

Content of the Rules:

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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 Insurance Programs attached hereto (Supplements No. 3_1-3_4). 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: individuals – citizens of the Russian Federation, foreign citizens and stateless persons with civil capacity or Russian or foreign legal entities of any legal form registered and operating in accordance with the legislation of the Russian Federation.

1.5. Under the terms of these Rules, Insurance Policies shall be concluded in favor of the Insureds – foreign citizens or stateless persons arriving to the Russian Federation with an intention to or actually working by virtue of a labour permit or a patent in accordance with the legislation of the Russian Federation (hereinafter referred to as the Migrant Workers).

1.6. The Insurer on the basis of these Rules shall have the right not to conclude the Insurance Policy in respect of persons who at the time of conclusion of the Policy:

- are not Migrant Workers (are persons who do not carry out or do not intend to carry out labour activity);
- are under 18 years old;
- are on hospital treatment.

2. THE OBJECT OF INSURANCE

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 care (1) due to health disorder or status of the Insured, requiring the organization and provision of medical and other services, medicine support (2).

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(1) See the meaning of the medical care in Section 13 of the Rules “Glossary – terms used in the Rules”

(2) See the meaning of the medicine support in Section 13 of the Rules “Glossary – terms used in the Rules”

(3) See the meaning of other services in Section 13 of the Rules “Glossary – terms used in the Rules”

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, service company and/or other institution, agreed with the Insurer, for medical and/or other services (3), medicine provision, specified in the Insurance Program, in terms of diseases and conditions requiring primary health care and specialized medical care in urgent form, included in the basic program of compulsory medical insurance according to part six of article 35 of Federal Law No. 326-FZ as of November 29, 2010 "On compulsory insurance in the Russian Federation", excluding, unless otherwise provided by the contract:

3.2.1. The Insured's appeal for medical and other services, medicine provision on the following occasions:

- cholera (A00), anthrax (A22), plague (A20), equinia and melioidosis (A24), smallpox (B03);
- arthropod-transmitted viral fevers and viral hemorrhagic fevers (A90-A99), helminthiasis (B65-B83), diphtheria (A36), malaria (B50-B54), polio (A80, B91);
- tuberculosis (A15-A19), leprosy (A30);
- pediculosis, acariasis and other infestations (B85-B89);
- sexually transmitted infections (A50-A64), hepatitis B (B16; B17; B18), hepatitis C (B17. 1; B18. 2), human immunodeficiency virus (HIV) (B20-B24)
- malignant neoplasms (C00-C97);
- diabetes mellitus (E10-E14);
- mental and behavioral disorders (F00-F99);
- pregnancy, childbirth, postpartum period and abortion (O00-O99);
- SARS (U04)

3.2.2. Payment for the following medical and / or other services, medicine provision:

- . not provided by the Program or the Contract of Voluntary Medical Insurance:
- . costs for the provision of services to Migrant Workers, not specified in the Insurance Policy as the Insured;
- . if the Insured has applied for medical assistance without first contacting the Insurer's round-the-clock contact center via telephone numbers specified in the Contract /Insurance Program;
- . when providing any medical or other services without prior approval from the Insurer;
- . when providing any medical and other services outside the territory of the insurance Program;
- . when providing medical assistance to the Insured in case of pathological conditions, poisoning and injuries that occurred when the Insured was in a state of any form of alcoholic intoxication or under the influence of other psychoactive substances and / or medicines used without a doctor's appointment;
- . when providing medical assistance in the event of traumatic injuries or other health disorders that occurred as a result of intentional illegal actions committed by the insured person;
- . when providing medical assistance in case of attempted suicide of the Insured, except for those cases when the Insured was brought to such a state by illegal actions of third parties;
- . when providing medical assistance in case of intentional infliction of bodily injuries by the Insured;
- . when providing the medical care to the Insured person, which is not appointed by the doctor rendering medical care within the limits of these Rules and/or the Insurance Program developed on their basis;
- . when providing the methods of treatment defined by the Ministry of Health of the Russian Federation as high-tech medical care.
- . medicines and medical devices in addition to the list of vital and essential medicines and medical devices included in the list of medical devices implanted in the human body in the provision of medical care in an emergency form approved by the government of the Russian Federation;
- . medicines and medical devices not used by medical personnel in the provision of primary health care and / or specialized medical care in emergency form;
- . related to pregnancy, childbirth, postpartum period and abortion of the insured person.

3.3. In the event of an Insured Accident, the Insurer shall pay the costs of medicines included in the list of vital and essential medicines for medical use and medical devices approved by the government of the Russian Federation and medical devices included in the list of medical devices approved by the government of the Russian Federation implanted in the human body under the medical care according to the program of state guarantees of free provision of medical care to citizens, that have been used by medical personnel emergency medical care in accordance with the standards of primary health care and specialized medical care including payment for medical nutrition in the hospital and donor blood and its components.

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 services provided by the Insurance Policy and Program of Insurance in the amount not less than 100 000 (one hundred thousand) roubles per each Insured for the insurance period, and shall be specified in the Insurance Policy.

4.3. Unless otherwise provided by the Insurance Policy, the Insurance Coverage shall be reduced, calculated as the difference between the Insurance Coverage at the beginning of the term of the Insurance Policy of Migrant Workers and the amount of insurance indemnity made by the Insurer during the period of the Insurance Policy of Migrant Workers for all insured events (aggregate sum insured). The amount of insurance payments for all insured events under the Insurance Policy concluded under the terms of these Rules may not exceed the amount of the insured amount established by such contract, unless otherwise provided by the Insurance Policy.

The Insurer, in agreement with the Policyholder, within the total Insurance Coverage established in accordance with paragraph 4.2. of the Rules, the aggregate insurance amount may be set separately for each type of medical care / risk specified in the Insurance Program or other limits for certain types of services. If the aggregate Insurance Coverage is exhausted in full, the Insurer's obligations under the Insurance Policy shall be deemed fulfilled. In this case, the Insurance Policy shall be terminated prematurely, and the Insurance Premium paid to the Insurer – not refundable to the Policyholder.

4.4. The Insurer shall notify the Policyholder and the Insured person of the reduction of the aggregate Insurance Coverage to less than 10 000 (ten thousand) roubles within five business days from the date of such reduction.

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 from 00 hours 00 minutes on the day following the day of payment of the Insurance Premium (first Insurance Installment).

5.3. The Insurance Policy of Migrant Workers may contain a condition of its entry into force not earlier than the date of commencement of a work permit or a patent.

5.4. The Insurance provided due to the Insurance Policy concluded on the terms of these Rules shall cover all the Insured Accidents occurred after the conclusion 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, including the availability of the franchise and its size in accordance with the terms of the insurance

6.4. Insurance rates for Insurance Programs are given in Supplement No. 4 to these Rules. 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 of the Insured, as well as the information specified by the Insured (the Policyholder) in the 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. 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.

6.6. 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 hours 00 minutes 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 00:00 (12AM) 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.).

7.3. The Insurance Policy, unless otherwise provided in it, must contain, the following information but not limited by it:

7.3.1. Information on the Policyholder:

a) for Policyholders - legal entities:

- form of incorporation;
- full and (if available) abbreviated name, including the company name for commercial organizations in Russian. If the constituent documents of a legal entity indicate its name in one of the languages of the peoples of the Russian Federation and (or) in a foreign language, the name of the legal entity in these languages shall also be indicated;
- address (location) of the permanent executive body of the legal entity (in the absence of a permanent executive body of the legal entity -another body or individual entitled to act on behalf of the legal entity without a power of attorney), which is carried out communication with the legal entity;
- contact information (phone (fax), website address and (or) e-mail (if any));

- surname, given name, patronymic (if any) and position of the person authorized to sign the Insurance Policy and the document on the basis of which it signs the Insurance Policy on behalf of the Policyholder;

b) for Policyholders – individuals:

- surname, given name, patronymic (if any) in Russian (for foreign citizens and stateless persons such information shall be additionally indicated using the letters of the Latin Alphabet on the basis of information contained in a document provided by the Federal Law or recognized in accordance with an international treaty of the Russian Federation as a document certifying the identity of a foreign citizen or a stateless person);

- gender;

- date of birth;

- nationality (if any);

- address of the place of residence (registration) or address of the place of stay in the territory of the Russian Federation, date of registration;

- data of the main identity document of the Migrant Worker (type and data of the document provided by the Federal Law or recognized according to the international treaty of the Russian Federation as identifying documents of a foreign citizen or a stateless person for foreign citizens and stateless persons)

- contact information (phone, e-mail (if available));

c) if the Policyholder is an individual registered as an individual entrepreneur in accordance with the procedure established by the legislation of the Russian Federation:

- surname, given name, patronymic (if any) in Russian (for foreign citizens and stateless persons such information shall be additionally indicated using the letters of the Latin Alphabet on the basis of information contained in a document provided by the Federal Law or recognized in accordance with an international treaty of the Russian Federation as a document certifying the identity of a foreign citizen or a stateless person);

- date of birth;

- nationality (if any);

- place of residence in the Russian Federation (the address at which the individual entrepreneur is registered at the place of residence in the order established by the legislation of the Russian Federation is specified);

- data of the basic document proving the citizen's identity (for Migrant Workers should contain type and the document data provided by the Federal Law or recognized in accordance with the international treaty of the Russian Federation as identity document of a Migrant Worker);

- contact information (phone, e-mail (if available));

- the date of state registration of an individual as an individual entrepreneur and data of the document confirming the fact of entering the record of the specified state registration into the Unified State Register of Individual Entrepreneurs;

7.3.2. Information on the insured person:

- surname, given name, patronymic (if any) in Russian (for Migrant Workers such information shall be additionally indicated using the letters of the Latin Alphabet on the basis of information contained in a document provided by the Federal Law or recognized in accordance with an international treaty of the Russian Federation as a document certifying the identity of a foreign citizen or a stateless person);

- gender;

- date of birth;

- type and data of the document provided by the Federal Law or recognized in accordance with the international treaty of the Russian Federation as identity document of a migrant worker;

- address of residence (registration), address or place of residence on the territory of the Russian Federation;

- nationality (if any);

- contact information (phone, e-mail (if available)).

7.3.3. Information on the Insurer:

- form of incorporation and full company name;

- number and date of issue of the license for the implementation of voluntary personal insurance, except for voluntary life insurance;

- address (location);

- telephone (fax);

- address of the official website in the Internet;

- banking details;

- surname, given name, patronymic (if any) and position of the person authorized to sign the Insurance Policy on behalf of the Insurer, and the document on the basis of which the person may sign the Policy.

7.3.4. Other essential conditions: the date of the Policy, territory of activity, the validity of the Insurance Policy; the Insurance Coverage; the Insurance Premium (Insurance Installments) payable under the Insurance Policy; the terms and procedure of its payment; the terms and timing of the entry of the Insurance Policy in force, as well as its cessation, and other, not contradict the legislation of the Russian Federation, conditions.

7.4. 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.

7.4.1. 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.

7.4.2. If the submitted documents do not contain the information provided in clauses 7.3. and 7.4. 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.

7.4.3. 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.

7.5. By signing the Insurance Policy, the Policyholder confirms that the Insured meets the requirements of paragraphs 1.4-1.6. of the Rules of Insurance imposed on the Insured. 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 by the legislation.

7.6. The fact of conclusion of the Insurance Policy of the Migrant Worker shall be certified by signing one document - the Insurance Policy (Supplement No. 1) and/or by issuance to the Policyholder and/or the Insured of the Certificate of Voluntary Medical Insurance (hereinafter referred to as the Certificate of Insurance) of the established form (Supplement No. 2) signed by the Insurer.

7.7. 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.

7.8. The Insurance Policy is formed at the choice of the Policyholder, agreed with the Insurer. The Insurance Policy may contain various insurance programs from among the programs that are an Annex to the Insurance Rules (Supplements No. 3_1 - 3_4), contain a Program drawn up at the conclusion of the Insurance Policy. The insurer and the Policyholder may agree on the amount of insurance coverage, insurance limits of the insurance Program by determining the list of diseases (conditions), treatment of which is an insured event under the relevant Insurance Policy, as well as on the procedure for providing medical care to the Insured. The list of medical and other services under the Insurance Policy under a specific insurance program, as well as any combination of insurance programs may have the original name. In this case, the amount of coverage under such Program may not be less than that established in accordance with part six of article 35 of Federal Law No. 326-FZ as of November 29, 2010 "On compulsory insurance in the Russian Federation" in the basic program of compulsory medical insurance, taking into account the features specified in clauses 3.2.1. and p. 3. 2. 2. hereof.

7.9. The Certificate of Insurance is a registered document. The Policyholder (the Insured) is prohibited to transfer the Certificate of Insurance (insurance card) to another person for the purpose of receiving services under the Insurance Policy.

7.10. 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.

7.11. 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.

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

7.12.1. at the expiration of the Insurance Policy;

7.12.2. 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;

7.12.3. 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;

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

7.12.5. 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;

7.12.6. by agreement of the Parties;

7.12.7. 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 6.6. hereof);

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

7.13. 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.

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

7.14.1. upon expiry of the Insurance Policy;

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

7.15. 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. The Insurer that was notified on the circumstances entailing increase of the Insured risk, including when primarily finding a disease listed in paragraph 3.2.1 of the Rules during the validity of the Insurance Policy, 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 and compensation for losses caused by termination of the Policy in accordance with the legislation of the Russian Federation.

7.17. 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.

7.18. 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.

7.19. The territory of insurance is defined in the Insurance Policy and includes the territory of the subject of the Russian Federation, where the Insured intends to work.

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 insurance programs from among those proposed by the Insurer and in agreement with them;

8.1.2. in coordination with the Insurer, if it is provided by the Policy/Insurance Program – 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, if it is provided by the Insurance Policy, 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. 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;

8.3.4. when organizing and / or paying for medical services, the Insured shall have the right to request a valid patent (work permit) and/or the necessary medical documentation and materials for the purpose of carrying out the appropriate examination and confirmation of the insured event.

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 care to the Insured in accordance with the Insurance Policy on the basis of institutions of the relevant profile, determined at the discretion of the Insurer;

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. notify the Policyholder and the Insured on the reduction of the aggregate Insurance Coverage within 5 business days starting from the date of reducing the amount of the Insurance Coverage to less than 10 000 (ten thousand) roubles;

8.4.7. 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. inform the Insurer on cases of non-provision, incomplete or poor-quality provision of services under the Insurance Policy;

8.5.4. get a duplicate of the Certificate of Insurance (insurance card) in case of its loss. In this case, the Insurer shall have the right to demand to pay the cost of a duplicated Certificate of Insurance.

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.

8.6.6. when concluding the Insurance Policy and during its validity, present all information on the circumstances essential for determination of probability of occurrence of the Insured Accident to the Insurer along with the sizes of possible losses from its occurrence (the Insurance Risk), including information on premature termination of labor activity, the expiry/termination of the work permit (patent), etc.

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

8.8. 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 Insurer via telephone numbers indicated by it in accordance with the procedure provided for in the Insurance Program / Policy. When organizing medical services, the Insurer has the right to request a valid patent (work permit) from the Insured.

9.2. 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.

9.3. 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.

9.4. The insurance payment shall be determined by the cost of medical and other services, medicine, provided in accordance with the terms of the Contract of Voluntary Medical Insurance, and may not exceed the amount of insurance established under the Policy or the amount of insurance for individual risks.

9.5. The insurance payment for the medical care provided to the Insured shall be made in the following order:

9.5.1. to a medical or other organization in such order and in such terms and due to the costs established by the Policy for the organization and/or provision of medical and other services concluded between the Insurer and the medical or other organization; or, if there are a direction from the Insurer, on the terms agreed between the Insurer and the medical and/or other organization. The payment shall be made on the basis of invoices issued to the Insurer, with the application of the register with medical services rendered.

9.5.2. in the form of the Insurer's indemnification of the Policyholder's (the Insured's) expenses for payment for medical and other services, if it is directly provided by the Program/Contract of Voluntary Medical Insurance.

9.6. To make payments in accordance with clause 9.5.2. hereof, 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.

9.6.1. 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.

9.6.2. If the submitted documents do not contain information specified in clause 9.6. hereof that is necessary for the decision on the amount of the Insurance Benefit and its payment and also contain contradictory information, the Insurer shall have the right to the following (in agreement with the Policyholder (the Insured)):

- to request additional documents required to make a final informed decision;
- to carry out a reasonable examination of the submitted documents, independently find out the causes and circumstances of the insured event;
- to make the uncontested part of the Insurance Benefit confirmed by the documents provided at the time of payment, in case of refusal of the Policyholder (the Insured) from providing the requested documents;
- to send a justified refusal in insurance payment.

9.6.3. The payment of the Insurance Benefit to the Insured shall be made on the basis of the insurance act approved by the Insurer. The insurer draws up and approves the insurance act within 20 (twenty) business days upon receipt of all documents necessary and sufficient to establish the fact, causes, circumstances of the insured event and the amount of losses.

The Insurance Benefit shall be paid to the Insured within 15 (fifteen) business days after the approval of the insurance act.

10. GROUNDS FOR REFUSAL TO PAY THE INSURANCE BENEFIT

10.1. The Insurer shall have the right to refuse paying the Insurance Benefit in the presence of at least one of the following circumstances:

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 conditions for the implementation of the insurance payment provided for by these Rules are not fulfilled;

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

10.1.10. in case of failure by the Policyholder / Insured to provide documents on the fact of the claimed event, in the part of the insurance payment that is not documented;

10.1.11. if the Insured has not granted a patent (work permit) or the Insured does not have a valid patent (work permit) at the time of provision of medical or other services.

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.

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.

11.3. 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.

11.4. At occurrence of the circumstances provided by clause 11.3., 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 Companies (PAO Rosgosstrakh) - legal entities 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 Migrant Worker is a foreign citizen or a stateless individual arrived to the Russian Federation with an intention to or actually working by virtue of a labour permit or a patent in accordance with the legislation of the Russian Federation.

The Contract of Voluntary Medical Insurance is a written agreement between the Policyholder and the Insurer that determines the procedure, terms and conditions of the insurance under these Rules. The Rules of Insurance are an integral part of the Insurance Policy and they shall be subject to compulsory implementation by both the Insurer and the Policyholder.

The Insurance Benefit is a payment or reimbursement of the cost for medical and other services, medicine provided to the Insured in accordance with the terms of the Insurance Policy and the insurance program upon the occurrence of an Insured Accident.

The Insurance Coverage is the amount of money determined by the Insurance Policy, within which the Insurer shall remain liable under the Insurance Policy.

The Program of Voluntary Medical Insurance (the Insurance Program) is a list, procedure for provision and conditions for provision of medical and other services and medicine from among those provided by Supplements to these Rules within the framework of the Insurance Policy, which will be paid by the Insurer upon occurrence of an Insured Accident.

The place of residence (registration) is the address of residence (registration) or place of residence on the territory of the Russian Federation where the Insured resides permanently or predominantly.

Medical institutions are licensed medical and health care institutions, research and medical institutions 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.

The specialized medical care is medical care provided by medical specialists in hospital settings, including diagnosis and treatment of diseases and conditions requiring the use of special methods and complex medical technologies, as well as medical rehabilitation.

The medical services are activities or a set of activities aimed at the diagnosis and treatment of diseases / conditions and 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 provision, aimed at meeting the needs of the Insured in maintaining and restoring health.

The emergency care usually means assistance provided in case of sudden acute diseases, conditions, exacerbation of chronic diseases, without obvious signs of threat to the life of the patient.

The primary health care includes activities for the diagnosis and treatment of diseases and conditions and is provided on an outpatient basis and in a day hospital.

The trauma is a physical damage to a body, which can be mechanical (bruise, fractures, etc.), thermal (burns, frostbite), chemical, as well as barotraumas (under the influence of sudden changes in atmospheric pressure), electric traumas.

The medicine support are expenses for medicines used by medical personnel in standard and emergency medical treatment in accordance with the standards of primary health care and specialized medical care within the framework of the Program of Voluntary Medical Insurance for migrant workers, included in the list of vital and essential medicines for medical use and medical devices approved by the government of the Russian Federation, and medical devices, included in the list of medical devices approved by the government of the Russian Federation implanted in the human body when providing medical care within program of state guarantees of free medical aid to be rendered to citizens, including medical nutrition in patient and donor blood and its components.

The other services are services related to provision or organization of medical care and included in the Program, including: accommodation services, information services related to the provision or organization of medical care, as well as medical transportation services, repatriation services provided to the Insured in accordance with its medical insurance program.

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):

- 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 - to the country of permanent residence in 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, from the place of stay by a vehicle chosen in accordance with the state of health to a transport hub closest to the place of permanent residence of the Insured with which there is a direct international communication from the place of stay of the Insured.

- 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.