"APPROVED"
Minutes of the Board of Directors
Insurance Company Basel JSC
Minutes No 09/25 dated April 01, 2025

RULES

voluntary health insurance
Insurance Company "BASEL" JSC

Almaty, 2025

CONTENTS

Under the terms and conditions of these Rules of Voluntary Health Insurance (hereinafter referred to as the Insurance Rules), BASEL Insurance Company JSC enters into voluntary health insurance contracts with individuals and legal entities (hereinafter referred to as the Insurance Agreement).

1. DEFINITIONS

1.1. The insurer is BASEL Insurance Company JSC.

1.2. Insurant – a person who has entered into a voluntary health insurance agreement with the Insurer.

1.3. Insured Person (Insured, Beneficiary) is an individual in whose favor the Agreement is concluded and to whom Medical Care is directly provided.

1.4. Medical Care – services for the organization of the provision of medical services, the provision of medical services or the sale of pharmaceuticals to the Insured Person by the Medical Service Providers in accordance with the Program Insurance.

1.5. Doctor - a specialist with higher medical education, who has a license to engage in private medical practice, or works for a Medical Service Provider.

1.6. Insurance Agreement – a voluntary health insurance agreement concluded between the Insurer and the Insured in relation to the medical insurance of the Insured Persons.

1.7. Insurance program is a description of the selected insurance coverage that determines the main features of the insured event and the insurance amounts (insurance limits), both in general under the insurance contract and for individual types of services or diseases. The terms of the programs are provided for in the insurance contract.

1.8. Insurance premium is the amount of money that the Insured is obliged to pay to the Insurer for the latter's assumption of obligations to make an insurance payment in the amount determined by the Insurance Agreement.

1.9. Medical service providers are medical institutions that have entered into a cooperation agreement with the Insurer's Representative (Assistance) for medical care of the Insured Persons specified in the insurance agreement.

1.10. Authorized health care providers are also Beneficiaries under the insurance contract.

1.11. Medical plastic card/electronic extract of the established form from the Insurance Agreement or insurance policy - issued by the Insurer to the Insured Person (Insurant) in accordance with the Insurance Agreement, which indicates the identification number, surname, name and patronymic of the Insured, the dates of the beginning and end of the insurance coverage, as well as the phone numbers of the CALL-center of the Insurer's Representative (Assistance) Medical plastic card/electronic extract of the established form from the insurance contracts or insurance policy that confirm the Insured Person's right to receive Medical Care from Authorized Medical Service Providers and/or reimbursement of medical expenses in accordance with the Insured Person's Insurance Program. A medical plastic card/electronic extract of the established form from the insurance contract is valid only upon presentation of the identity card of the Insured Person.

1.12. Disease – any detectable negative change in the state of health of the Insured Person during the validity of the Insurance Agreement, taking into account the definitions and exceptions provided for by these Insurance Rules, the Insurance Agreement and the relevant Insurance Program of the Insured Person.

1.13. Chronic disease is a negative change in the state of health of the Insured Person, which has at least one of the following signs:

1) is permanent and/or a permanent diagnosis is made;
2) leads to partial disability;
3) the cause is irreversible pathological changes;
4) requires a special regimen of the patient for rehabilitation;
5) is expected to require a long period of supervision, observation or care, according to the treatment protocol.

1.14. Insurance coverage is the terms of insurance payment provided for by the Agreement and the relevant Insurance Program (including the sum insured - total and for certain types of Medical Care, deductibles - if applicable, etc.).

1.15. Insurance amount (insurance limit) is the maximum amount of liability of the Insurer in the event of an insured event or several insured events for the entire period of validity of the Insurance Agreement.
1.16. Family members are direct relatives of the Insured: spouse under the age of 65 and children under the age of 18, unless otherwise provided by the Insurance Agreement.
1.17. Doctor's referral is a document of the established form issued by a doctor or a coordinating doctor, authorized by the Insurer's Representative (Assistance), which determines the list, scope and procedure for the provision of medical services to the Insured.
1.18. Assistance (Medical Service Company) - Representative of the Insurer - a legal entity that has entered into an agreement with the Insurer for the organization and provision of various types of medical services for the Insured.
1.19. Medical indications are objective reasons and conditions for receiving certain medical services for the diagnosis and treatment of the disease.
1.20. Emergency indications are deterioration of the Insured's health, posing a threat to the life of the Insured, caused by a sudden and unforeseen illness of the Insured, which first arose during the period of insurance coverage. Unless otherwise provided by the insurance program, emergency medical indications (conditions) are:
    1) pain symptoms;
    2) burns and injuries;
    3) shock states;
    4) convulsions, loss of consciousness, suffocation;
    5) symptoms of changes in blood pressure;
    6) bleeding;
    7) acute allergic reactions (angioedema, Lyell's syndrome, Stevens-Jones syndrome, acute urticaria).
1.21. Therapeutic indications are medical indications that require diagnosis and/or treatment of Diseases that do not require emergency medical care (conditions not listed as emergency indications in paragraph 4 of this article).
1.22. Insurance policy is an agreement of adhesion to the Insurance Rules, issued to the Insured upon conclusion of the insurance agreement (on paper or in electronic form).
1.23. Insurance territory is the territory of the Republic of Kazakhstan or the territory of other countries where insurance is carried out.
1.24. Standards and protocols for the diagnosis and/or treatment of diseases are a document approved by the authorized body in the field of health care of the Republic of Kazakhstan.
1.25. **Database formation and maintenance organization** – a non-profit organization with state participation, which forms and maintains a database on compulsory voluntary types of civil liability insurance on the basis of the Law of the Republic of Kazakhstan "On Insurance Activities and Legislative Acts of the Republic of Kazakhstan on Compulsory Types of Insurance".

2. OBJECT OF INSURANCE

2.1. The object of voluntary health insurance is the property interests of the Insurant (Insured) that do not contradict the legislation of the Republic of Kazakhstan, associated with the risk of incurring costs for medical care.

3. INSURED

3.1 Individuals aged 1 to 65 years can be insured, unless otherwise specified in the Insurance Agreement.
3.2 Persons who on the date of conclusion of the insurance contract are not subject to insurance:
    1) are disabled of groups I – II for any disease, children of the category of disabled children;
    2) are registered in narcological, psychoneurological, tuberculosis and dermatovenerologic dispensaries;
    3) are hospitalized at the time of conclusion of the insurance contract for any disease;
    4) have the following diseases as of the date of conclusion of the insurance contract:

- HIV (AIDS);
- malignant, including oncohematological tumors.

3.3 Expenses for the treatment of diseases specified in paragraph 3.2. of this Article shall not be covered by the Insurer.

3.4 If the fact of concealment by the Insured (Insured) of information about the Insured's condition and/or previously diagnosed diseases specified in clause 3.2 at the time of conclusion of the insurance agreement is revealed. of this Article at the time of conclusion of the Insurance Agreement, the Insurer shall have the right to terminate the Insurance Agreement concluded in respect of such persons ahead of schedule.

4. INSURANCE AMOUNT. PROCEDURE FOR DETERMINING INSURANCE AMOUNTS

4.1. Total insurance amount (insurance limit) – the amount of money determined by the Insurance Agreement, within which the Insurer undertakes to make an insurance payment, and which is the basis for determining the amount of the insurance premium.

4.2. The Insured's sum insured is the maximum amount of the Insurer's liability under the Insurance Agreement in the event of an insured event or several insured events for the entire period of validity of the Insurance Agreement, which is determined by agreement between the Insured and the Insurer separately for each Insured in accordance with the selected Insurance Program.

4.3. The sum insured may be established both for the entire Insurance Agreement and for certain types of services and/or Diseases, both for each Insured and for the Insured as a whole, in accordance with the terms of the Insurance Agreement and the selected Insurance Program.

4.4. During the term of the contract, the sum insured may be changed by agreement of the parties by entering into an addendum to the Insurance Agreement.

5. MEDICAL INDICATIONS

5.1. Medical services and medicines are considered prescribed in accordance with medical indications, if these medical services and medicines are necessary and sufficient for the diagnosis and/or treatment of the Disease in the Insured.

5.2. Medical services and medicines are not considered prescribed in accordance with medical indications if these medical services and medicines:

1) are not necessary for the diagnosis and/or treatment of the Disease in accordance with the current standards and protocols for the diagnosis and/or treatment of such a Disease;

2) are prescribed in an amount (in terms of intensity, quantity or duration) greater than is required for the diagnosis and/or treatment of the Disease in accordance with current standards and protocols;

3) are appointed as part of an experiment or research work.

5.3. The insurer does not cover the costs associated with additional diagnostics of other diseases and treatment of concomitant or additionally diagnosed diseases, as well as additional costs for accommodation in superior rooms.

6. INSURED EVENT

6.1. Insured Event shall mean the occurrence of a disease in the Insured, which resulted in the Insured Person's application to the Medical Service Providers during the term of the Insurance Agreement for medical care/medicines or services provided for by the Insurance Program.

6.2. The Insured Person's application for medical services shall not be considered an Insured Event:

1) not provided for by the insurance contract;

2) received in medical institutions, not from the list of the Insurer's Representative or not provided for by the Insurance Program, without prior agreement with the Insurer's Representative (Assistance);

3) in connection with the injury of the Insured Person when driving any vehicle in a state of alcoholic, narcotic or toxic intoxication, as well as when transferring control to a person who was in a state of alcoholic, narcotic or toxic intoxication;

4) in connection with the intentional infliction of bodily harm by the Insured Person, suicide attempts, except for those cases when the Insured Person was brought to such a state by illegal actions of third parties.

6.3. The Insured Person's application for medical services, the need to receive which arose as a result of:
1) the impact of a nuclear explosion, radiation or radioactive contamination;
2) accidents at production and other facilities that caused mass damage;
3) military operations, as well as maneuvers or other military measures;
4) civil war, civil unrest of all kinds and strikes, the introduction of a state of emergency or a state of emergency by order of the military and civil authorities;
5) natural disasters (floods, fires, earthquakes and other natural disasters).

6.4. The Insurance Agreement is concluded under the Insurance Program, which provides for the terms of insurance coverage, the main features of the Insured Event and the insurance amounts (insurance limits) both under the insurance contract as a whole and for certain types of services or Diseases. These Insurance Programs may provide for the provision of the following types of medical services to the Insured Person:
1) outpatient care, home care;
2) inpatient medical care;
3) emergency medical care;
4) rehabilitation and rehabilitation treatment;
5) as well as coverage of other expenses or provision of services in accordance with the Insurance Program and the terms of the Insurance Agreement.

6.5. The Insurer shall not be liable for the result or quality of medical and other services, procedures, treatment or counseling provided to the Insured under the Insurance Agreement.

6.6. The insurer is not responsible for the timely receipt of medical services when quarantine measures are introduced in the insurance territory.

7. EXCLUSIONS FROM INSURED EVENTS AND INSURANCE LIMITATIONS

7.1. Is not a Disease and/or an Insured Event, according to the terms of these insurance rules, unless otherwise specified in the insurance program:
1) diseases specified in the Order of the Minister of Health of the Republic of Kazakhstan dated October 14, 2009 No. 526 "On Approval of the List of Diseases, the Treatment of Which Is Prohibited in the Non-State Healthcare Sector", as well as diseases specified in the Order of the Minister of Health and Social Development of the Republic of Kazakhstan dated May 21, 2015 No. 367 "On Approval of the List of Socially Significant Diseases and Diseases Posing a Danger to Others:
   a) quarantine infections: smallpox, poliomyelitis (caused by wild poliovirus), human influenza (caused by a new subtype), severe acute respiratory syndrome (SARS), cholera, plague, yellow fever, Lassa fever, Marburg virus disease, Ebola virus disease, West Nile fever, dengue fever, Rift Valley fever, meningococcal disease;
   b) especially dangerous infections: HIV infection (AIDS), Crimean hemorrhagic fever, hemorrhagic fever with renal syndrome, leprosy, rabies, leptospirosis, listeriosis, tuberculosis, tularemia, brucellosis, anthrax, foot-and-mouth disease;
   c) parasitic diseases: echinococcosis, malaria, scabies, etc.;
   d) airborne infections: diphtheria, whooping cough, measles, rubella, mumps, carriage of diphtheria pathogens, congenital rubella infection (congenital rubella syndrome), haemophilus infection, tetanus;
   e) Acute infectious diseases:
   - acute viral hepatitis, typhoid fever and paratyphoid A, B, C, salmonellosis, dysentery, yersiniosis, rickettsiosis, tick-borne viral encephalitis;
   f) epidemics and epizoodies, unless otherwise provided by the insurance program.
2) in other cases provided for by the legislative acts of the Republic of Kazakhstan, these Insurance Rules and the insurance agreement.

7.2. Also, the following is not a Disease and/or an Insured Event, according to the terms of these Rules:

1) mental illnesses (as well as injuries and somatic diseases arising in connection with diseases of a mental nature), epilepsy;
2) narcological diseases (drug addiction, substance abuse, alcoholism);
3) hereditary degenerative diseases of the nervous system and muscles (Parkinson's disease, Huntington's chorea, myasthenia gravis, myopathy, hereditary cerebellar ataxias of Pierre-Marie, Friedreich's disease, progressive muscular dystrophy, neural amyotrophies; hepato-cerebral dystrophy (Wilson-Konovalov disease);
4) demyelinating diseases of the nervous system (Alzheimer's disease, multiple sclerosis, Devic's disease, leukoencephalopathy, Guillain-Barré syndrome, syringomyelia, ALS – amyotrophic lateral sclerosis); cerebral palsy;
5) Phenylketonuria; Cystic fibrosis; congenital ichthyosis;
6) parasitic and infectious diseases (caused by helminths and arthropods): ascariasis, giardiasis, hookworm, opisthorchiasis, cestodiasis, demodicosis, arachnoses, entomoses, etc.;
7) the state of rehabilitation after myocardial infarction;
8) the state of rehabilitation after cerebral circulation disorders;
9) benign and malignant neoplasms, including oncohematological, cysts, polyps, papillomas, fibroids, condylomas, etc., and hyperplastic processes (adenoid growths, cervical erosion, including pseudoerosion, leukoplakia, endometriosis, etc.);
10) chronic skin diseases: mycoses, psoriasis, neurodermatitis, atopic dermatitis, alopecia, congenital ichthyosis, vitiligo, acne, as well as any types/forms of lichen, regardless of nosology;
11) mycoses, except for mycoses caused by recent antibiotic therapy, as well as mucous membranes of the oral cavity, ENT organs, pulmonary mycosis, gastrointestinal candidiasis;
12) diagnosis and treatment of sexually transmitted diseases (STDs) (ELISA, PCR and RIF), including: gonorrhea, syphilis, chancroid, inguinal granuloma, trichomoniasis, chlamydia, mycoplasmosis, cytomegalovirus infection, genital herpes, ureaplasmosis, gardnerellosis, candidiasis, etc.;
13) intestinal diseases: Crohn's disease, ulcerative colitis, dysbacteriosis, celiac disease, chronic enteritis, etc.;
14) diagnosis and treatment of diseases of the musculoskeletal system (scoliosis, kyphosis, lordosis, flat feet, osteoporosis, heel spur, dysplasia, chronic osteomyelitis, etc.);
15) inpatient treatment of osteochondrosis;
16) eye and eyelid diseases: myopia, astigmatism, hyperopia, cataracts, glaucoma, retinopathy, chalazion, spasm of accommodation, long-term consequences of eye injury in the form of retinal detachment, eyelid massage and eyeball biostimulation services Costs associated with surgical vision correction, including the use of laser, manipulations associated with the use of hardware and software systems in ophthalmology;
17) medical expenses associated with plastic reconstructive (restorative) operations; cosmetic treatment and other treatments related to the elimination of appearance imperfections or bodily abnormalities, including rhinoplasty for cosmetic and therapeutic purposes; medical expenses associated with weight and body correction; expenses related to sex reassignment surgery, etc.;
18) diagnosis and treatment of nutritional disorders and metabolic disorders: obesity, uric acid diathesis, gout, dystrophy, etc.;
19) diagnosis and treatment of endocrine diseases: thyroid diseases, including hypothyroidism, hyperthyroidism, endemic goiter and their consequences (except for the initial consultation with an endocrinologist and single examinations before diagnosis); glucose intolerance syndrome, type I-II diabetes mellitus, diabetes insipidus, Addison's disease, chronic hypocorticism;
20) diseases related to rheumatic diseases: systemic lupus erythematosus, periarteritis nodosa, systemic scleroderma, dermatomyositis, ankylosing spondylitis, Shagren's disease, polioosteoarthrosis, spondylosis, rheumatoid arthritis; polyarthritis, DOA (deforming osteoarthritis), rheumatism, systemic vasculitis, microcrystalline arthritis (for example, gout)

and other diseases related to rheumatic diseases according to the working classification of rheumatic diseases of the World Health Organization;

21) autoimmune diseases: AIT (Hashimoto's disease), AIH (hepatitis), AI blood diseases, etc.);
22) diseases of the genitourinary system: polycystic kidney and ovarian disease; chronic glomerulonephritis, chronic renal failure, renal amyloidosis, nephroangiosclerosis, hydronephrosis, congenital anomalies of the kidneys and urinary tract, enuresis of any origin;
23) diagnosis and treatment of gynecological diseases, unless it is provided for by the Insurance Agreement;
24) diagnosis and treatment of prostatitis and prostate adenoma, urological massage;
25) diagnosis and treatment of infertility, menstrual disorders, potency disorders, menopause, all methods of contraception; medical expenses related to genetic research and/or other family planning services;
26) chronic diseases of the respiratory system: bronchial asthma, bronchiectasis, COPD (chronic obstructive pulmonary disease), pulmonary emphysema and other chronic lung diseases with respiratory failure;
27) chronic diseases of the cardiovascular system with circulatory insufficiency;
28) liver diseases: cirrhosis of the liver, chronic hepatitis of any etiology, steatohepatosis (fatty hepatosis);
29) chronic renal failure, chronic heart failure and chronic liver failure, and other diseases of organs and tissues that require hemodialysis, as well as other extracorporeal methods of treatment: plasmapheresis and hemosorption, ultraviolet blood ultraviolet radiation, laser irradiation of blood (VLOK);
30) diseases of the central nervous system: conditions after cerebral circulation disorders and its consequences;
31) chronic vascular diseases: varicose veins of the lower extremities, varicocele, varicose veins of the rectum - requiring surgical treatment; aneurysm, Takayasu's disease (nonspecific aortoarteritis), Buerger's disease (thromboangiitis obliterans), endoarteritis obliterans, Wegener's syndrome that obliterates atherosclerosis;
32) medical expenses related to the treatment of chronic diseases, except for cases that pose a threat to the life of the insured (emergency indications);
33) chronic and other diseases and their consequences that arose before the beginning of the insurance period, unless it is provided for by the insurance contract;
34) diagnosis and treatment of visible hereditary pathology (dwarfism, accelerated puberty), hereditary, gene, chromosomal diseases and congenital and acquired malformations, cerebral palsy;
35) medical expenses associated with diagnostics on the Unicap device and treatment of allergic chronic diseases, allergy diagnostics, treatment of allergic diseases by the method of specific hyposensitization;
36) therapeutic methods used in the period of remission of respiratory allergoses (e.g., specific hyposensitization, histamine therapy and methods of vegetative therapy);
37) the use of pharmaceuticals, outpatient and inpatient treatment, immunogram, ELISA diagnostics, physiotherapeutic procedures in the period of clinical and laboratory remission of allergic diseases;
38) non-traditional methods of diagnosis and treatment: iridology, auriculodiagnostics, water procedures, dry and underwater extracts, mud therapy, autohemotherapy, hyperbaric oxygenation (HBO), vacuum therapy, manual therapy, acupuncture reflexology, herbal medicine, treatment in a hyperbaric chamber, fluting baths, occupational therapy, hirudotherapy, Voll study, IFS, bioresonance therapy, acupuncture, SWT, etc., homeopathy, intestinal irrigation, pearl and other baths, hijama;
39) massage not prescribed by a doctor for medical reasons in connection with a disease or carried out more than one course;
40) age-related degenerative changes in the body;
41) selection, purchase and repair of corrective equipment (glasses, lenses, prosthetic and orthopedic products, hearing aids, etc.);

42) diseases of organs and tissues requiring their transplantation or implantation, or prosthetics, including endoprosthetics, reconstructive operations, organ and tissue transplantation operations, as well as the consequences of such operations;
43) medical expenses associated with coronary angiography; as well as surgical interventions on the heart (coronary artery bypass grafting, stenting, IVR installation, etc.);
44) consultations and all methods of laboratory and instrumental examinations related to pregnancy and obstetrics, unless otherwise included in the insurance program;
45) expenses related to sterilization related to the termination of pregnancy (medical and medical abortions), except for cases that directly threaten the life of the Insured. Consequences and complications of such manipulations;
46) patronage of a child under 1 (one) year of age, unless otherwise provided by the insurance program;
47) issuance of sick leave for child care, if the parent to whom the sick leave is issued and/or the child is not the Insured, unless it is provided for by the Insurance Agreement;
48) medical costs associated with ELISA, PCR and RIF diagnostic methods in order to determine the level of sex hormones of the blood responsible for reproductive function;
49) medical expenses related to diagnostic examinations by computed tomography (CT), magnetic resonance imaging (MRI, NMR), unless it is provided for by this Insurance Agreement;
50) dental expenses for prosthetics, preparation for orthopedics, cosmetology (whitening, cleaning and removal of dental plaque), orthodontics, unless otherwise provided by the insurance program;
51) medical expenses related to the services of a psychologist and psychotherapist;
52) occupational diseases (diseases resulting from the impact of unfavorable factors of the working environment on the body);
53) diseases or accidents resulting from military actions or direct participation of the Insured in public disorders, strikes, civil unrest of various kinds, rallies, natural disasters;
54) injury, illness, deterioration of health resulting from alcohol or narcotic, psychotropic intoxication, with the exception of the use of medicines with high and medium concentrations of alcohol or narcotic drugs and psychotropic substances as prescribed by a doctor;
55) intentional infliction of bodily harm, including attempted suicide;
56) diseases or injuries resulting from professional or amateur sports, including mountaineering, speleology, participation in horse races, car racing, aircraft control, participation in various types of tests;
57) damage caused by the activities of persons that create an increased danger to others (a source of increased danger) and who, in accordance with the legislation of the Republic of Kazakhstan, are obliged to compensate for the damage caused;
58) damage caused by persons who, in accordance with the legislation of the Republic of Kazakhstan, bear civil liability and are obliged in accordance with the legislation of the Republic of Kazakhstan to compensate for harm caused to the life and health of third parties;
59) acute and chronic radiation sickness;
60) medical expenses associated with passing a medical commission (medical examination) for admission to study, preschool and school institutions, for work or military service, for participation in sports events, for obtaining permission to enter another state, for obtaining permission to drive a vehicle, carry weapons, for obtaining a deferment or exemption from military service, for obtaining certificates for attending sports (health) organizations, events;
61) expenses for diseases with preventive and planned treatment, unless otherwise provided by the insurance program;
62) costs associated with the treatment of allergic diseases and allergy diagnostics;
63) purchase of medical devices for prophylactic, therapeutic indications (masks, inhalers, thermometers, bandages, cotton wool, adhesive plaster, enemas, etc.), as well as the purchase of non-medical drugs (exceptions syringes, systems, venous catheters for any indications; plates, wires, screws, plaster necessary for emergency indications);

64) other cases provided for by the legislative acts of the Republic of Kazakhstan, these Insurance Rules and the insurance agreement.

7.3. The following medicines are not included in the Insurance Coverage (is not an Insured Event):
1) contraceptives (except for those cases when prescribed for therapeutic indications);
2) multivitamins (except vitamins for intravenous and intramuscular use);
3) anti-tuberculosis drugs in the treatment of tuberculosis (except for cases when antibiotics are used for allergy to all other groups of antibiotics);
4) biologically active additives (BAAs);
5) homeopathic medicines;
6) anorexants;
7) cosmetics and hygiene products;
8) biological stimulants;
9) enzymes (other than digestive enzymes);
10) antidepressants, nootropics.

7.4. The Insurance Plan may provide for the re-inclusion in the Insurance Coverage of some of the exclusions specified in clauses 7.1. and 7.2. of this article, or additional exclusions from the Insurance Coverage may be provided. This clause shall apply to cases where the parties conclude and sign an insurance contract in writing on paper.

7.5. Insurance restrictions are specified in clause 3.2. Article 3 of these Rules.

8. AMOUNT, PROCEDURE AND TERMS OF PAYMENT OF THE INSURANCE PREMIUM

8.1. Insurance premium is the amount of money that the Insured is obliged to pay to the Insurer for the obligation assumed by him to make an insurance payment to the Insured (beneficiary) in the amount determined by the insurance contract.

8.2. Insurance premium - when paying the insurance premium in installments - a part of the insurance premium paid by the Insured.

8.3. The amount of the insurance premium under the insurance contract depends on the Insurance Programs selected by the Insured, the amount of the insured amount and the insurance period.

8.4. The insurance premium is paid by the Insured in a lump sum - as a one-time payment for the entire insurance period at the conclusion of the insurance contract or in installments (payment of insurance premiums). The procedure for payment of the insurance premium is determined in the insurance contract.

8.5. If the insurance premium or the first insurance premium is not paid on time, the Insurer has the right to terminate the Agreement early from the date of non-payment of the insurance premium. In this case, a written notification of the Insurer to the Insured is not required.

8.6. If by the time of the insured event the insurance premium (first insurance installment) is still not paid, the Insurer:
- is exempt from fulfilling its obligations under the Agreement and is not responsible for insured events that occurred during the specified period, or
- has the right to set off the amount of unpaid insurance premium (insurance premium) when determining the amount of insurance payment.

8.7. The insurance premium may be paid by the Insured or on his behalf by another person by:
1) non-cash payments;
2) in any other way not prohibited by the current legislation of the Republic of Kazakhstan, by agreement of the parties.

9. INSURANCE CONTRACT: TERM AND PLACE OF VALIDITY, PROCEDURE FOR CONCLUSION, TERMS OF TERMINATION

9.1. An insurance contract (insurance policy) shall be concluded for a period of not more than 12 months with validity in the territory of the Republic of Kazakhstan, unless otherwise provided by the terms of the insurance agreement.

9.2. The Insurant shall compile a list of the Insured Persons in the form established by the Insurer, which shall be attached to the insurance agreement and shall be an integral part thereof.

9.3. The Insured Person may be replaced by the Insurant with the consent of the Insurer. Until the Insurer receives the said changes, the concluded agreement remains in force in relation to the Insured Persons specified in the previously submitted lists, except for cases of insurance of individuals under an insurance policy.

9.4. The Insurer has the right to request the Insured Person to fill in a medical questionnaire in the prescribed form. The Insured/Insured is responsible for the accuracy and completeness of the information provided by him/her during the medical questionnaire. At the same time, the Insured is obliged to inform the Insured (the person who will be included in the list of the Insured) of such a need. When insuring individuals, filling out a medical questionnaire is mandatory.

9.5. The Insurer has the right to verify the accuracy of the data specified by the Insured Person. In the event that it is established that the Insured/Insured has provided false data about himself/herself that are essential for assessing the degree of insurance risk, the Insurer may offer to pay an additional insurance premium or refuse to conclude an insurance contract with the Insured, and if the Agreement has been concluded, then refuse to make an insurance payment.

9.6. An insurance contract (insurance policy) is concluded by drawing up one document signed by the Insured and the Insurer.

9.7. Within 7 working days after payment of the insurance premium (insurance premium), subject to the submission of the List of the Insured, the Insured shall be provided with Medical Plastic Cards (according to the number of Insured Persons) with the Insurance Rules and Insurance Programs attached, except for cases of insurance of individuals under the insurance policy.

9.8. The Insurer has the right to independently (personally or through an insurance intermediary) hand over the above documents to the Insured Persons.

9.9. Unless otherwise provided herein, the insurance contract (insurance policy) shall enter into force on the day following the day after the receipt of the insurance premium in full to the Insurer's bank account and shall be valid until the end of the term established in the insurance agreement (insurance policy).

9.10. Insurance stipulated by the insurance contract extends its effect to insured events that occurred within the terms specified in the insurance contract in the territory of the Republic of Kazakhstan or in the territory of other countries, if it is provided for in the insurance agreement (insurance policy). The minimum insurance period for individuals is at least 7 days, the maximum is 12 months.

9.11. In addition to the general grounds for termination of obligations provided for by the legislation of the Republic of Kazakhstan, the Insurance Agreement shall be terminated early in the following cases:

1) expiration of its validity period;
2) fulfillment by the Insurer of its obligations under the insurance contract in full (payment of the cost of medical services in the amount of the insured amount);
3) death of the Insured Person, if only one person was insured under the insurance contract and this is not an insured event;
4) adoption by the court of a decision to invalidate the insurance contract;
5) termination of the contract by agreement of the parties;
6) termination of the insurance contract at the initiative of the Insured;
7) termination of the insurance contract at the initiative of the Insurer in the following cases:
   - ✓ failure by the Insured to pay the insurance premium (its next insurance premium) within the established time limits;
   - ✓ refusal of the Insured, notified of the increase in the cost of medical services, to change the terms of the contract or to pay an additional insurance premium at the request of the Insurer;
   - ✓ establishment of the fact of transfer of the Medical Plastic Card by the Insured Person to another person for the purpose of receiving medical services under the insurance contract;
8) in other cases provided for by the legislation of the Republic of Kazakhstan and the insurance agreement.

9.12. The Insured has the right to withdraw from the Insurance Agreement (insurance policy) at any time by giving the Insurer a written notice 3 (three) business days prior to the expected date of termination.

9.13. In case of early termination of the insurance contract (insurance policy) under the circumstances provided for in paragraph 1 of Article 841 of the Civil Code of the Republic of Kazakhstan, the insurer shall be entitled to a part of the insurance premium in proportion to the time during which the insurance was in effect, and the Insurer shall have the right to deduct administrative costs for conducting business in the amount of 25% of the insurance premium, unless another amount is established by the insurance contract. Return of insurance premiums (contributions) in case of liquidation of the Insurer shall be carried out in accordance with the priority of satisfaction of creditors' claims established by the legislation of the Republic of Kazakhstan on insurance and insurance activities.

9.14. In case of early termination or termination of the Insurance Agreement (insurance policy) under circumstances other than those specified in paragraph 1 of Article 841 of the Civil Code of the Republic of Kazakhstan, as well as in case of the Insured's refusal from the insurance contract, the insurance premium paid by the Insured to the Insurer shall not be refunded.

9.15. In cases where early termination of the Insurance Agreement (insurance policy) is caused by non-fulfillment of its terms through the fault of the Insurer, the latter is obliged to return to the Insured the insurance premium paid by him in full, no later than 30 (thirty) calendar days after establishing the fault of the Insurer, in the manner prescribed by the legislation of the Republic of Kazakhstan.

9.16. In case of refusal of the Insured-individual from the Insurance Agreement, within fourteen calendar days from the date of its conclusion, the Insurer shall be obliged to return to the Insurant-individual the insurance premium (insurance premiums) received minus a part of the insurance premium (insurance premiums) in proportion to the time during which the insurance was in effect and the costs associated with the termination of the Insurance Agreement, not exceeding ten percent of the insurance (received) received premiums (insurance contributions).

9.17. If an insurance payment was made under the Insurance Agreement (insurance policy), then the paid insurance premium, regardless of the grounds for the occurrence of early termination of the Insurance Agreement, is not subject to refund.

9.18. The Insurance Agreement (insurance policy) may be terminated at the request of the Insurer in case of non-fulfillment or improper fulfillment by the Insured of his obligations under the Insurance Agreement, or in case of exceeding the limit by the Insured for one of the types of services, when he refuses to pay for the received medical services at his own expense. In this case, the insurance premium is not refundable.

9.19. Amendments to the Insurance Agreement (insurance policy) at the initiative of the Insured shall be made on the basis of a written application submitted to the Insurer and the consent of the Insurer.

9.20. Changes to the Insurance Agreement shall be made in writing.

9.21. The conditions and consequences of invalidation of the Insurance Agreement (insurance policy) are provided in accordance with the norms of the current legislation of the Republic of Kazakhstan.

10. RIGHTS AND OBLIGATIONS OF THE PARTIES

10.1. **The Insured (Insured) has the right to:**

3) familiarize themselves with the terms and conditions of insurance, receive a copy of the Insurance Rules, receive explanations about the Insurance Rules, the terms and conditions of the Insurance Agreement and the Insurance Programs, as well as the procedure for the provision of Medical Services and Authorized Medical Service Providers;
4) contact the Insurer's Representative to arrange Medical Care in case of Illness;
2) appeal in court against the Insurer's refusal to make the Insurance Payment;
3) early terminate the Insurance Agreement in accordance with the procedure established by the legislation of the Republic of Kazakhstan;
4) monitor compliance with the terms of the Insurance Agreement;

5) change the composition and number of the Insured by sending a written notice to the Insurer. In this case, an additional agreement to the Agreement is concluded and the amount of the insurance amount and insurance premium is recalculated;
6) exercise other rights provided for by the legislation of the Republic of Kazakhstan and this Agreement.

10.2. The Insured (Insured) is obliged to:

1) when entering into the Insurance Agreement, inform the Insurer of all circumstances known to it that are essential for the assessment of the insurance risk and the Insurer's decision to conclude the Insurance Agreement in accordance with the Insurer's request (questionnaire);
2) pay insurance premiums in the amount, procedure and terms established by the Agreement;
3) in case of occurrence of an insured event, notify the Insurer in the manner provided for by paragraph 1 of Article 13 of these Rules;
4) comply with the terms of the Agreement, the prescriptions and prescriptions of the attending physician received during the treatment of the Disease, as well as the regime and routine of the hospital in case of hospitalization. Failure to comply with this requirement may serve as a basis for refusal of the Insurance Payment for insured events resulting from a proven violation of such appointments and instructions, regime and order;
5) take care of the safety of the medical plastic card, and not transfer it to other persons for the purpose of receiving medical services by such persons under the Insurance Agreement, immediately after the discovery of this fact, notify the Insurer;
6) in case of loss of the Medical Plastic Card or indication of incorrect information by the Insured when filling in the data for ordering the card, to pay the amount determined by this Insurance Agreement on account of reimbursement of the Insurer's costs for re-issue of the Medical Plastic Card;
7) in case of dismissal of the Insured in connection with dismissal, termination of the employment contract, notify the Insurer of the termination of insurance in respect of such employee and members of his/her family no later than within 24 (twenty-four) hours after termination of the employment contract. In case of untimely provision of the above information, the Insured shall reimburse the Insurer for the costs of Medical Care of the detached Insured, incurred in the period after termination of the employment contract and before the date of notification of the Insurer;
8) provide the Insurer with all available information and documents that allow to judge the causes, course and consequences of the insured event, the nature and amount of the loss caused;
9) take all possible and appropriate measures to prevent or reduce losses from the insured event;
10) independently inform the Insured of his/her rights and obligations under this Agreement;
11) familiarize the Insured with the terms and conditions and Rules of insurance;
12) ensure the written consent of the Insured to the collection, processing and transfer, storage of the Insured's personal data by the Insurer and other persons directly related to the provision of services under the Insurance Agreement;
13) provide the documents and information requested by the Insurer regarding the Insured (the risk assumed by the Insurer) and necessary to comply with the requirements of the legislation of the Republic of Kazakhstan.

10.3. The insurer has the right to:

1) check the information provided by the Insurant (Insured Person), as well as the fulfillment by the Insurant (Insured) of the requirements and terms of the Insurance Agreement;
2) request medical history and any other medical information about the Insured Person, including information about the state of health of the Insured Person;
3) send inquiries to the relevant Medical Service Providers and other competent organizations on the fact of the insured event;

4) independently find out the causes and circumstances of the event that has signs of an insured event;
5) require the Insured to fill out the Insurer's questionnaire on the state of health and/or send the Insured to undergo a medical examination to assess the actual state of his health (at the expense of the Insurer). In case of detection of inaccurate information in the questionnaire or refusal of the Insured to undergo a medical examination, the Insurer has the right to terminate or limit the insurance coverage in respect of such Insured;
6) require from the Insurant (Insured Person) information and documents necessary to establish the fact of the insured event, the circumstances of its occurrence, as well as to undergo an independent medical examination (at the expense of the Insurer) to confirm the reimbursable expenses;
7) refuse to pay the insurance indemnity if the Insured Person has not provided documents confirming the receipt of Medical Care, has refused to undergo a medical examination;
8) refuse insurance payment if the Insured has received medical services not provided for by the insurance agreement, has not notified the Insurer or its representative about the insured event when applying to a medical institution for medical services;
9) refuse insurance payment if the insured has received medical services without the referral or permission of the Insurer's Representative, has received medical services in medical institutions not included in the list of the Insurer's Representative (except for cases when he/she has received the permission of the Insurer's Representative to receive medical services in medical institutions not from the Insurer's list);
10) require amendments to the terms of the Insurance Agreement or payment of an additional insurance premium in proportion to the increase in risk if significant changes in the insurance risk have occurred after the signing of the Insurance Agreement;
11) require the Insured/Beneficiary to provide documents and information necessary for the identification of the client (his/her representative) in accordance with the requirements of the legislation of the Republic of Kazakhstan;
12) block the validity of the medical plastic card of the Insured Person and suspend the insurance coverage, in cases provided for by the insurance agreement;
13) suspend/refuse to carry out transactions with money and (or) other property under the Insurance Agreement in order to comply with the legislation on combating the legalization (laundering) of proceeds from crime and the financing of terrorism.

10.4. **The insurer is obliged to:**

1) familiarize the insured with the terms of insurance and, at his request, submit (send) a copy of the Insurance Rules. Sending the Insurance Rules to the e-mail address specified by the Insured or providing the Insurance Rules by posting them on the Insurer's website is the proper provision of the Insurance Rules;
2) in the event of an insured event, make an insurance payment in the amount, procedure and terms established by the Insurance Agreement;
3) reimburse the Insurant (Insured Person) for the expenses incurred by him/her to reduce losses in case of an insured event;
4) ensure the secrecy of insurance;
5) within 7 (seven) working days, after payment of the insurance premium, issue medical plastic cards / electronic extract of the established form from the insurance contract to the Insured (Insured Person);
6) to provide the Insured with insurance protection in the territory of insurance;
7) at the written request of the Insured, within 7 (seven) business days after receipt of the request, provide a report on the insured events for the period from the beginning of the Agreement to the date of the request;
8) organize the provision of Medical Services to the Insured provided for by the Agreement and the relevant Insurance Program, taking into account the working hours of the Medical Providers.

10.5. The Parties shall have the right to exercise other rights and perform other obligations provided for by the Insurance Rules and the provisions of the current legislation of the Republic of Kazakhstan.

10.6. **The insured has the right to:**

1) apply for the necessary medical care to medical organizations from the List of the Insurer's Representative specified in the Appendix to the Insurance Agreement;
2) to receive medical services as part and in the amount provided for by the Insurance Agreement and Appendices to the Insurance Agreement;
3) before contacting a medical organization from the list of the Insurer's Representative for medical care (service) established by the Agreement, contact the Insurer's Representative and receive information on further actions;
4) other rights provided for by the Insurance Rules and provisions of the current legislation of the Republic of Kazakhstan.

10.7. **The insured is obliged to:**

1) take care of the safety of the Medical Plastic Card and not transfer it to other persons for the purpose of receiving medical services;
2) inform the Insurer or its representative about the occurrence of an insured event when applying to a medical institution for medical services;
3) comply with the terms of the Insurance Rules and the Insurance Agreement, comply with the instructions of the attending physician and the procedure established in the medical organization;
4) provide the Insurer's Representative with all the information available to him/her that allows him to judge the causes, course and consequences of the insured event, the nature and amount of the damage caused;
5) take care of their health;
6) when receiving medical services provided for in the insurance programs, present to the doctor and/or to the medical organization from the list of the Insurer's Representative the medical plastic card of the Insured and the identity card;
7) obtain a written permission from the Insurer's Representative or a referral from a doctor from the list of the Insurer's Representative in cases specified in the insurance programs of Article 13 of the Agreement;
8) in case of emergency hospitalization to a medical organization not from the list of the Insurer's Representative, as well as from the List of the Insurer's Representative, no later than 3 (three) business days, inform the Insurer's Representative personally or through his representative about the occurrence of the insured event.
9) transfer to the Insurer's Representative all information, including medical and other documents related to the insured event, necessary for the Insurer's Representative to clarify all circumstances related to the occurrence of the insured event;
10) keep the medical plastic card and not transfer it to other persons for the purpose of receiving medical services;
11) The Insured or members of his/her family in case of receiving medical services and/or purchasing medicines after the termination of the insurance coverage in respect of the Insured, or not provided for by the insurance program, are obliged to reimburse the Insurer's Representative for these expenses within 3 (three) business days from the date of receipt of the request for payment;
12) upon dismissal, immediately return the identification card to the Insured;
13) within 3 (three) business days after receipt of the Insured's notification about the excess of the insurance amount by the Insured for the medical services rendered to him/her, is obliged to pay the amount of overexpenditure to the bank account of the Insurer's Representative, or in cash to the cash desk of the Insurer's Representative;
14) inform the Insurer about the circumstances entailing an increase in the insurance risk;
15) provide all documents and information requested by the Insurer necessary to comply with the requirements of the legislation of the Republic of Kazakhstan;

16) perform other duties provided for by the Insurance Rules, the Insurance Agreement and the legislation of the Republic of Kazakhstan.

11. CONSEQUENCES OF AN INCREASE IN INSURANCE RISK DURING THE TERM OF THE INSURANCE CONTRACT

11.1. A significant increase in the insurance risk is the detection of any chronic disease or circumstance included in the list of exclusions from insured events or Diseases provided for in clause 3.2 in the Insured Person. of Article 3 of these Rules that are not known to the Insurer and/or the Insured before the date of conclusion of the Insurance Agreement. Such an increase in insurance risk can be identified on the basis of questionnaires, medical treatment, in the course of Medical Care and on the basis of information of the Insured Person, or on the basis of other factual data.

11.2. An insurer who has become aware of the circumstances entailing an increase in insurance risk has the right to demand a change in the terms of the insurance contract or payment of an additional insurance premium in proportion to the increase in insurance risk.

11.3. In case of detection of signs of fraudulent actions (fraud) on the part of the Insured Person, the Insurer has the right to demand the exclusion of such Insured Person from the list of Insured Persons without revising the insurance premium under the Insurance Agreement.

11.4. The Insurer is not entitled to demand changes in the terms of the Insurance Agreement, if the circumstances entailing an increase in the insurance risk have already disappeared.

12. SUBSTITUTION/INCREASE/EXCLUSION OF THE INSURED

12.1. Replacement/increase/exclusion of the Insured shall be carried out with the mandatory written notice of the Insurer and shall enter into force after the signing of an additional agreement to the Insurance Agreement by the authorized representatives of the parties. After signing such an additional agreement to the Insurance Agreement, the insurance premium shall be recalculated for the shortened insurance period.

12.2. Information about the Insured's employees with whom the employment relationship has been terminated shall be transferred to the Insurer upon termination of the employment relationship, and such an insured shall be obliged to return the medical plastic card/ek to the Insurer. In case of exclusion of the main insured (employee), family members are automatically detached. In cases where insurance payments for the Insured with whom the employment relationship has been terminated and for his/her family members have not been made, the Insurer shall return to the Insured the insurance premium for the Insured and family members of the main Insured in accordance with the table in accordance with the Appendix to the Insurance Agreement.

In case the Insured and family members of the main Insured apply for medical services, the insurance premium for the Insured with whom the employment relationship has been terminated and for members of his family shall not be returned to the Insured.

12.3. The insurance coverage in respect of the Insured's employees with whom an employment contract has been concluded during the validity period of the Insurance Agreement shall commence on the date specified in the additional agreement signed by both Parties.

12.4. In the event that the Insured excluded from the list of the Insured (on the basis of his/her dismissal) has not used the medical services provided by doctors and/or medical organizations from the list of the Insurer's Representative, the Insured shall be replaced by the Insured without additional payment of the insurance premium for the new Insured, provided that the latter is insured under a similar insurance program, as agreed by the Parties.

12.5. In the event that the Insured excluded from the list of the Insured has used medical services provided by doctors and/or medical organizations from the list of the Insurer's Representative, the Insurer shall be entitled to receive an additional insurance premium for the new Insured. The calculation of the additional insurance premium due to the Insurer for the shortened insurance period (for the new Insured) is carried out in accordance with the Appendix to the Agreement, while the insurance premium for the insured family members is paid in full. In this

case, the sum insured for the program and for individual medical services is recalculated in proportion to the remaining period of insurance coverage in accordance with the Appendix to the Agreement.

12.6. In case of inclusion in the list of Insured Employees of the Insured, with whom employment relations were commenced during the validity period of the Insurance Agreement, the insurance premium for the newly hired Insured is calculated in proportion to the remaining period of insurance coverage in accordance with the Appendix to the Agreement. In this case, the sum insured for the program and for individual medical services is recalculated in proportion to the remaining period of insurance coverage in accordance with the Appendix to the Insurance Agreement.

12.7. The Insurer shall issue to the Insured a medical service card issued to the newly admitted Insured within 7 (seven) business days from the date of payment of the insurance premium and transfer by the Insurant to the Insurer of the additional agreement signed by the Parties and annexes thereto, while the insurance documentation of the Insured shall indicate the dates of the beginning and end of the insurance coverage period for this Insured. Other terms may be established by agreement with the Insured.

12.8. Replacement of the Insured entails making appropriate changes to the Agreement by signing additional agreements to the Agreement. In case of replacement of the Insured, the Insured shall send to the Insurer a written notice of issuance of the relevant documents to the new person and return the documents of the Insured excluded from the list of the Insured.

12.9. Additional assignment of family members of employees is carried out within the first 30 (thirty) calendar days from the date of the start of the insurance contract. The insurance premium calculated for a family member is not subject to change regardless of the term of insurance, is not subject to refund when the main insured is detached. Replacement of attached family members with other family members of the Insured during the term of the Insurance Agreement is not allowed, unless it is provided for by the Insurance Agreement.

12.10. When insuring persons over 65 years of age (both the main insured and family members), the insurer has the right to require filling out a questionnaire for individuals and annexes to the questionnaire, subject to detailed information on diseases. In this case, the insurer applies adjustment factors.

12.11. Making additions to already selected insurance programs (increasing the volume of services provided) is formalized by an additional agreement indicating the cost of such an addition.

12.12. Insurance coverage in respect of the insured excluded from the List of Insured shall be terminated from 0.0 h 00 min. of the day following the date of notification of the insurer on termination of employment relations and exclusion from the List of Insured, in this case the medical plastic card of such insured shall be considered invalid from the moment of notification of the insurer and shall be returned to the insurer.

12.13. Insurance coverage of the insured included in the List of Insured begins according to the date specified in the application for assignment after the execution and signing of the relevant additional agreement to the insurance contract. The Insurer shall issue a medical plastic card to the insured included in the List of Insured within 3 (three) business days from the date of signing the relevant addendum to the insurance agreement.

12.14. In the event that after the date of exclusion of the insured from the List of Insured and before the date of return of the medical plastic card of such insured, an insured event occurred, and the insurer (Representative of the Insurer) made the insurance payment, the insurant/insured shall reimburse the cost of the insurance payment actually made to the Insurer.

13. ACTIONS OF THE INSURED PERSON UPON THE OCCURRENCE OF INSURED EVENT

13.1. In the event of the Disease, the Insured notifies of the occurrence of an insured event in one of the following ways:

1) apply to the Insurer's Representative (Assistance) for the organization of Medical Care by calling the CALL-center of the Insurer's Representative (Assistance) - whose phone number is indicated on the medical plastic card or in the electronic statement. The Insurer's

Representative (Assistance) organizes medical care for the Insured in medical institutions from the list of the Insurer's Representative

2) notify the Insurer's Representative (Assistance) of applying for Medical Care to a medical institution in case of emergency indications by calling the CALL-center of the Insurer's Representative (Assistance) within 24 (twenty-four) hours from the moment of application.

3) in case of an emergency call for an ambulance 103, notification of the insured event must be made within 24 hours from the time of arrival of the ambulance. Notification can be made by the Insured, relatives of the Insured or an ambulance doctor by calling the Insurer's CALL-center;

13.2. In the event that the Insured fails to notify the Insurer of the insured event in the manner described in paragraph 1 of this Article, the Insurer shall have the right to refuse the insurance indemnity or limit it to the amount at its own discretion.

13.3. Medical care prescribed by a doctor in connection with the Insured's Illness is considered an insured event, provided that such services are included in the insurance coverage in accordance with the terms of the Insurance Agreement and the relevant Insurance Program of the Insured. In the event of receiving Medical Services from Authorized Medical Service Providers, the Insurer shall pay the cost of Medical Services directly to such provider. In case of the Insured's application to a medical institution not from the Insurer's list, and without the referral or permission of the Insurer's Representative, payment of the insurance indemnity shall be made only in cases where the Insured has applied with a disease that poses a threat to his life (emergency indications, and provided that he or his representatives have notified the Insurer's Representative within the terms established by the contract to receive Medical Care in accordance with the terms of the Insurance Agreement upon submission of documents confirming the occurrence of an insured event in accordance with paragraph 1 of Article 14 of these Rules on the basis of the Application of the Insured (Insured) for reimbursement of the Insured's expenses (insurance payments). The application must be submitted no later than 10 (ten) days after receiving the services.

14. PROCEDURE FOR THE PROVISION OF MEDICAL SERVICES AND PAYMENT OF MEDICAL EXPENSES

14.1. In case of illness, the Insured/Insured shall apply to the Insurer's Representative for the organization of medical services from the list of the Insurer's Representative. In the event of an acute illness, when the state of health of the Insured does not allow him/her to go to a medical institution on his/her own, as a result of acute pain in the abdomen or in the area of the heart, hypertensive crisis, poisoning, body temperature above 38.5 C, the Insured/Insured has the right to call a doctor at home on weekends and working days or at the workplace on weekdays, if it is provided for by the Insurance Agreement. In case of emergency indications, contact the dispatcher by phone, who, if necessary, will call an ambulance team (or an intensive care team). In case of an unjustified call (false call, absence of the Insured at the place of call, call to an uninsured person, call to the Insured Person who is in a state of alcoholic, narcotic, substance abuse), the Insured/Insured is obliged to reimburse the costs incurred by the Insurer.

14.2. When applying to doctors and/or medical institutions from the Insurer's list, the Insured/Insured is obliged to present a medical plastic card and an identity card, a referral from a family doctor. The transfer of a medical plastic card to third parties is not allowed. If such a fact is detected, the card is withdrawn.

14.3. If necessary, the Doctor shall refer the Insured to a medical institution from the list of the Insurer's Representative to receive certain medical services (reception of narrow specialists, laboratory and instrumental tests, therapeutic measures, inpatient treatment, receipt of medicines, etc.). Receiving medical services or purchasing medicines is carried out only on the basis of a doctor's referral/prescription, excluding dental care.

14.4. The Insurant/Insured shall notify the Insurer's Representative of the results of visits to medical institutions and provide copies of conclusions, referrals, results of examinations and other documents drawn up when the Insured/Insured received medical services. The Insured/Insured shall receive medical services prescribed by a specialist (examinations, purchase of medicines,

etc.), as well as re-appointment with a specialist, only after receiving a referral/prescription from a family doctor, a coordinating physician of the Insurer's Representative.

14.5. The Insured/Insured shall not apply to doctors and/or medical institutions not specified in the Insurer's list.

14.6. The Insured's/Insured's application to doctors and/or medical institutions without the referral or consent of a family doctor/coordinator is not subject to reimbursement, and the Insurer is not responsible for the quality and volume of medical services received in these institutions.

14.7. Medical organizations and/or doctors are responsible for treatment in accordance with the legislation of the Republic of Kazakhstan.

15. LIST OF DOCUMENTS CONFIRMING THE OCCURRENCE OF AN INSURED EVENT AND THE AMOUNT OF LOSSES

15.1. The documents confirming the occurrence of an insured event and the amount of insurance payment are:

1) copies of an extract from the medical history of the Insured (outpatient or inpatient treatment), certified by the personal seal of the doctor and medical institution;
2) copies of medical reports of attending physicians, copies of prescription forms, dental work orders, copies of radiologists' conclusions, and other documents confirming the receipt of medical services;
3) originals of fiscal receipts and sales receipts (invoices, payment receipts) indicating the name of each medical product, procedures, doctors' consultations, their quantity and cost.
4) to receive reimbursement of the Insured's expenses for receiving Medical Care - application of the Insurant (Insured) with the attachment of documents specified in subparagraphs 1)-3) of this Article. The Insured is responsible for the provision of the above documents, their completeness and authenticity. All these documents shall be provided by the Insured/Insured no later than within 10 (ten) working days after the occurrence of the insured event. In case of submission of documents later than the above period, the Insurer has the right to refuse to reimburse expenses.

15.2. The specific list of documents is determined by the Insurance Agreement.

15.3. The Insurer has the right to request information from the Insured and/or the Medical Service Provider who provided the Medical Care to establish the fact of the occurrence of the insured event and the amount of the insurance payment. All such documents and information shall be submitted to the Insurer free of charge. Additional documents, as well as missing documents in accordance with clause 15.1. of Article 15 of these Insurance Rules shall be requested by the Insurer within 15 (fifteen) business days after receipt of the invoice from the Medical Service Provider or the application from the Insured.

15.4. Indemnity for insured events can be received either by the Insured himself, upon presentation of an identity card, or by his authorized person upon presentation of a power of attorney, certified by a notary, from the Insured with a copy of the identity card attached.

16. INSURANCE PAYMENT. PROCEDURE AND CONDITIONS FOR THE IMPLEMENTATION OF DECISIONS ON THE IMPLEMENTATION OF INSURANCE PAYMENTS OR REFUSAL OF INSURANCE PAYMENT

16.1. The beneficiary under these rules is:

1) An authorized provider of medical services in case of providing medical services to the Insured;
2) The insured in case of payment for medical services at his own expense in accordance with the terms of the Rules/Insurance Program.

16.2. The amount of insurance payment is equal to the cost of Medical Care received by the Insured in connection with the insured event, and is established on the basis of the documents listed in paragraph 15.1. of Article 15 of these Rules, in accordance with the Insurance Programs and the Insurance Agreement. The decision to make the insurance payment or refuse to make it shall be

made within 10 (ten) business days from the date of receipt by the Insurer of all the necessary documents specified in clauses 15.1. and 15.2. Article 15 of these Rules.

16.3. The deadline for consideration of documents and making insurance payment under voluntary insurance contracts of Insurants - individuals, after submission of all necessary documents to the Insurer, is no more than 15 (fifteen) business days.

16.4. In the event that the decision to make the insurance payment cannot be made within the established time limits, additional information or data to the submitted documents is required, the Insurer shall notify the Insurant – individual (Insured, Beneficiary) with an explanation of the reasons for the need to extend the terms of insurance payment. At the same time, the period does not exceed 15 (fifteen) working days from the date of the deadline for consideration of documents for insurance payment, under voluntary insurance contracts of Insurants - individuals.

16.5. The Insurer has the right, at its own expense, to conduct an examination of the volume and quality of Medical Services assigned to the Insured and to appoint an additional medical examination to establish the state of health of the Insured and the correctness of the prescribed treatment. The results of such examination or additional medical examination may serve as the basis for the Insurer's decision to make the insurance payment or refuse to pay the insurance payment.

16.6. The Insurance payment shall be made by paying the cost of the relevant Medical Services received by the Insured in connection with the Insured Event, directly by the Representative of the Insurer (Assistance) or by reimbursing the Insured's expenses for Medical Services received in connection with the Insured Event. Insurance payment can be made both in cash and in non-cash form.

16.7. The total amount of insurance payments and/or the amount of insurance payments for certain types of Medical Services during the entire period of validity of the concluded Agreement, made in favor of the Insurer's Representative (Assistance) or the Insured, may not exceed the total insurance amount established by the Insurance Agreement, the Insured Insurance Program and/or insurance amounts for the relevant types of Medical Services. In the event that the total insurance amount established by the Insurance Agreement, the Insurance Program of the Insured is exhausted, the Insurer's obligations in respect of such Insured under the Insurance Agreement shall be terminated. In the event that the insurance amount for the relevant type of Medical Care is exhausted, the Insurer shall terminate insurance payments for this type of Medical Care.

16.8. The Insurer has the right to refuse the Insured in the insurance payment if the insured event occurred as a result of:

1) war, invasion, hostile actions of a foreign state, military or similar operations (whether war is declared or not) or civil war;

(2) Insurrection, strike, lock-outs, civil disturbances of magnitude or escalating into popular uprising, riot, civil unrest, military mutiny, revolution, military seizure or usurpation of power, confiscation, requisition or nationalization of property, acts of terrorism;

3) radioactive radiation or contamination with radioactive fuel or radioactive waste from the combustion of nuclear fuel.

16.9. The grounds for the Insurer's refusal to make the insurance payment are:

1) communication by the Insurant (Insured) to the Insurer of knowingly false information about the object of insurance, insurance risk, insured event and its consequences;

2) deliberate actions of the Insurant (Insured) aimed at the occurrence of an insured event;

3) obstruction by the Insurant (Insured) to the Insurer in investigation of circumstances of occurrence of insured accident and in establishment of the amount of loss caused by him;

4) failure to notify within the established period of the occurrence of an event that has signs of an insured accident and/or the consequence of which may be the occurrence of an insured event;

5) when it is proved that the Insured did not comply with the prescriptions and instructions of the attending physician or violated the hospital or outpatient regime determined by the attending physician;

6) the Insured's application for medical care for the disease and its consequences that occurred before the beginning of the insurance period/after the end of the insurance period;
7) the Insured's appeal in connection with the Diseases that are exceptions from the insured event in accordance with Article 7 of these Rules or in case of violation of the Insured's procedure in the event of an insured event in accordance with paragraph 13.1. Article 13 of these Insurance Rules;
8) reference studies, i.e. cases of the Insured's application to more than two different providers of medical services for the same insured event (Disease) and for the same type of services.
9) in cases provided for by the legislation on combating the legalization (laundering) of proceeds from crime and the financing of terrorism.

16.10. The insurer does not make an insurance payment for:
1) indirect commercial losses of the Insured (Insured), penalty, lost profit;
2) moral damage;
3) legal costs, unless otherwise provided for by the Insurance Agreement.

16.11. In case of receipt of Medical Care by the Insured for an amount exceeding the relevant insurance amounts and for the relevant types of Medical Services in accordance with the Insurance Program of the Insured, the Insured (Insured) is obliged to reimburse the Insurer for the difference within 5 (five) working days from the date of receipt of the request for payment. In the event that the indemnity is not received within the above period, the Insurer has the right to suspend the organization of Medical Care and the implementation of insurance payments in respect of such Insured until the indemnity is made.

16.12. In case of receiving Medical Care before/after the start / termination of the insurance coverage in respect of the Insured (Insured) or not provided for by the Insurance Program of the Insured, the Insured is obliged to reimburse the Insurer or the medical institution for these expenses within 5 (five) working days from the date of receipt of the request for payment.

16.13. Based on the results of consideration of the documents submitted by the Insured (Insured, Beneficiary) to confirm the occurrence of the insured event and the amount of damage caused, the Insurer shall take one of the following actions:
1) makes an insurance payment.
2) refuses to make an insurance payment
3) makes a decision on the impossibility to make or refuse to make an insurance payment.

16.14. The insurer shall make the insurance payment or refuse to make the insurance payment in the manner specified in these Rules.

16.15. The procedure for consideration of insured events is carried out in writing and in electronic form by exchanging electronic information resources between the Insurer, the Insured (Insured, Beneficiary) and the organization for the formation and maintenance of the database.

16.16. The procedure for the exchange of electronic information resources between the organization for the formation and maintenance of the database and the Insurer, the Insurer and the Insurant (Insured, Beneficiary) shall be determined by the regulatory legal act of the authorized body.

16.17. The Insurer's decision on the impossibility to make or refuse to make the insurance payment shall be made if it is impossible to establish from the submitted documents the circumstances of the event that has occurred, the amount of damage caused as a result of the occurrence of such an event, the fulfillment by the Insurant (the Insured, the Beneficiary) of its obligations.

16.18. In turn, the impossibility of establishing the circumstances specified in the Insurer's decision does not allow the Insurer to make a decision on making or refusing to make an insurance payment, taking into account the provisions of the Insurance Rules, the terms of the Insurance Agreement/Appendices to these Rules.

16.19. In this case, the Insurer in its decision shall indicate which circumstances of the event and/or the amount of damage caused as a result of the occurrence of such an event, the facts of the Insured's (Insured, Beneficiary's) fulfillment of its obligations, cannot be established and what actions the Insured (Insured, Beneficiary) should take.

17. ADDITIONAL CONDITIONS

17.1. The insurance rules are drawn up in the state and Russian languages. In case of discrepancies between the texts of the Insurance Rules in the Kazakh and Russian languages, the text in Russian shall prevail.

17.2. By signing the Insurance Agreement, the Insured agrees that the secrecy of insurance may be disclosed by the Insurer to the Insurer's Representative (Assistance) in connection with the conclusion and performance of the Insurance Agreement.

18. DISPUTE RESOLUTION PROCEDURE

18.1. Disputes arising under the Insurance Agreement shall be considered by the Parties through negotiations.

18.2. In the event of disputes, the Parties are obliged to comply with the following pre-trial dispute settlement procedure:

- In the event of a dispute, the Party is obliged to file a written claim with the other Party and receive a response to the claim. If the Party refuses to satisfy the requirements set forth in the claim, or does not give a written response to the claim within 15 (fifteen) working days from the date of receipt of the claim, or fails to take actions evidencing partial or full recognition of the claim, the Party shall apply to the insurance ombudsman to resolve the dispute. Resolution of the dispute, in fact, by the insurance ombudsman is a mandatory stage of compliance with the pre-trial stage of dispute settlement. At the same time, the execution of the decision of the insurance ombudsman for the Insured (Insured, Beneficiary) is not mandatory.
- In the event of a dispute regarding the contestation of the amount of insurance payment, the Insurant (Insured, Beneficiary) shall be obliged to receive the undisputed part of the insurance payment, after which he shall perform the actions specified in subparagraph 1) of this paragraph.

18.3. If an agreement is not reached and it is impossible to settle the dispute in a pre-trial manner, the Parties file a claim with the court of the Medeu district of Almaty (if one party to the dispute is an individual or) or the specialized inter-district economic court of Almaty (if the dispute is between legal entities or individual entrepreneurs), that is, contractual jurisdiction is established.

18.4. These Insurance Rules are drawn up in 2 (two) copies in the state and Russian languages. In case of discrepancy between the content of the text of these Rules drawn up in the state language and the content of the text of these Rules drawn up in Russian, the Parties shall be guided by the text of these Rules drawn up in Russian.