Terms and conditions of group health insurance SanaPlan

INTRODUCTION

1. SanaPlan group health insurance is a product designed exclusively for legal persons and assimilated, wanting to conclude such an agreement for a group of employees, as Policyholder.

2. Allianz-Ţiriac Asigurări S.A. covers individuals (natural persons) for risks expressly specified in the insurance policy and conditions.

3. The insurance terms and conditions, insurance offer, Table of benefits along with all documents signed by the Policyholder and/or Insured person/ Insured dependent upon the Insurer's request, as well all documents issued by the Insurer related to this insurance are part of the insurance contract.

DEFINITIONS

4. Throughout the present terms and conditions, the following definitions applies:

Second medical opinion: service provided by the Insurer through specialized medical partners in order to confirm/evaluate a complex diagnosis or a prescribed medical treatment;

Accident: any event sudden, violent causing bodily injury due to the action of external factors and occurs beyond the control of the Insured/Insured dependent. Under present terms and condition only medical services accessed within maximum 180 days from accident occurrence are covered.

Occupational accident: accident that occurs during work or while performing official duties.

Road accident: accident that occurs on a road open to public traffic that involving at least one moving vehicle in motion, registered under the laws in force in Romania.

Coverage continuity: the situation in which the Insured/Insured dependent benefits of protection from a group health contract, as follows:

- uninterrupted, by running a contract or successive contracts with the Insurer;
- by written confirmation of the Insurer regarding the unitary nature of the coverage, before the start of a new contractual agreement:
  - after an interruption in the coverage of risk by running one or more contracts with the Insurer;
  - successive to an insurance contract with a different insurer.

Act of terrorism: any act which:

- implies – without limitation – the use of force, violence or threat to any person or group of persons;
- is undertaken by persons who acts individually on behalf of or in connection with organizations or governments;
- represents:
  - an act committed for political, religious, ideological or other similar purposes, or
  - the intention to influence any government and/or to induce panic and intimidation among population, creating a state of terror

or which:

- involves the use of any material, device or biological, chemical, radioactive or nuclear weapons.

Acute disease: a sudden disease/ illness or which have begun up to maximum 90 days, that following an appropriate treatment in the short term, leads to regaining of health condition prior to its installation.

Preexisting illness/ medical condition: any injury, illness or their consequences and any health related or pathological manifestation resulting from an illness or accident occurred prior to the most recent date on which the Insured/ Insured dependent has a continuous coverage of the same insurance plan, whether or not the treatment has been administered and for which the Insured/ Insured dependent:

a) has been diagnosed, or
b) requested, received treatment or medical services, or
c) knew about its existence, or
d) there were signs/ symptoms/ objective manifestation recorded in the medical documents issued by a doctor or medical institution.

Outpatient: medical services provided by a medical institution to the Insured/ Insured dependent in order to diagnose and treat ailments and/or bodily injuries, occurring as a result of an accident or illness, without the need for overnight hospitalization. For the purpose of these terms and condition, short-term hospitalization is assimilated to services provided on an outpatient basis according to the Table of benefits.

Insured: natural person whose state of health is insured by the insurance contract.

Insured dependent: a person whose health status is insured under present terms and conditions of the insurance contract and is the husband/wife or the natural or adopted child of the Insured person or other person who is in any other relation with the Insured person, accepted by the Insurer, having the same responsibilities as the Insured person, that are mentioned in the present terms and conditions.

Insurer: Allianz-Ţiriac Asigurări S.A., registration number RA-017 in the Register of insurers and brokers of insurance.

Illness: any abnormal, pathological condition, determined by temporary or irreversible damage of the structure and / or normal functioning of the whole organism, or any part thereof, diagnosed by a medical doctor according to clinical, paraclinical or specific laboratory criteria.

Chronic illness: medical condition that has at least one of the following characteristics:

a) it's the expression of irreversible physio-pathological and/ or anatomic-pathological changes;
b) clinical and / or paraclinical manifestations have begun for more than 90 days;
c) is incurable, although the clinical and/or paraclinical manifestations may be absent for various periods of time;
d) the evolution is gradual, with or without treatment;
e) the evolution is regressive, but there is potential for permanent relapse/relapse /worsening /complications;
f) it's required constant medical and/or therapeutic intervention.

Category: a subgroup of insured persons, homogeneous in terms of health plan and benefits for which they are covered under present terms and conditions of insurance contract.

Certificate: the document acknowledging the conclusion of the insurance contract issued by the Insurer for each Insured/ Dependent.

Consultation: clinical interview and medical examination carried out by a medical doctor in a medical specialized unit, clinic or hospital ward.

Policyholder: the legal person that concludes the insurance contract with the Insurer, and as such, has the rights and responsibilities stipulated in the present terms and conditions.

Preventive annual check-up: a pre-defined package of medical services conducted once a year at the request of Insured/ Insured dependent for an early detection of any symptomatology that might indicate the presence of insured risk. Package description can be found in the table of benefits.

Date of entry into force of the insurance contract: date stated in the policy at which the Insurer liability starts.

Maturity date of the insurance contract: date stated in the policy at which the contract expires.

Termination date of the insurance contract: date when the Insurer liability stops for the risks occurring after this date.

Debts based on the insurance contract: insurance premiums owed and unpaid at the due date, fees and other costs, owed and unpaid to the Insurer according to the insurance terms and conditions.

Direct settlement: payment method used by Insurer to pay medical services covered by the insurance contract, after they've been provided to an Insured/ Insured dependent by a preferred medical partner.

Diagnosis: the process of identification of a disease/ illness or bodily injury, on the basis of clinical data and of the data resulted from paraclinical investigations.

Force majeure: under present terms and conditions of insurance contract, force majeure means an external event, unforeseeable absolutely invincible and inevitable, independent of any control of the party concerned, resulting in a temporary or permanent inability to perform in part or all the contractual obligations and constitute or is of the nature of one or many of the following events: natural disasters, fires, floods, explosions, lightning, tornadoes, earthquakes, landslides, epidemics, war, civil war, blockades, insurrection, sabotage, terrorism, civil rebellion, state of necessity or emergency.

Deductible/Copayment: total or partial medical costs expressed as value or percentage, or medical services included in the insurance contract that are not settled by the Insurer, but are financially supported by the Insured/ Insured dependent on accessing insurance benefits listed in the Table of benefits.

Medical services provider: natural or legal entity authorized and approved by the Romanian Ministry of Health to provide medical services, according to the Romanian legislation in force.

Group: association of individuals constituted for a purpose other than concluding and possessing of an insurance group contract.

Insurance indemnity: amount paid by the Insurer to the Insured/ Dependent in case one of the insured risks through the insurance contract occurs.

Intermediary: sales representative, person or entity authorized to conduct insurance mediation activity under legal regulations, which, under an agent / broker contract with the Insurer has specific rights and responsibilities concerning the conclusion/ management of the insurance contract.

Surgical Intervention: classic medical procedure performed by a surgeon at the recommendation of a medical doctor, exclusively for therapeutic purpose that fulfils the following cumulative conditions:

a) it's performed accordingly with recognized medical standards and regulations, by a surgeon or a specialized surgery team, in the presence of an anesthesiologist, in a surgery unit of a hospital;
b) it's performed using local or general anesthesia, by an incision or equivalent technique/ procedure with the main purpose to remove the pathological process;
c) the person that undergoes surgery must be hospitalized;

Additionally, there are considered surgical interventions other surgical procedure that fulfills the following criteria:

d) it's the optimal solution recommended by a medical doctor in order to remove the pathological process;
e) it has the advantage of a decreased period of hospitalization;
f) it's characterized by a reduced period of recovery and a reduced number of complications;
g) it has a reduced invasive feature in comparison with the classic surgical procedures, being less traumatic or has a low level of pain for the Insured/ Insured dependent perspective and there are less post-incision complications.

Outpatient surgery: surgical intervention performed in specialized clinics on the recommendation and under the supervision of a medical specialist which do not involve hospitalization.

Coverage limit: maximum sum insured/maximum number of medical services for which the Insurer pays an insurance indemnity/ reimburses costs or performs direct settlement with a preferred medical provider for medical services in case of an insured risk occurs.

Medical doctor: the person with superior specialized medical training that owns the right of free practice in Romania.

Complementary/ Alternative medicine: health care procedures which are not included in the main health care system, but are used as an adjuvant therapy or replacement therapy to classic procedures. This alternative field includes natural therapeutic procedures, biological, nutritional, bio electromagnetic and energy based, like: apitherapy, aromatherapy, acupuncture, homeopathy, acupressure, reflexology, traditional Chinese medicine etc.

Currency of the insurance contract: currency in which the coverage limit, insurance premium and insurance indemnity are expressed.

Medical necessity: an adequate medical service for diagnosis or treatment of an illness or posttraumatic injury.

In order to be considered medical necessity, a medical service must meet the following criteria:

a) comply with professional medical practice and standards generally accepted;
b) the reason for a medical service is not represented solely by the comfort need of the patient or medical staff;
c) its effectiveness is proven and recognized in compliance with medical instructions;
d) medical services are performed by an authorized medical provider;
e) duration corresponds to medical indications, depending on the evolution of the patient's health state.

Insurance offer: document provided by the Insurer to the Policyholder, based on the options of the latter, including information required to conclude the insurance contract.

Validity period of the insurance contract: period of time between the date of entry into force and the maturity date when the insurance contract is in force.

Waiting period: continuous period of time when Insurer does not cover the Insured/ Insured dependent for certain benefits from the latest date on which a continuous coverage began. Waiting period (if any) is mentioned in the Table of benefits.

Insurance plan: a category of benefits (Outpatient, Inpatient and Dental) included in the group health insurance contract, mentioned in the Table of benefits for which an insurance premium is due.

Policy: written document confirming the conclusion of the insurance contract.

Insurance premium: the amount owed by the Policyholder to Insurer, consisting of the amount of individual premiums for the insurance plans included in the contract and specified in the Table of benefits.

Risk underwriting procedures: all procedures and regulations set by the Insurer with the purpose to evaluate, to measure and classify the undertaken risk through the insurance contract, with the purpose to undertake/ modify the risk.

Acute flare of a chronic illness or/and a pre-existing medical condition: sudden aggravation of symptoms of chronic or pre-existing conditions or new severe signs and symptoms which require medical intervention in maximum 90 days to prevent death/ organ lesions/ irreversible functional decompensation.

Reimbursement of medical services costs: the settlement method used by the Insurer to pay to the Insured, in whole or in part, the cost of medical services paid directly and covered by the insurance contract, provided to the Insured/Insured dependent by an authorized medical institution from Romania.

Regularization: represents the periodic recalculation of the insurance premium at contract level according to the fluctuations in terms of the number, age structure and categories of group members, as a result of entries and exits in/ from the group insured.

Preferred provider network (PPn): all healthcare providers that Insurer has contracted for providing medical services for Allianz-Tiriac's Insured. The list of preferred healthcare providers is constantly updated and available on the Insurer's website www.allianztiriac.ro.
Payment due date: date specified in the policy when the Policyholder owes an insurance premium.
Medical services: medical consultations, treatments, surgery, procedures or medical investigations provided/ performed by specialized medical personnel, authorized by the competent national authorities, according to the methods recognized, approved and clinically tested in Romania or countries where the insurance contract provides coverage.
Additional services: assistant and support services that can be included in the insurance benefits, aiming to increase the comfort and protection offered to the Insured/ Insured dependent such as, but not limited to: dedicated telephone and e-mail support services, consulting services, remote medical advice provided through technology, appointment services, access to Allianz-Țiriac application, etc.
Social Health Insurance System (SHIS): public healthcare system regulated by Romanian law.
Hospital: public or private authorized healthcare institution that cumulative fulfills the conditions stipulated by law to provide healthcare during the internment (hospitalization) of patients.
Hospitalization: continuous period of internment in a hospital, which include at least one night, recommended by a medical doctor for the sole purpose to diagnose and treat diseases and/or bodily injury which occurred as a result of an accident or an illness.
Table of benefits: detailed list of benefits, medical and additional services included in the insurance contract as a result of Policyholder option for each category. The table of benefits for each category is an integral part of the insurance contract.
Telemedicine: services provided remotely through technology such as telephone or video consultations, which may include beside the interview the exchange of documents between doctor and patient (Insured) in order to diagnose and treat a disease/ medical condition.
Treatment: medical service necessary to cure a disease, alleviation of an illness or a bodily injury. Under current terms and conditions, treatment does not include surgical interventions.
Treatment or procedure performed for experimental purpose: any medicine (drug), medical device, procedure or treatment will be considered experimental if:

a) safety data and long term effects of treatment or procedure published in the specific literature after performing clinical trials are insufficient, or
b) despite meeting the legislative requirements, although not started the promotion, or
c) are certified by national medical authority as treatments or experimental procedures
d) all existing protocols, specific treatments or procedures, recognized their classification in the experimental stage.

Medical emergency: a bodily injury or an acute illness which presents an immediate risk to a person's life or affects the health condition on long term and requires immediate medical care according to the in force legislation.
Dental medical emergency: a dental medical condition involving lesions of the oral cavity elements: teeth, gums, lips, cheeks or tongue with symptomatology which includes pain (acute pain of teeth or jaws, acute mastication pain or hot / cold pain that spreads to ears or throat), bleeding in the oral cavity (post-extraction bleeding, dento-alveolar trauma or dental fractures), dental fracture or tongue or lip lesions of dental causes, infections.
Hospitalization day: one calendar day regardless of the time of hospitalization and discharge of the Insured/ Insured dependent, if it is part of a continuous hospitalization episode with at least one night of accommodation in a hospital.

BEGINNING OF THE INSURER LIABILITY

5. Insurer's liability for each Insured/ Insured dependent begins on the date on which the quality of Insured/ Insured dependent is confirmed following the completion of underwriting procedures and the payment of the insurance premium, but no earlier than hour 0:00 of the validity start date mentioned in the insurance policy/ certificate.

CONCLUDING THE INSURANCE CONTRACT

6. The insurance contract is concluded for a period of 1 (one) year.
7. The currency of the insurance contract is Romanian Leu (RON).
8. The Insurer may accept the Insured status for a group member if, upon the request date to entry in the insurance contract, the person fulfils the following cumulative conditions:

a) Insured person's age must be between 16-64 years; it is taken into account age in completed years;
b) performs activities for the benefit of the Policyholder under an employment contract, mandate or service agreements, or is a partner/shareholder of the Policyholder, or develops other activities that are forming the core business of the Policyholder (e.g. as a member of a non-profit association, foundation, union, etc.) and is not in temporary work disability;
c) is appointed by the Policyholder by nomination and identified by name, surname and personal identification number. According to the appointing way, the Policyholder accepts the right of the Insurer to initiate, depending on the sum insured and the percentage of enrollment, the application of risk underwriting procedures in order to determine the eligibility of a member as an Insured person.

9. The Policyholder may choose to include one or more Insured dependents in the insurance contract. If the Insurer does not decide otherwise, insured dependents will be included in the insurance contract at the same time as their principals Insured.
10. The age of the Insured Dependent at the policy issuing date must be between 0-64 years. Under the present insurance contract, is taken into account age in completed years at the date of entry into insurance.
11. The insurance contract is concluded based on the insurance offer accepted and confirmed by the signature of the Policyholder and also based on the list of the Insured persons to be taken into insurance delivered by the Policyholder, which are integral parts of the insurance contract.
12. The insurance contract is concluded as a result of issuing the insurance policy by the Insurer and by payment of the initial insurance premium by the Policyholder.

INSURED RISK

13. The Insurer the risk of illness (disease) and accident of the Insured/ Insured dependent during the period of the validity of the insurance contract. In connection with the occurrence of these risks, the Insurer takes over the costs of medical and additional services related to the benefits indicated in the contractual documents, after the expiry of the waiting period (if any) and performed during the validity period or within maximum 30 days from the termination/ maturity date of the contract, if the coverage for the Insured/ Insured dependent is not renewed by a new contract with the Insurer for risks occurred during the validity period of the insurance contract.
14. The Insurer takes over the cost of medical services by the following methods:

a) For Outpatient Plan the Insurer applies direct settlement or reimburses necessary medical services cost provided to the Insured/ Insured dependent in accordance with the Table of benefits for Outpatient Plan.
b) For Hospitalization Plan the Insurer applies direct settlement, pays insurance indemnity or reimburses necessary medical services cost

provided to the Insured/ Insured dependent in accordance with the Table of benefits for Hospitalization Plan.

c) For Dental Plan the Insurer applies direct settlement or reimburses necessary medical services cost provided to Insured/Insured dependent in accordance with the Table of benefits for Dental Plan.

RISK UNDERWRITING

15. The Insurer reserves the right to perform risk evaluations according to its underwriting procedures before undertaken/ re-undertaken / increasing a risk or any time the Insurer exposure to the risks covered changed from an occupational, residential, lifestyle and of insurable interest point of view.

16. After the underwriting procedures are finalized, the Insurer may decide to undertake/ re-undertake/ increase a risk as follows:

a) under requested conditions;
b) other conditions than requested;
c) decline undertaking the risk;
d) postpone decision.

TERRITORIAL LIMIT

17. The insurance contract is valid for medical services, hospitalization and surgery services accessed in Romania, if the Table of benefits do not specify otherwise.

COVERAGE LIMITS

18. The coverage limits are specified in the Table of benefits for each category.

EXCLUSIONS*:*

19. The insurer does not cover the risk caused directly or indirectly by:

a) events of war (whether declared or not) or the action of an external enemy invasion, the civil war, revolution, insurrection, military dictatorship, conspiracy, terrorism consequences and any other costs related directly or indirectly to measures taken in order to control, prevent or suppress any event therein;
b) pollution or radioactive contamination, action of chemical or biological weapons;
c) illness or accidents that Insured intentionally committed, attempting suicide or self-mutilation, even if the Insured has been in a situation where his good judgment was affected;
d) drunken state, chronic alcoholism, consumption of medication or drugs, except medication prescribed by a medical doctor, and administered according to his medical prescription;
e) poisoning or intoxication caused by ingestion or inhalation of solid, liquids or gaseous substances, unless they were caused by an accident;
f) evolution of an infectious disease that starts in the context of an epidemic/ pandemic state officially declared by the empowered authority;
g) engaging in dangerous occupations as: armed forces (special services, activities involving explosive devices, air force, military navy, military fire-fighters), aviation (utility aviation, testing pilots, fuel platforms pilots), divers using explosives, police special forces, private security services, utilitarian climbing (rope), mining activities (underground), fuel installations, activities on oil and gas platforms, activities in explosives industry;
h) practicing any sport at a professional level, both during training and competitions; practicing amateur or professional level of activities or hobbies considered dangerous such as, but without limitation to: climbing, rock climbing, martial arts, racing motorized vehicles, rugby, aviation activities and navigation not intended for authorized carriage of people, K1, fighting body, boxing, parachuting, gliding, paragliding, hang gliding, ski jumping, bungee-jumping, caving, surfing, racing horseback riding, rodeo, motor racing circuits for drivers, rafting, deep free diving or under ice;
i) the Insured's participation in military training or military missions (including peacekeeping missions);
j) active participation of the Insured to terrorism or internal disturbances - riots, social revolts, revolution - for the party that generated them;
k) Insured intentionally committed acts that are incriminated as criminal offences by the state where the acts have been committed (established by a judicial document issued by the authority where the incriminated offence has been committed), if those acts are similarly incriminated by Romanian law;

20. Also, if not otherwise specified in the Table of benefits, the Insurer does not cover medical services and hospitalization related to:

a) chronic illness or disease/ pre-existing medical conditions;
b) pregnancy monitoring, state of pregnancy or childbirth and complications arising from pregnancy or after childbirth. This exclusion does not apply for the first diagnosis/ confirmation of pregnancy and emergency medical services necessary to stabilize the medical condition for the following complications: ectopic pregnancy, gestational diabetes, pre-eclampsia and eclampsia, pregnancy stopped in evolution and miscarriage;
c) sexual dysfunctions, infertility, sterility, artificial insemination, pre-conception, in-vitro fertilization or embryo transfer, induced miscarriage, circumcision at request, intentions of sex change, frigidity and/or impotence, hospitalization for treatment of any sexual identity disorder;
d) experimental medical procedures, investigations and treatment that are specific to medical research and their consequences;
e) misdiagnosis or malpractice of a health professional (certified medical negligence);
f) medical conditions that result from the fact that the Insured ignores or does not comply with the guidelines and recommendations from the treating physician;
g) cosmetic surgery or any other treatment done for aesthetic purposes only, except necessary treatment to correct functional defects as a result of an accident (purely psychological reason is not valid). Treatments, medical services and/or hospitalization performed for the purpose of weight loss are also excluded;
h) treatment of HIV / AIDS and its consequences;
i) congenital abnormalities or complications / diseases involved by congenital anomalies, whether the insured have been or not have been aware of them;
j) organ transplant and organ procurement in scope of transplant, including expenses for searching organ donors;
k) routine medical checkups, prophylactic consultation or any type of vaccine except those for curative purpose (e.g. tetanus and rabies);
l) the issuance of certificates, reports or any type of medical documents that is not aimed for diagnosis or treatment of a disease (e.g. prenuptial certificate, medical certificate for driving license, epidemiological certificate, medical certificate for weapons license);
m) logopedic treatment or speech therapy;
n) treatment or recovery session in hospitals, nursing homes, health and rest centers, convalescence homes or similar institutions; alcoholism or addiction therapies; medical rehabilitation, physical recovery, physiokinetotherapy and geriatrics;
o) mental illness and other mental disorders of the Insured/Insured dependent;
p) dental treatments, dental surgery including expenses for dental devices, dental prosthesis, artificial teeth, dental crowns/bridges and other dental services with the exception of those specified in the Table of benefits;
q) human genetic tests, research to determine the genetic map or other genetic methods of diagnosis and treatment.

21. Also, if not otherwise specified in the Table of benefits, the Insurer does not cover:

a) expenses for acquisition of medicines, medical devices and medical disposables, prescribed by the medical doctor or for any self-medication purpose;
b) expenses for acquisition, replacement or restoration of any kind of prostheses or eyeglasses, including contact lenses;
c) any costs related to complementary/ alternative medical specialty;
d) medical services and hospitalization based on doctor's referral notes or medical letters older than 90 days from the issuance.

PREMIUM

22. The insurance premiums are payable in the currency of the insurance contract.

23. The insurance premiums have to be paid in the same time for all group members, according to the due date mentioned in the payment document issued by the Insurer.

24. Contractual premiums are due at payment due dates, in the quantum mentioned in the policy and the Policyholder is solely responsible for their payment, as well as following the rules and guidelines established by the Insurer for payment such as: bank account, currency, particulars of the payment destinations. Upon payment, the Policyholder will request/obtain and keep proof of payment of the contractual premium (receipt, invoice, payment order, etc.). Initial premium must be paid before issue date of the insurance contract.

25. Contractual premium payments can be made by any method accepted by the Insurer. In case of direct debit payments, the Insurer will send the bank account interrogation details of the Policyholder before the premium due date. For payments by bank transfer, the Policyholder is required to pay in the account and at the bank specified by the Insurer in the most recent correspondence.

26. Policyholder will bear all charges and fees related to contractual premiums and other amounts owed to the Insurer.

27. The insurance premium may be paid fully in advance for the entire covered period or by installments at due dates in the amount specifically mentioned in the policy by the Insurer.

28. If the insurance premium is not fully paid in due dates, then the result will be termination of the insurance contract without formal notice or any other formality. In this case, the Insurer is entitled to recover from the Policyholder the value of medical services which has been rendered to the Insured/ Insured Dependent, due to Insurer's payment obligations to the medical services provider. If the insurance premium is not paid out, the Insurer is entitled to refuse payment of insurance indemnities and/or reimbursement of medical services costs for the period of time between the payment due date and the date when the insurance premium has been paid.

29. If, following the risk underwriting Insurer refuse to cover the requested risks and through this refuse to conclude the insurance contract or the potential Policyholder does not accept the terms imposed by the Insurer, the initial insurance premium will be refunded to the Policyholder without any interest. In this case the premium will be refunded to Policyholder in the amount and currency in which the premium was paid.

30. Amounts to be refunded to the Policyholder, other than the ones specified at the paragraph above, will be paid in the currency of the insurance contract in a bank account of the Policyholder, specified in written by him/her and opened at a bank on the Romanian territory or through any method of payment accepted by the Insurer.

POLICYHOLDER RIGHTS

31. Insurer offers to the Policyholder the following rights:

- the right to modify the number of Insured / Insured dependent,
- the right to offer coverage during interruption of occupational activity of the Insured, according to detailed specifications in the present terms and conditions.

CHANGING THE NUMBER OF INSURED PERSONS

32. Policyholder has the right to include or exclude Insured persons in/from the group health insurance contract, monthly, by notifying the Insurer and communicating the list of the Insured/ Insured dependent.

33. The risk coverage for those Insured persons is valid after the written confirmation of the Insurer was sent to Policyholder.

34. For Insured persons who are included/ excluded from the group health insurance contract, the premium is calculated pro-rata according to the number of months for which the adjustment is made. Policyholder is required to pay the additionally amount resulted due to adjustment of premium in maximum 10 calendar days from the date when the amount is communicated. Otherwise, it will be considered that the newly included Insured persons are not covered by the group health insurance contract.
If the insurance premium paid in the immediately preceding due date is greater than the premium payable by Policyholder, the difference in premium is deducted from the next due premium. If there is not any other premium due, the difference will be refunded to the Policyholder at the maturity date of the insurance contract or at the termination date.
Each month started is considered a full insurance valid month.

RISK COVERAGE FOR THE INSURED DURING INTERRUPTION OF OCCUPATIONAL ACTIVITY

35. The Insurer agrees to maintain the Insured covered under the insurance contract during the period of interruption of activity, provided the insurance premiums are continuously paid (including in the interruption of activity period) during the validity period of the insurance contract, the following cases of temporary interruption of normal activity at work:

a) paid annual leave;
b) unpaid time off (to study or according to collective labor agreement);
c) maternity leave (postnatal or prenatal);
d) childcare leave.

POLICYHOLDER AND INSURED PERSON RESPONSIBILITIES

36. Policyholder/ Insured/ Insured dependent are required to:

a) to provide correct answers and complete information in documents filled out at the conclusion of the insurance contract or requested afterwards by the Insurer;
b) to notify the Insurer in written, in 30 calendar days, if one of the covered risks occurred and the Insured person/ Dependent has received outpatient care or hospitalization outside PPn for which the Insurer pays insurance indemnity or reimburses medical services costs, mentioning the place, date, hour, causes and circumstances in which the risk occurred.
c) to provide all information and documents within maximum 30 days from request of the Insurer and to facilitate the access to all necessary information needed to determine the circumstances in which the risk occurred;

In case of not fulfilling the obligations from the above mentioned point a), the Insurer reserves the right to:

1. to terminate the insurance contract and refuse to pay insurance indemnity if the information and/or documents that were not provided to the Insurer would have led him not to conclude the insurance contract, or
2. to offer the insurance contract with a different level of premium. The insurance premium adjustment is made for each month in proportion of 1/12 from annual premium. If the Policyholder does not accept the proposed amendment, the insurance contract will be terminated with effect from the date of proposed amendment. In case of contract

termination, the Insurer will retain an insurance premium calculated in proportion of 1/12 of the annual premium for the period already covered by insurance and the difference will be returned to the Policyholder, if there are no claims notified or paid. Each insurance month started is considered a full insurance month.

In case of non-compliance of obligations referred to in points b) and c) above, the Insurer reserves the right to refuse fulfillment of its obligations under the insurance contract, if for this reason could not determine the cause and circumstances of the risk occurred.

37. If the Insured/ Insured dependent suffers from an accident or illness has the responsibility to seek for and accept treatment as soon as possible, and to follows doctor's recommendations in order to restore his/ her health status. The Insurer may refuse to pay any indemnities and/or reimbursement of medical services costs if it is discovered that the Insured/ Insured dependent did not requested medical treatment, did not complied with medical instructions or was engaged in activities that are advised against the illness or bodily injury suffered.

38. In case the Insured/ Insured dependent received medical services for risks that are not covered by the insurance contract, it will be held liable for payment of those services directly to the medical provider in the shortest time. This obligation is assumed by the Insured/ Insured dependent under this agreement and by signing the medical report when receiving medical services. In case the Insured/ Insured dependent does not comply with his obligation, the Insurer will make all efforts to recover the debt, representing the medical services provided by the healthcare provider from the Insured/ Insured dependent. If, within 15 days from notification the Insured/ Insured dependent did not paid for medical services that are not covered by the insurance contract, the Insurer reserves the right to stop (suspend) coverage or/and to eliminate the Insured/ Insured dependent from the insurance group contract until the claim is settle with the medical provider.

39. The Policyholder is required:

a) to notify the Insurer in written about any change of its contact details, personal or contact data of the Insured/ Dependent;
b) to provide information related to the insurance contract to the Insured/ Dependent: terms and conditions, table of benefits, insurance premiums, any policy changes that might occur during the validity period of the contract;
c) to hand over nominal insurance certificates to its Insured/ Insured dependents within 10 calendar days from the date on which the Policyholder receives them from the Insurer.

NOTIFICATION OF RISK INSURED

40. Notification in case a covered risk occurs will be made as follows:

a) For benefits included in the insurance plans for which the Insurer provides direct settlement, the notification will be made through the reception desk of the medical provider from PPn;
b) For the benefits included in the insurance plans for which the Insurer reimburse costs for medical services or pays insurance indemnity, the notification should be made after medical services were provided, by submitting the following documents:
    1. claim request form which is available on our website at: www.allianztiriac.ro
    2. copy of identification document;
    3. invoices and receipts on which the Insured has paid medical services provided by the medical services;
    4. medical documents attesting diagnosis and medical services paid by the Insured for which an invoice has been issued; these documents must contain details regarding type of medical investigations and treatment and the date when the medical services has been received by Insured (in original);
    5. valid only for Hospitalization plan – releasing report from hospital (in original);
    6. valid only for Dental plan – treatment plan prepared by the dentist together with a panoramic dental radiography;
    7. valid only for Dental plan – the accident report from the competent authorities that proves the event was a consequence of an occupational or road accident;
    8. any other document required to solve the claim file requested by the Insurer.
c) In order to access Second medical opinion service, the Insured / Insured dependent will submit the request for confirmation / evaluation of a complex diagnosis or treatment on the dedicated portal, available at section Life and Health Claims on the Insurer's website.

41. The Insurer reserves the right to request an additional medical examination of the Insured/ Dependent to establish the medical necessity which conducted to respective medical services. The additional medical examination will be conducted by one of the proved medical doctors of the Insurer; case in which the medical services cost is incurred by the Insurer.

42. In order to determine the value of insurance indemnity, Insurer is authorized by the Insured/Dependent to obtain all medical information considered to be necessary from third parties (medical doctors, medical providers, etc) and to release those implicated of professional secrecy regarding the required information.

INSURER DECISION AFTER THE NOTIFICATION OF A RISK INSURED

43. If in connection with the occurrence of a risk insured, against the Insured /Insured dependent/ third party was set an investigation or a criminal law procedure, the Insurer has the right to postpone a decision on the classification of the event under these terms and conditions of insurance, only if the investigation or criminal proceedings in question is directly related to the occurrence of risk insured and up to the completion of these legal actions.

44. Any obstacle or incomplete or incorrect information provided by the Insured person/Policyholder/Third party that prevents the Insurer to determine the causes in which the insured risk occurred, allows the Insurer to refuse payment of the insurance indemnity, to reimburse any medical cost or to make direct settlement to medical services provider from PPn.

45. The Insurer is not responsible for the quality of services provided by medical institutions or medical personnel.

INSURER RESPONSIBILITIES:

46. The Insurer is required:

a) to confirm eligibility within 2 working days from receiving all documents and information required for approval of medical services which are subject of direct settlement;
b) to validate the conformity of documents/information requested, Insured's eligibility and coverage limits, to finalize all the investigations related to the notified risk and to submit his decision within 30 calendar days from the date of receiving all documents necessary for the claim file assessment, in case of a covered risk for which the Insurer pays insurance indemnity or reimburse cost for medical services.

47. If, based on the documents/information required, Insurer decides that the event which occurred during the validity period of the contract is a covered risk under present terms and conditions, in the agreed term for communication its decision, it will pay the insurance indemnity or reimburse medical cost to the Insured, or it will make the direct settlement to a medical services provider with respective amount but up to maximum coverage limits specified in the corresponding Table of benefits.

48. Depending on the insurance plan/plans chosen and the medical services provider, Insurer covers totally or partially medical services cost according to Table of benefits for insurance plans. For those medical service providers which are not part of PPn the maximum cost to be compensated for medical services in scope of diagnosis and treatment will

not exceed the amount charged for a similar case (type and severity) usually provided in that locality.

49. If, based on the documents/information required, Insurer decides that the event which occurred during the validity period of the contract is not a covered risk under present terms and conditions, will notify the Policyholder/Insured about the decision to reject the claim.

REGULATION OF THE PAYMENTS DUE BY THE INSURER UNDER CONTRACTUAL OBLIGATIONS

50. The insurance indemnities or reimbursement of medical costs will be paid in the currency of the insurance contract, in a bank account communicated in written to the Insurer and opened at a bank on the Romanian territory or through any payment method accepted by the Insurer, within maximum 30 calendar days from the date of submitting all required documents to Allianz-Tiriac Asigurari S.A.

51. Fees and commissions related to the payment of the benefits related to the insurance contract will be borne by the Insurer. In case the payment details communicated by the Policyholder/Insured person are not correct and/or complete, and the payment made by the Insurer can't be completed, the Insurer reserves the right to retain the fees and commission related to a new payment from the amount to be paid.

52. Indemnities from the insurance contract that are due but not cashed out will be kept in the Insurer's records as per in force legislation.

ENDING OF THE INSURER LIABILITY

53. The contractual liability of the Insurer terminates in the following cases:

a) at Policyholder initiative, following the registration of cancellation request at the Insurer headquarter;
b) at the Insurer initiative, according to the terms and conditions or legal provisions (including provisions of international sanctions);
c) at hour 24:00 of the day specified in policy as maturity date.

54. Risk coverage provided by the insurance contract terminates as follows:

a) for all persons covered by the insurance contract:
   1. once the Insurer's liability terminates as per insurance conditions;
   2. at the maturity date of the insurance contract, specified in the policy;

b) for Insured:
   1. at the date on which the status of Insured person is lost under the insurance contract;
   2. at the date when the payment of insurance indemnities or cost reimbursement for medical services to the Insured equals the maximum benefits according to the Table of benefits corresponding to the Insured's category.
   3. at the next contract anniversary after the insured reaches the age of 65;

c) for Insured Dependent:
   1. at the date when the coverage for the Insured person terminates;
   2. at the date on which the status of Insured Dependent is lost under the insurance contract;
   3. at the date when the payment of insurance indemnities or cost reimbursement for medical services to the Insured Dependent equals the maximum benefits according to the Table of benefits corresponding to the Insured dependent's category;
   4. at the next contract anniversary after the Insured Dependent reaches the age of 65.

CORRESPONDENCE RELATED TO THE INSURANCE CONTRACT

55. Amendments to the insurance contract available for the Policyholder through the present terms and conditions, shall be made as a signed request delivered by the Policyholder to the Insurer's headquarter, accompanied by all supporting documents requested by the Insurer.

56. Any communication addressed by the Insurer to the Policyholder can be done using the most recent contact information communicated by the Policyholder, even if those data belongs to a third party. The content of any communication is opposable to the Policyholder, even if he was not respecting the contractual obligations to inform the Insurer about the change of this contact data.

57. The Insurer is not liable for any effect or consequence due to any delay, not receiving, deterioration, lost or other errors in sending messages, letters or documents from reasons that are not related to the Insurer.

58. In case of changing the parameters or any other elements from the terms and conditions, the Insurer can use any other communication method with the Policyholder (example: newspaper with nationwide distribution coverage, website, letters, phone, fax, SMS, email etc.)

59. Direct correspondence with Policyholder is possible in written form as letters only on Romanian territory.

FINAL PROVISIONS

60. The compliance of the Policyholder/ Insured's obligations, as well as the supposition that the declarations and the answers are honest and sincere, represents conditions that precede any liability or obligation of the Insurer to reimburse cost for medical services or to pay insurance indemnities.

61. In case of any amendment, denunciation or termination of the insurance contract, its provisions apply in all cases of claims incurred before the change, denunciation or termination. In the above mentioned situations, insurance premiums already paid will not be refunded.

62. The Policyholder has the right to withdraw from the insurance contract and to request termination within the first 14 calendar days from the start without invoking any reason, provided that no insured risks have occurred. In this situation Allianz-Tiriac will return the initial premium paid in full, based on the written request to terminate contract received from the Policyholder.

63. The Policyholder may terminate the insurance contract during its validity period based on a written request submitted to the Insurer within a period of 20 calendar days prior to termination becomes effective, but shall remain liable to pay any insurance premiums owed, until the effective termination of the insurance contract.

64. The right of action based on an insurance or reinsurance report it prescribes within 2 (two) years. That period shall begin from the date of insured risk occurrence. The insured is liable to submit the claim for damages or compensations within above mentioned period of time.

65. Any request referring to the insurance contract must be signed by the Policyholder and/or Insured person. If the signature does not match the one from insurance offer, the Insurer may require the Policyholder or the Insured, as is appropriate, a confirmation of change of signature; in this regard, the Policyholder/ Insured shall provide to Insurer a specimen of the new signature.

66. The applicable low for the insurance contract is the Romanian law.

67. Possible litigations result from or indirect depending on the insurance contract that could not be solved on mutual basis, will be solved by competent legal court.

68. Force majeure defend the party appealing it and it will be communicated to the other party within 5 days; in the following 15 days all documents issued by the Chamber of Commerce and Industry able to attest the events, must be submitted.

69. After the occurrence of any of the cases of force majeure, parties will make all the efforts to ensure the restart of normal performance of their contractual obligations. The obligations of the parties will be fulfilled as much as possible prior to normal situation reinstatement.