Insurer shall have no legal grounds/obligations to pay the Insurance Benefit:

10.1.1. if the individual / legal entity claiming the Insurance Benefit is not the Policyholder / the Insured or the representative of any of these;

10.1.2. if the Insurance Policy is invalid in accordance with the legislation of the Russian Federation;

10.1.3. if the claimed event (loss) did not actually take place or is not confirmed by the relevant documents;

10.1.4. if the event does not meet the signs of the Insured Accident provided by these Rules and / or the Insurance Policy;

10.1.5. if the claimed event occurred before the conclusion of the Insurance Policy;

10.1.6. if the occurred events and / or losses are excluded from insurance in accordance with the terms of these Rules and / or the Insurance Policy;

10.1.7. if there are grounds for exemption of the Insurer from the Insurance Benefit provided by the legislation of the Russian Federation;

10.1.8. if any of terms and conditions specified by Section 9 of these Rules are not fulfilled and such nonfulfillment has resulted in the Insurer's obligation to pay the insurance indemnity (article 961 of the Civil Code);

10.1.9. if the loss has been already reimbursed by third parties;

10.1.10. in the part of the Insurance Benefit, which is not documented, and the lack of documents on the fact of occurrence of the claimed accident does not allow the Insurer to find the appropriate size/part of the losses;

10.1.11. if the Policyholder unilaterally refused to fulfill its obligations and / or changed the terms of the present Insurance Rules and / or the concluded Insurance Policy.

10.2. In all cases, the Insurer shall not pay for medical and / or other services that are of an expert or research nature or were provided at the request of the Insured, but contrary to the recommendations of a doctor or other specialist within their competence.

11. LIABILITY OF THE PARTIES

11.1. Liability of the Insurer.

11.1.1. In case of an unjustified refusal from a medical institution, service company or other institution to provide the Insured with the services established by the Insurance Policy or incomplete or substandard performance thereof, the Insurer, on the basis of a written application of the Policyholder (the Insured), shall take measures to organize the provision of necessary services to the extent provided by the Insurance Policy.

11.1.2. The validity of the Insured's claims shall be determined by an expertise consisting of representatives of the Insurer, the Policyholder (the Insured) and such medical institution (service company or other institution), and, if necessary, of an independent expertise.

11.1.3. In the event of any damage incurred to health of the Insured by a medical or other institution, the Insurer shall take possible measures in accordance with the legislation of the Russian Federation aimed at compensation of such damages to the Insured.

11.2. Liability of the Policyholder / the Insured.

11.2.1. The Insured (the Policyholder) shall reimburse the Insurer all the associated costs, including the payment of appropriate penalties to medical or other institutions for unjustified invocation of a physician, ambulance and emergency medical in power, the use of sanitary vehicles not for medical reasons, violation of the therapeutic regimen, failure to appear without prior notice at procedures pre-agreed with medical or other institution, other techniques, doctors and other services.

11.2.2. The house-call of a doctor, ambulance and emergency medical teams and use of sanitary transport shall be considered unreasonable if:

11.2.2.1. a call was made by the Policyholder (the Insured) for medical care of an uninsured person;

11.2.2.2. when a call made by the Insured or another person acting in their interests contained intentionally distorted information concerning the need for medical care, the urgency of medical care (for the purpose of obtaining planned medical services, etc.) and / or the place of stay of the Insured;

11.2.2.3. the call was not made for medical purposes.

11.3. If the Policyholder (the Insured) fails to reimburse the Insurer for the expenses incurred as a result of actions of the Policyholder (the Insured) in the cases specified in paragraphs 9.11., 11.2.1. hereof within 30 days upon issuance of the relevant invoice by the Insurer, the insurance due to the Insurance Policy concluded on the terms of these Rules shall not apply to Insured Accidents that occurred after the specified period; in addition, the Insurer shall have the right to unilaterally refuse to fulfill its obligations under the Insurance Policy, notifying the Policyholder of this decision. In the latter case, part of the insurance premium shall not be refunded in proportion to the time, during which the insurance remained effective.

11.4. The Parties shall be released from liability for partial or complete nonfulfillment of obligations under the Insurance Policy, if the reason for such nonfulfillment is a force majeure, as a result of which the fulfillment of obligations under this Insurance Policy became impossible.

11.5. At occurrence of the circumstances provided by clause 11.4., each Party shall be obliged to notify the other Party in writing on the circumstances confirmed by the authorized organizations within seven business days; and also to take all measures depending on it to make it possible to continue the fulfillment of obligations under the Insurance Policy and to agree the change of terms or volumes of the services in writing, meaning the acceptable alternative ways of performance of the Insurance Policy.

12. DISPUTE SETTLEMENT PROCEDURE

12.1. Disputes arising under the Insurance Policy shall be resolved through negotiations of the Parties with the involvement of the conciliation commission, which consists of representatives of the Policyholder and the Insurer of equal quotas and, if necessary, the relevant experts at the request and expense of the requesting Party.

12.2. If the Parties fail to reach an agreement, the dispute shall be settled in accordance with the procedure established by the legislation of the Russian Federation.

13. GLOSSARY – TERMS USED IN THE RULES

The Insurer is Rosgosstrakh System Insurance Company (PAO IC Rosgosstrakh is a legal entity established in accordance with the legislation of the Russian Federation and duly licensed to carry out insurance activities).

The Policyholder is a person who has concluded a Contract of Voluntary Health Insurance with the Insurer for the benefit of third parties or for its own benefit and it is obliged to pay the insurance premium.

The Insured is an individual, in whose favor the Contract of Voluntary Medical Insurance is concluded, and whose property interests are the object of insurance under the Contract of Voluntary Medical Insurance concluded between the Policyholder and the Insurer.

The Contract of Voluntary Medical Insurance is a written agreement between the Policyholder and the Insurer specifying that the Insurer shall, within the period of validity of the Insurance Policy, arrange and pay for medical, medical transportation services, repatriation and other services stipulated by the Insurance Policy within the established insurance coverage upon occurrence of an Insured Accident, and the Policyholder shall pay the Insurance Premium (Insurance Installments) within such time and in such amount as established by the Insurance Policy. Insurance Policies may be individual or collective.

The Insurance Benefit is a payment for medical and other services provided to the Insured in accordance with terms and conditions of the Insurance Policy.

The Program of Voluntary Medical Insurance (the Insurance Program) is a set of medical and other services from the List of Medical and Other Services (Supplement No. 1 hereto), formed for each Insured when concluding the Insurance Policy, which will be paid by the Insurer upon occurrence of an Insured Accident, as well as a list of medical institutions, service companies and other establishments, where the Insured can receive medical and other services specified in the Insurance Policy.

The place of residence is a place where the Insured resides permanently or predominantly.

The main place of work is an organization with labour relations with the Insured on the basis of an employment agreement (contract).

Medical institutions are licensed medical and health care institutions, research and medical institutions or other, including rehabilitation and sanatorium institutions, as well as individuals engaged in medical activities on the basis of a license, both on the territory of the Russian Federation and abroad, providing medical and health care services (medical services) under the Voluntary Medical Insurance in accordance with the Contract with the Insurer.

Service companies are licensed service or assistance companies and institutions that have contracts with the Insurer for organization of medical, expert, medical transport and other (including medical and social) services, and providing assistance for repatriation.

Pharmacies are organizations engaged in retail trade of medicines, manufacturing and distribution of medicines in accordance with the requirements of the legislation of the Russian Federation, licensed to carry out pharmaceutical activities, providing medicines, medical products and services to the Insured.

The medical services are a measure or a set of measures aimed at the prevention of diseases, their diagnosis and treatment, having an independent complete value and a certain cost.

The medical care is a set of measures, including medical and other services, organizational and technical measures, medicine support, provision of medical products, aimed at meeting the needs of the Insured in maintaining and restoring health.

The medicine support means the organization and / or payment of supply and / or delivery of medicines provided by the Insurance Policy and medicines prescribed by an attending physician of an outpatient medical institution or prescribed by an attending physician of an inpatient medical institution if the Insured faced the Insured Accident, including by means of dispensing medicines from pharmacies.

The medical device support involves a payment of costs of prosthetic and orthopedic products, glasses, hearing devices, contact lenses, implants, etc. (and, if necessary, their delivery) included in the Insurance Policy and discharged (appointed) by an attending physician of an outpatient medical institution or discharged (appointed) by an attending physician of an inpatient medical institution, and such payment shall be made on the Insurer's expense.

The prosthetic and orthopedic support is a payment for prosthetic and orthopedic products and services for their manufacture and installation, as well as medical services for the rehabilitation of patients of this profile.

The other services are services related to provision or organization of medical care and included in the Insurance Policy, including: accommodation services (rooms of improved comfort including additional food, means of communication, TV, computer, refrigerator, air conditioning, shower, toilet, etc.); food and stay when receiving a hospital or sanatorium treatment, if it is not included in the cost of medical services (cost of one day); execution and registration of various medical documentation by a medical institution; services for the organization of medical care in other medical institutions; information services related to provision or organization of medical care.

The medical transportation services are services related to the transportation of the Insured:

- to the profile medical institution in the territory of the Russian Federation by an ambulance or other means of transport from the place of occurrence of an event with signs of the Insured Accident;

- to another medical institution in the territory of the Russian Federation and abroad for medical reasons (on the orders of a doctor) by a vehicle chosen in accordance with the state of health of the Insured (if necessary, accompanied by medical personnel);

- to a specialized medical institution nearest to the place of permanent residence of the Insured in the territory of the Russian Federation by a vehicle chosen in accordance with the state of health of the Insured (if necessary, accompanied by medical personnel).

Repatriation services are services related to transportation by a vehicle chosen in accordance with the state of health, including, if necessary, medical personnel and equipment (depending on the conditions specified in the Insurance Policy):

- for foreign citizens – to a transport hub nearest to the place of residence of the Insured or to the doctor, to a hospital nearest to the airport of the place of residence of the Insured subject to there is a direct international communication from the place of stay of the Insured;

- to the nearest transport hub in the territory of the Russian Federation having international communication with the country of permanent residence of the Insured, or

- to the country of residence from the place of stay by a vehicle chosen in accordance with the state of health of the Insured to transport hub nearest to the place of the Insured's permanent residence subject to there are direct international connections from the place of residence of the Insured in the event of diseases/conditions requiring maintenance by a qualified medical personnel using the methods of continuous intensive monitoring and hardware management of vital functions of the body.

- for citizens of the Russian Federation – transportation of the Insured to the nearest medical institution to receive medical care (depending on the conditions specified in the Insurance Policy) from the country of stay to the territory of the Russian Federation by a vehicle chosen in accordance with the state of health;

- for remains of the Insured – to a transport hub nearest to the place where the Insured resided subject to there are direct international connections from the place of stay of the Insured's remains or to a transport hub on the territory of the Russian Federation that has international connections with the country of residence of the Insured.