Allianz

GENERAL SUMMARY OF PRODUCT AND SERVICE INFORMATION (RIPLAY)

PT Asuransi Allianz Life Indonesia

ALLIANZ PREFERRED MEDICAL

An individual health insurance product that provides primary benefits including Inpatient and Surgical Benefits, Major Disease Benefits, Emergency Care Benefits, and additional supplementary benefits. This product is valid for a period of one (1) year commencing from the Policy Effective Date and is automatically renewed on each Policy Anniversary for the subsequent one (1) year Policy Term.

This General Summary of Product and Service Information (RIPLAY) is intended to provide a brief explanation regarding the benefits and important aspects of the Policy You are about to purchase. Please seek direct clarification from Our Marketing Personnel before deciding to purchase the Policy.

"We/Our/Us/Insurer" refers to PT Asuransi Allianz Life Indonesia

You/Your/Policyholder" refers to the Person whose name is specified in the Policy Data as the party entering into the coverage with the Insurer.

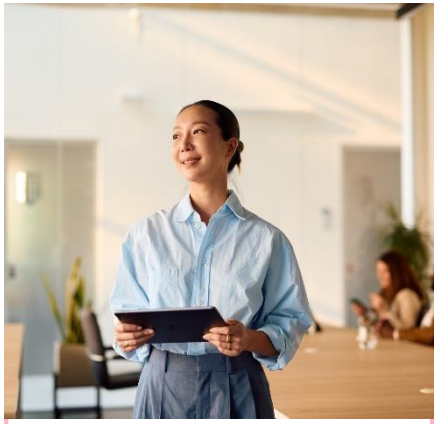
"Insured" means the Person whose life is covered under the Policy, and whose name is specified in the Policy Data.

"Premium" means Sum of money that You or the Premium Payor (as applicable) pay to Us in relation to the Coverage, which includes Basic Insurance Premium and Rider Premium (if any). The Premium shall be payable on each Premium Due Date as agreed upon in the Policy.

More definitions and information can be found in the Policy issued by Us.

WHAT ARE THE INSURANCE BENEFITS PROVIDED BY THIS PRODUCT?

Inpatient and Surgical Benefits	Reimbursement of Reasonable Fees for Medically Necessary including Inpatient Care and Surgical Procedures, in accordance with the Benefit Table under the selected Plan.
Major Illness Benefits	Reimbursement of Reasonable Fees for Healthcare Services related to the treatment of Major Diseases for the Insured, provided such services are Medically Necessary, in accordance with the Benefit Table under the selected Plan.
Emergency Care Benefits	Reimbursement of Reasonable Fees for Healthcare Services related to Emergency Treatment for the Insured, which are Medically Necessary and arise from an Emergency Condition, Force Majeure, Accident, or Incident, in accordance with the Benefit Table under the selected Plan.
Additional Benefit	Reimbursement of Reasonable Fees for Healthcare Services, in accordance with the Benefit Table under the selected Plan.
Death Benefit	We shall pay the Death Benefit to the Beneficiary if the Insured passes away. The amount of the Death Benefit shall be as stipulated in the Benefit Table.
Premium Saving Facility	A Premium Reduction shall be applied at the time of Policy renewal or for the subsequent Insurance Period, amounting to 5% of the Renewal Premium. The Premium Saving Facility shall be available provided that no claims are made during one (1) Observation Period and the Policyholder selects automatic premium payment via auto-debit (savings account or credit card).



PT Asuransi Allianz Life Indonesia

Allianz Preferred Medical

Product Name
Allianz Preferred Medical

Product Type
Traditional Individual Health Insurance Product

Insurance Product Line
Health Insurance

Insurer Name
PT Asuransi Allianz Life Indonesia

Marketing Channel
Allianz Star Network

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GENERAL SUMMARY OF PRODUCT AND SERVICE INFORMATION (RIPLAY)

PT Asuransi Allianz Life Indonesia

WHAT ARE THE INSURANCE BENEFITS PROVIDED BY THIS PRODUCT?

BENEFIT	DESCRIPTION	PLAN STANDARD	PLAN EXTRA	PLAN PREMIER
DEATH BENEFIT		**15.000.000 Starting Age 80: 30.000.000**	**15.000.000 Starting Age 80: 30.000.000**	**15.000.000 Starting Age 80: 30.000.000**
INPATIENT				
COVERAGE AREA		**Indonesia**	**Asia *except* Singapura, Hong Kong, Japan**	**Asia + Australia**
Inpatient and Surgical Care Benefit				
Room and Accommodation Fees			Whichever higher between cheapest 1 bedded with attached bathroom or R&B Rate Limit	Whichever higher between cheapest 1 bedded with attached bathroom or R&B Rate Limit
	Room Charge Limit Per Day; Maximum 365 Days	700.000	1.300.000	1.650.000
Intensive Care Unit (ICU) Fees	Per Day; Maximum 365 Days	1.200.000	As Charged	As Charged
Surgery Fees	Per Hospitalization	60.000.000		
One-Day Surgery Fees	Per Treatment	15.000.000		
Prostheses and Implants Fees		-		
Doctor Visit Fees	Per Day; Maximum 365 Days	225.000		
Specialist Doctor Visit Fees	Per Day; Maximum 365 Days	325.000		
Inpatient Care Miscellaneous Fees	Per Hospitalization	12.000.000		
Pre-Inpatient Care Fees*	Per Hospitalization; Max. 60 Days prior to Inpatient Care	1.800.000		
Post-Inpatient Care Fees*	Per Hospitalization; Max. 90 Days after Inpatient Care	1.800.000		
Outpatient Physiotherapy Care Fees*	Per Policy Year; Max. 60 Days prior to Inpatient Care Max. 90 Days after Inpatient Care	-		
Alternative Inpatient Care Fees*	Per Policy Year;	-	200.000.000	300.000.000
Additional Inpatient Care Fees*	Per Policy Year; Max. 90 Days after Outpatient Physiotherapy benefits end	-	15.000.000	25.000.000
Traditional Medicine Fees*	Per Policy Year; During Inpatient Care, Max. 90 Days after Inpatient Care	-	15.000.000 maximum 1.000.000 per Claim	25.000.000 maximum 1.000.000 per Claim
Outpatient Care Psychiatrist Consultation Fees*	Per Policy Year; Max. 90 Days after Inpatient Care	-	15.000.000	25.000.000
Local Ambulance Fees	Per Hospitalization	400.000	As Charged	As Charged

*) Claims can only be made on a Reimbursement basis

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PT Asuransi Allianz Life Indonesia

WHAT ARE THE INSURANCE BENEFITS PROVIDED BY THIS PRODUCT?

BENEFIT	DESCRIPTION	PLAN STANDARD	PLAN EXTRA	PLAN PREMIER
Death Benefit		**15.000.000 Starting Age 80: 30.000.000**	**15.000.000 Starting Age 80: 30.000.000**	**15.000.000 Starting Age 80: 30.000.000**
Inpatient				
Coverage Area		**Indonesia**	**Asia *except* Singapura, Hong Kong, Japan**	**Asia + Australia**
Major Illness Benefit				
Dialysis Fees*	Per Policy Year	60.000.000	As Charged	As Charged
Organ Transplantation Fees		-		
Organ Transplant Donor Fees*		-		
Cancer Outpatient Care Fees, including: Cancer Remission Screening & Laboratory tests	Per Policy Year	120.000.000		
HIV/ AIDS Treatment Fees	Per Policy Year	-	15.000.000	15.000.000
Palliative Care Fees (“Critical Illness Benefit”)	Per Policy Year	-	250.000.000	250.000.000
Emergency Care Benefit				
Outpatient Care Fees due to Emergency, Fore Majeure, Accident, or Incident including Dental Care due to Emergency, Force Majeure, Accident or Incident*	Per Policy Year; Within 2 days of experiencing an Emergency, Force Majeure, Accident, or Incident	5.000.000	As Charged	As Charged
Continued Outpatient Care Fees for Emergency, Force Majeure, Accident, or Incident*	Within 30 days of experiencing an Emergency, Force Majeure, Accident, or Incident	-		

*) Claims can only be made on a Reimbursement basis

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PT Asuransi Allianz Life Indonesia

WHAT ARE THE INSURANCE BENEFITS PROVIDED BY THIS PRODUCT?

BENEFIT	DESCRIPTION	PLAN STANDARD	PLAN EXTRA	PLAN PREMIER
Death Benefit		**15.000.000 Starting Age 80: 30.000.000**	**15.000.000 Starting Age 80: 30.000.000**	**15.000.000 Starting Age 80: 30.000.000**
Inpatient				
Coverage Area		**Indonesia**	**Asia *except* Singapura, Hong Kong, Japan**	**Asia + Australia**
Additional Benefit				
Outpatient Care Fees due to Dengue Fever and/or Typhoid/Paratyphoid Fever* a) Dengue Fever Lab NS1 with positif (+) result or Dengue lgM with positif (+) result and Trombosit less than or same with 150,000 per microliter blood b) Typhoid/Paratyphoid Fever Lab Tubex with positif (+) result with score more than or same with 6, or Widal score more than with 1/160, or kultur Salmanella typhoidal with positif (+) result	Per Policy Year	8.000.000	8.000.000	8.000.000
Durable Medical Equipment Fees*	Per Policy Year; During Inpatient Care, Max. 90 Days after Inpatient Care	-	15.000.000	15.000.000
Artificial Limbs Fees*	Per Policy Year; During Inpatient Care, Max. 90 Days after Inpatient Care	-	250.000.000	250.000.000

Other Services**			
Expert Medical Opinion	-	Available	Available
Medical Assistance	-	Available	Available
Annual Benefit Limit	1.000.000.000	15.000.000.000	20.000.000.000
Additional Annual Benefit Limit	1.000.000.000	15.000.000.000	20.000.000.000

*) Claims can only be made on a Reimbursement basis

**)This service is an additional service provided by partner companies appointed by Allianz and may be amended or discontinued from time to time. Allianz shall not be responsible for any services provided by such partner companies.

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GENERAL SUMMARY OF PRODUCT AND SERVICE INFORMATION (RIPLAY)

PT Asuransi Allianz Life Indonesia

WHAT ARE THE INSURANCE BENEFITS PROVIDED BY THIS PRODUCT?

BENEFIT	DESCRIPTION	PLAN STANDARD	PLAN EXTRA		PLAN PREMIER		
Death Benefit		15.000.000 Starting Age 80: 30.000.000	15.000.000 Starting Age 80: 30.000.000		15.000.000 Starting Age 80: 30.000.000		
Inpatient							
Coverage Area		Indonesia	Asia except Singapura, Hong Kong, Japan		Asia + Australia		
Own Risk Per Policy Year			*Preferred Network*	*Other Network* (Asia *except* SG, HK, JP)	*Preferred Network*	*Other Network* (Asia *except* SG, HK, JP)	*Other Network* (SG, HK, JP,AUS)
	Own Risk Option 1	-	6.000.000	12.000.000	6.000.000	12.000.000	25.000.000
	Own Risk Option 2	-	10.000.000	20.000.000	10.000.000	20.000.000	40.000.000

Notes:

a. SG, HK, JP, AUS : Singapura, Hong Kong, Japan, Australia

b. An Additional Annual Benefit Limit shall be granted when the Insured suffers from one of the following conditions:

- Heart Attack
- Stroke
- Invasive Cancer

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GENERAL SUMMARY OF PRODUCT AND SERVICE INFORMATION (RIPLAY)

PT Asuransi Allianz Life Indonesia

SERVICES

Expert Medical Opinion

Scope of Expert Medical Opinion Services

The Expert Medical Opinion Service can be used by the Insured subject to the Benefit Table Limit. This Expert Medical Opinion Service can only be used by the Insured under the following circumstances:

a) The Insured seeks clarification or validation regarding a serious and complex medical condition;
b) The Insured is required to make a medical decision, such as opting for Surgery or undergoing other significant medical procedures;
c) The Insured has been diagnosed with a critical medical condition and seeks information about alternative treatment options; and/or
d) The Insured requires an additional medical opinion regarding alternative treatment options.

For more detailed information regarding the Expert Medical Opinion Service, please access the following link: https://alz.id/EMO

Medical Assistance

Scope of Medical Assistance

The following Medical Assistance may be provided to the Insured if the Insured passes away, suffers an Incident , or suffers an Illness or certain conditions as specified below, to the extent that the event occurs during the coverage period of this Medical Assistance, PROVIDED that the following shall apply:

a) The Insured is travelling more than 100 (one hundred) kilometers from their Place of Residence or when the Insured is abroad for a period not exceeding 90 (ninety) days; and
b) The Insured must first contact the 24-Hour Emergency Assistance at the telephone number provided in the medical assistance card before arranging or performing any action that requires arrangement/fees from the Partner Company.

For more detailed information regarding the Expert Medical Opinion Service, please access the following link: https://alz.id/EMO

SUMMARY INFORMATION

Product Type
Traditional Individual Health Insurance Product

Entry Age (Nearest Birthday)
Insured
1 month – 75 years old
Policyholder
Minimum 18 years old.

Insurance Period
1 year and renewable annually up to age 100

Currency
Rupiah.

Elimination Period or Cancer Treatment Benefit
The first three (3) months from and including the Coverage Effective Date.

Waiting Period

Plan Standard

- For each Illness and Insurance Benefit, except those arising from Accidents, Incidents, or Force Majeure: 30 days*.
- For Cancer Illness or Cancer Treatment Benefits: three (3) months after the end of the Elimination Period.
- For Specified Illness or Healthcare Services related to Specified Illness: Specified Illness shall not be covered, unless the Policy is renewed, in which case such Specified Illness shall be covered for the subsequent renewal year.

Plan Extra dan Premier

- For each Illness and Insurance Benefit, except those arising from Accidents, Incidents, or Force Majeure: 30 days*.
- For Cancer Illness or Cancer Treatment Benefits: three (3) months after the end of the Elimination Period.
- For Specified Illnesss or Healthcare Services related to Specified Illnesss: a six (6)-month Waiting Period followed by a six (6)-month Own Risk period, with an Own Risk amount for Specified Illnesss of IDR 100,000,000.
- For HIV/AIDS Treatment: six (6) months*.

*) Calculated from the Coverage Effective Date.

Premium Payment Period
Annual and renewable on a yearly basis up to age 99.

Premium Payment Frequency
Monthly, quarterly, semi-annual, and annual

Multiplication Factor for Premium Payment Frequency:

Payment Frequency	Multiplication Factor
Annual	100%
Semi-Annual	52%
Quarterly	27%
Monthly	10%

Grace Period
1 (one) day before the same date in the following month

Underwriting
Full Underwriting.

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GENERAL SUMMARY OF PRODUCT AND SERVICE INFORMATION (RIPLAY)

PT Asuransi Allianz Life Indonesia

SUMMARY

Own Risk (Deductible)

- The Deductible amount payable for each Inpatient Treatment or Surgical Procedure shall apply in accordance with the Hospital or Clinic Category, as set forth in the Benefit Table
- The applicable Deductible borne by the Policyholder shall be determined based on the category of the Hospital or Clinic where the Insured receives Healthcare Services, namely Preferred Network or Other Network.
- The Insurer may update the List of Hospitals and Clinics, including any changes to categories related to Cashless Facilities, Preferred Network, Other Network, and/or the designation of Hospitals/Clinics Outside the Scope of Coverage, provided that such List shall be updated on the 1st day of each month. If the 1st day falls on a public holiday and/or a non-working day (including Saturdays and Sundays), the update shall be carried out on the nearest preceding working day.
- The applicable version shall be the List of Hospitals and Clinics available on the Insurer's official website and/or customer portal at the time the Insured receives Healthcare Services. The Policyholder and/or the Insured is required to review the most recent List of Hospitals and Clinics prior to the Insured receiving Healthcare Services.
- **Deductible shall not apply to the following:**
  a. Critical Illness (Palliative Care);
  b. Outpatient Services;
  c. HIV/AIDS Treatment;
  d. Accidents; and
  e. Force Majeure, being disasters officially declared by the Government (President, Governor, Regent/Mayor).
- For Extra and Premier Plan, Specific Illness shall be subject to a Deductible amount of IDR 100,000,000 on an aggregate basis per Policy Year, applicable for six (6) months after the completion of the six (6)-month Waiting Period, and shall apply to all Plans. From the second (2nd) Policy Year onwards, the Deductible shall apply in accordance with the Preferred Network provisions.

  The Specified Illnesses include, but are not limited to, the following:
  a. Kidney stones, urinary tract or bladder stones, and gallstones;
  b. Diseases of the heart, coronary vessels, and cerebral blood vessels (e.g. heart failure, coronary heart disease, stroke);
  c. Cataract;
  d. All types of benign tumors, masses, cysts, or polyps;Diseases of the tonsils or adenoids and abnormal conditions of the nasal cavity, intranasal septum, or turbinate concha, including sinus conditions requiring surgical intervention;
  e. Diabetes Mellitus;
  f. Tuberculosis and all related complications;
  g. Thyroid gland disorders;
  h. Hypertension and hyperlipidemia (e.g. hypercholesterolemia, hypertriglyceridemia);
  i. Chronic Renal Failure;
  j. All types of hernia and intervertebral disc prolapse;
  k. All types of hematological and autoimmune disorders.
  m. Hemorrhoids;
  n. All types of disorders of the male or female reproductive system, including but not limited to uterine fibroids / myomas; and/or
  o. Gastric ulcer (peptic ulcer disease).

DEFINITION

You
Policyholder.

We
PT Asuransi Allianz Life Indonesia

Insured
The individual whose life is the subject of insurance under this Policy.

Insurance Benefit
Benefits to which the Insured, the Policyholder, or the Beneficiary (as applicable) is entitled, in accordance with the Terms and Conditions of the Policy, as set forth in the Benefit Table

Own Risk (Deductible)
Deductible refers to the amount payable by the Policyholder or the Insured for each Healthcare Service received by the Insured before the Insurer becomes liable to pay the Insurance Benefits, in accordance with the Terms and Conditions of the Policy. The Deductible consists of:(i) Deductible Option 1 or Deductible Option 2; and(ii) a Deductible applicable to Specified Illness claims, each of which is further governed in the Terms and Conditions of the Policy.

Grace Period
A period that begins on the Premium Due Date and ends 1 (one) day before the same date in the following month if such date exists, or on the last calendar day of the following month if there is no date that is the same as the Premium Due Date in that month

WHAT ARE THE RISKS ASSOCIATED WITH THIS PRODUCT?

Credit Risk
Risks associated with Allianz's ability to pay its obligations to its customers. Allianz continually maintains its performance to exceed the minimum capital adequacy requirements set by the Government

Operational Risk
Risks arising from inadequate/failing internal processes, or from employee behavior and operational systems or from external events that may impact the company's operational activities.

Economic and Political Condition Change Risk
Risks associated with Allianz's ability to pay its obligations to its customers. Allianz continually maintains its performance to exceed the minimum capital adequacy requirements set by the Government.

Exclusion Risk
Risks associated with the terms where Allianz is unable to provide Insurance Benefits as stated in the Exclusion terms of the Policy.

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GENERAL SUMMARY OF PRODUCT AND SERVICE INFORMATION (RIPLAY)

PT Asuransi Allianz Life Indonesia

WHAT ARE THE APPLICABLE FEES?

You will only be subject to a stamp duty charge for the initial Premium payment

HOW TO APPLY FOR YOUR POLICY?

1. Completion and signing of the Individual Health Insurance Application Form (FAAKP).
2. Signing of the Benefit Illustration and the Personal Product and Service Information Summary (RIPLAY Personal).
3. Submission of a copy of a valid identification document of the prospective Policyholder and Insured (Identity Card / KITAS / KIMS), and completion of any other documents as may be required.

WHAT ARE YOUR OBLIGATIONS AS A POLICYHOLDER?

1. You are required to answer all questions in the Individual Health Insurance Application Form (FAAKP) completely and truthfully. You shall be fully responsible for the accuracy and completeness of all information provided to the Insurer, as any error or omission in the information required by the Insurer may result in the Policy being null and void, and the Insurer shall be released from any obligation to pay Insurance Benefits, as well as from any lawsuits, demands, claims, or portions thereof in any form and under any designation whatsoever, including any obligation to refund premiums, whether at present or in the future.
2. You are required to read and understand the Individual Health Insurance Application Form (FAAKP), the Benefit Illustration, the General Summary of Product and Service Information (RIPLAY Umum), and the Personal Product and Service Information Summary (RIPLAY Personal) prior to signing such documents.
3. You are required to pay the Premium on a timely basis.

ARE YOU ALLOWED TO CANCEL POLICY?

1. You are entitled to cancel the Policy and return it to the Insurer if you do not agree with the terms and conditions stipulated therein, within fourteen (14) calendar days from the date you receive your Policy (Cooling-Off Period).
2. Upon cancellation and return of the Policy as referred to in point 1 above, the Insurer shall refund no less than the amount of Premium paid, after deducting applicable costs (if any), no later than seven (7) working days from the date the Insurer has completely and correctly received the cancellation request together with all required supporting documents and has approved such cancellation. Thereafter, the Coverage shall automatically be terminated retroactively from the Policy Effective Date. The deductible costs shall include, but are not limited to, stamp duty and medical examination costs (if any).
3. After the Cooling-Off Period as referred to in point 1 above, the Policyholder may terminate the Coverage of the Insured under the Policy, and such termination shall become effective on the date the termination notice is received by the Insurer or on the date stated in the notice, whichever occurs later. No Premium refund shall be made if the Policy is terminated after the Cooling-Off Period.

HOW TO APPLY CLAIM?

Reimbursement Claim

Healthcare Services must be obtained by the Insured at one of the Hospitals or Clinics listed in the List of Hospitals and Clinics, excluding any Hospitals or Clinics Outside the Scope of Coverage. The Insurer reserves the right to reject any claim if the Healthcare Services are received by the Insured at a Hospital or Clinic Outside the Scope of Coverage

Reimbursement Claim Documents

1. Photocopy of the Identification Document of the Insured (in the form of Birth certificate (children), electronic Identity Card (KTP) for Indonesian citizens (adults), and passport for foreign citizens (adults);
2. Complete and correct Individual Health Insurance Claim Form signed by the Insured and/or You;
3. Medical Record form completed and signed by the attending Doctor with the original stamp/seal from the Hospital;
4. Proof of original payment for the treatment in the form of original receipts with fees details for each procedure and/or Healthcare Service;
5. Copy of diagnostic supporting examination results;
6. Copy of prescriptions related to treatment;
7. Referral letter from the Doctor for care and treatment by a specialist Doctor, diagnostic tests, and Physiotherapy;
8. Power of Attorney Form for the Disclosure of Medical Information and/or Data;
9. Police Certificate in the event the Insured has suffered an Accident;
10. Additional documents from the Doctor in the event the Insured suffered an Emergency condition; and
11. Other supporting documents, if required.

All claim documentations must be prepared and submitted to Us within no later than 30 (thirty) calendar days from the billing date or the date the Insured is discharged from the Hospital or Clinic, whichever is later. In the event this provision is not complied with, the Insured's claim shall not be paid.

If the claim is approved by Us, and subject to the other terms and conditions under these Policy Terms and Conditions (including provisions governing Eligible Claims and Deductibles), We will pay the Insurance Benefit for the claim to the Policyholder within 7 (seven) working days of receiving the correct and complete claim documents.

Version 2.1

GENERAL SUMMARY OF PRODUCT AND SERVICE INFORMATION (RIPLAY)

Cashless Claim

A Cashless Facility may be used by the Insured for Healthcare Services provided during Inpatient Care specified in the Benefit Table and in accordance with Your selected Plan.

To utilize the Cashless Facility, the following terms and conditions shall apply:

1. The Insured must undergo Healthcare Services at the Healthcare Service Network in accordance with the procedures and provisions that We determine from time to time.
2. The Insured must present the Insurance Card and other forms of identification to the Healthcare Service Network when applying for Healthcare Services.
3. The Healthcare Service Network shall carry out a verification process with Us before providing Healthcare Services
4. You, the Insured and/or the Healthcare Service Network must provide medical information and/or data related to the Healthcare Service plan completely and correctly. We shall carry out initial assessments on the medical information and/or data provided to assess whether the Healthcare Services request is included in the coverage under these Policy Terms and Conditions. We reserve the right to request additional documents/medical records, supporting examination results, and/or other information that We deem necessary for the assessment process, and reserve the right to delay or refuse the provision of the Cashless Facility if the requested information is not provided. After Our initial assessments:
   a. If the Healthcare Services to be provided are covered under these Policy Terms and Conditions, We shall issue an Inpatient Care approval letter to the Healthcare Service Network. However, We may cancel the Inpatient Care approval letter at any time if the Healthcare Services provided do not comply with these Policy Terms and Conditions or if there is an indication that the diagnosis or treatment is not covered or excluded under these Policy Terms and Conditions or if there is a discrepancy between the initial information and the actual condition/diagnosis/treatment. The Inpatient Care approval letter shall be temporary and administrative in nature, issued based on preliminary information, and is not a guarantee that the claim will be paid, which shall remain subject to final claim assessment under these Policy Terms and Conditions; or
   b. If We have not been able to assess if the Healthcare Services to be provided is covered under these Policy Terms and Conditions, We shall be entitled to not issue an Inpatient Care approval letter relating to the Healthcare Services to be received by the Insured. However, the Insured may submit a Reimbursement claim regarding the Healthcare Service fees to Us, in accordance with the Reimbursement claim submission procedure as stipulated in the Policy Terms and Conditions

Notes:

i. Before the Insured leaves the Hospital or Clinic, You and/or the Insured must pay all uncovered Healthcare Service fees (Insurance Excess Claim) under these Policy Terms and Conditions (including fees arising from the application of the Pro-Rated Payment provisions, and other uncovered fees exceeding the Benefit Table Limit, Annual Benefit Limit, Additional Annual Benefit Limit, or arising from room/service class upgrades at the Insured's request).

ii. Cashless Facility is an additional service or facility to facilitate the Insured in receiving Healthcare Services at the Healthcare Service Network. Therefore, We shall be entitled to limit or terminate this Cashless Facility at any time and/or determine the procedures of the Cashless Facility under this Coverage (including changing Healthcare Service Network from time to time).

Death Benefit Claim

The submission of a claim for Death Benefit payment must be accompanied with the following documents:

a. Death claim form fully and correctly completed by the Beneficiary.
b. Death claim form fully and correctly completed by the attending Doctor of the Insured.
c. Power of Attorney form for the Disclosure of Medical Information and/or Medical Data that has been filled out and signed on a stamp duty by the Beneficiary.
d. Photocopy of the Death Certificate from the relevant Government Institution (excerpt of Death Certificate).
e. Photocopy of the Police Report in case of an unnatural, unknown death or death due to Accident or Incident suffered by the Insured, as well as autopsy or post-mortem examination (visum) from a Doctor.
f. Statement letter explaining the chronological details of the Insured's death that shall be prepared thoroughly and correctly and signed by the Beneficiary (if the Insured died at home without treatment from a Doctor).
g. Photocopy of all medical examination results related to the Policy/the submission of this claim related to the medical procedures, treatments, and/or Healthcare Services carried out and/or received by the Insured
h. Notice form for the account number fully and correctly completed by the Beneficiary, and a photocopy of the Beneficiary's bank statement.
i. Photocopy of the identification document of the Insured in the form of Birth certificate (children), electronic Identity Card (KTP) for Indonesian citizens (adults), and passport for foreign citizens (adults).
j. Photocopy of the identification document of the Beneficiary in the form of birth certificate (children), electronic Identity Card (KTP) for Indonesian citizens (adults), and Passport for foreign citizens (adults).
k. Photocopy of supporting documents describing the relationship between the Insured and the Beneficiary.
l. Other documents (if necessary)

Notes:

- A completed and signed claim form, together with other supporting documents as required under the Terms and Conditions of the Policy, must be received at the Insurer's Head Office in Jakarta no later than sixty (60) days from the date the insured risk occurs. Failure to comply with this requirement shall result in the Insurer not paying the claim of the Insured.

- The Death Benefit claim shall be paid by the Insurer no later than fourteen (14) working days from the date the claim is approved by the Insurer and the complete and accurate claim documents have been duly received.

Insurance Excess Claim

Upon being discharged from the Hospital or Clinic, You and/or the Insured shall be responsible for paying any fees that are not covered (Insurance Excess Claim) under these Policy Terms and Conditions. You and/or the Insured shall not be released from the obligation to pay any Insurance Excess Claim and must still pay any Insurance Excess Claim if:

a. You and/or the Insured do not pay the Insurance Excess Claim upon being discharged from the Hospital or Clinic; or

b. After We have received the claim documents from the Hospital or Clinic (including the bills and details of Healthcare Services and fees), We discover that:
   1) The Hospital or Clinic has not billed or has underbilled the Insurance Excess Claim to You and/or the Insured;
   2) There are conditions that are inconsistent with these Policy Terms and Conditions or if there is an indication that the diagnosis or treatment falls within the scope of those not covered or excluded under these Policy Terms and Conditions; and/or
   3) There is an adjustment to the Insurance Benefit (including Insurance Benefit under the Benefit Table Limit, Annual Benefit Limit, Additional Annual Benefit Limit, or other provisions of this Policy) resulting in a difference for which You and/or the Insured shall be responsible.

Notes:
In the event of the aforementioned, and We shall charge You the Insurance Excess Claim. You and/or the Insured must pay Us the Insurance Excess Claim within 14 (fourteen) days from the date the Insurance Excess Claim is issued by Us. We shall not pay any Insurance Benefit and/or provide any further Cashless Facility if We have not received the Insurance Excess Claim payment after 14 (fourteen) days from the date We charged the Insurance Excess Claim. If You and/or the Insured have not paid the Insurance Excess Claim within 30 (thirty) days from the date We issue the Insurance Excess Claim bill, We reserve the right to take one or more of the following actions: (a) set-off the Insurance Excess Claim against Insurance Benefits payable at a later date; and/or (b) terminate Your Policy, without prejudice to Your and/or the Insured's obligation to pay the Insurance Excess Claim owed to Us.

EXCLUSIONS

I. We shall not have no obligation to pay the Death Benefit under the Terms and Conditions of the Policy if the Insured's death is caused, directly or indirectly, by any of the following:**

1. The Insured dies as a result of suicide within one (1) year from the Coverage Effective Date or the Policy Reinstatement Date, whichever occurs later.

2. The Insured dies during the Insurance Period as a result of capital punishment imposed by a court, or due to intentionally committing or participating in a criminal act or an attempted criminal act, whether actively or passively, or if the Insured's death arises from insurance fraud committed by any party who has or shares an interest in the Policy.

II. The Insurer shall not pay any Insurance Benefits for any Healthcare Services, treatment, and/or medical care arising from, caused by, or related to the following:**

1. Any care, treatment, and/or Healthcare Services incurred prior to the Coverage Effective Date.
2. Any care, treatment, and/or Healthcare Services related to a Pre-Existing Condition, including any complications arising therefrom.
3. Any care, treatment, and/or Healthcare Services incurred during the Waiting Period.

For the avoidance of doubt, if any Illness (including cancer and HIV/AIDS), Specified Illness, condition, or Injury, health condition, or disability constitutes a Pre-Existing Condition or falls under any other exclusions pursuant to the Terms and Conditions of the Policy, then any care, treatment, and/or Healthcare Services related thereto shall not be covered under the Policy.

pursuant to the Terms and Conditions of the Policy, then the Coverage under the Policy shall not apply, notwithstanding that any Healthcare Services for such Illness (including cancer and HIV/AIDS), Specified Illness, condition, or Injury, health condition, or disability are provided after the expiration of the Waiting Period.

4. Cancer occurring during the Elimination Period; in such event, the Insurer shall not pay any Insurance Benefits (including Cancer Treatment Benefits) for any Healthcare Services, care, and/or treatment related to such cancer, including any subsequent Healthcare Services, care, and/or treatment provided after the Elimination Period and the Waiting Period for cancer and/or Cancer Treatment Benefits have ended.
5. Any care, treatment, and/or Healthcare Services that are not Medically Necessary and/or that result in charges exceeding Reasonable Fees.
6. Mental, behavioral, psychiatric, psychological, or neurological disorders, including but not limited to anxiety, anorexia, depression, stress, psychosis, neurosis, fatigue, psychosomatic complications, psychogeriatric conditions, and any physiological or psychosomatic manifestations, as well as any care and/or treatment provided while the Insured is under the influence of or involved in the use of narcotics, alcohol, psychotropic substances, toxins, gases, or addiction to similar substances or drugs, except where such substances or drugs are used as prescribed medication by a licensed Physician.
7. Pregnancy (pre-, during, or post-pregnancy), including any pregnancy-related complications arising from Accidents or Incidents, miscarriage or childbirth, termination of pregnancy, pre-pregnancy care or post-delivery care, or complications arising from dysfunction or insufficiency, contraception, sterilization, birth control methods, testing or treatment for impotence, and all types of assisted reproductive procedures, as well as all hormonal therapies related to premenopausal syndrome, including all resulting complications.
8. Any care, treatment, and/or Healthcare Services for the purpose of weight reduction or weight gain, including any complications arising therefrom.
9. Any care, treatment, and/or Healthcare Services related to cosmetic purposes, including plastic surgery, except for Medically Necessary functional reconstructive plastic surgery, provided that such surgery is performed within six (6) months from the date of the prior Surgery that necessitates and is directly related to the functional reconstructive procedure.
10. Eye examinations, refractive errors of the eye including myopia, and/or the purchase or rental of spectacles or lenses (including but not limited to non-monofocal lenses used as a result of cataract surgery), except for LASIK treatment for refractive errors exceeding five (5) diopters.
11. Routine physical examinations, medical check-ups (Medical Check-Ups) (including but not limited to genetic testing intended to predict the risk of disease and/or for early prevention of a disease), or any diagnostic tests not related to the treatment or diagnosis of a covered Illness or Injury.
12. Expenses incurred that are not for the direct treatment of an Illness or Injury (non-medical expenses), excluding administrative fees.
13. Immunizations and vaccinations, including any care and/or treatment related to their complications.

GENERAL SUMMARY OF PRODUCT AND SERVICE INFORMATION (RIPLAY)

EXCLUSIONS

14. Any care, treatment, and/or Healthcare Services, including any complications arising therefrom, related to the following:
    a. Congenital abnormalities. For the avoidance of doubt, congenital abnormalities may arise or manifest at any stage of life and are not limited to those present at birth or where signs or symptoms appear at birth (birth defects). The determination of congenital abnormalities shall refer, among others, to a Physician's diagnosis and/or relevant medical literature or journals (both domestic and international);
    b. Growth and/or developmental disorders or delays; and/or
    c. Circumcision not related to an Illness or Injury.
15. Any care, treatment, and/or Healthcare Services, including any complications arising therefrom, related to sexually transmitted diseases, gender reassignment, sex change, or sexual disorders.
16. Family planning, including any care and/or treatment related to associated complications.
17. Any care, treatment, and/or Healthcare Services, including any complications arising therefrom, resulting from the following:
    a. Active involvement in war, riots, fights, or criminal acts;
    b. Intentional injuries and attempted suicide; and/or
    c. Any criminal act or attempted criminal act, violation of law or attempted violation of law committed by the Insured, or any resistance by the Insured at the time of detention carried out by the authorities against any person (including the Insured).
18. Any care, treatment, and/or Healthcare Services, including any complications arising therefrom, resulting from the Insured engaging in and/or participating in hazardous activities or sports (whether for remuneration or otherwise), including but not limited to racing, competitions or speed contests (other than walking or swimming), martial arts, potholing, rock climbing, mountaineering, rope-assisted climbing, diving at depths exceeding 30 meters, diving activities involving the use of breathing apparatus, skydiving, cliff diving, bungee jumping, BASE jumping (Building, Antenna, Span, Earth), paragliding, hang gliding, and parachuting.
19. Any care, treatment, and/or Healthcare Services, including any complications arising therefrom, resulting from the Insured participating in any aviation activity other than as a fare-paying passenger or as a crew member of a duly licensed commercial airline operating on a scheduled and regular basis.
20. Outpatient Services, except for Outpatient Services required by the Insured as a result of an Accident, Incident, Emergency condition, and/or Force Majeure
21. Any care, treatment, and/or Healthcare Services related to dental conditions and their complications, except where such services are required as a result of an Emergency, Force Majeure, Accident, or Incident. Notwithstanding the foregoing, dentures, dental crowns, and dental implants, for any reason whatsoever, including those arising from an Emergency, Force Majeure, Accident, or Incident, are excluded from coverage under the Terms and Conditions of the Policy.
22. Any care, treatment, and/or Healthcare Services that have been reimbursed or covered by the Government, BPJS Kesehatan, other health insurance providers, and/or any other third party.
23. Experimental treatment, including medications, use of drugs, technology, and/or non-conventional medical procedures that have not been proven effective based on established medical practices and have not received approval from recognized authorities in the country where the Insured receives care and/or treatment, including but not limited to the National Health Service Guidelines and Medical Service Standards issued by the Ministry of Health of the Republic of Indonesia.
24. Specifically for the Standard Plan, any care, treatment, and/or Healthcare Services arising from, caused by, or related to HIV/AIDS. Specifically for the Standard Plan, the following are excluded:
    a) Home care services (including nursing visits/medical personnel visits and caregiver services);
    b) Rehabilitation (including medical and non-medical rehabilitation programs);Traditional, complementary, or alternative treatments (including acupuncture, herbal medicine/jamu, chiropractic care, homeopathy, and similar treatments);
    c) Organ or tissue transplantation (including donor/recipient evaluation, procedures, transplant-related medications, and follow-up care);
    d) Purchase of durable medical equipment to assist the Insured's daily activities;
    e) Purchase of prosthetic limbs; and
    f) Palliative care.
25. Specifically for the Standard Plan, any care, treatment, and/or Healthcare Services related to Specified Illnesss, including any complications arising directly or indirectly from such Specified Illnesss.*
26. Exclusively for the Standard Plan, any treatment, medication, and/or healthcare services related to Special Illness, including any complications arising directly or indirectly from such Special Illness.*

III. If the Insured has disclosed a Pre-Existing Condition accurately and completely at the time of completing and submitting the Individual Health Insurance Application Form (FAAKP), the following provisions shall apply:
    a. Where the FAAKP application has been approved by the Insurer, whether subject to an additional premium (substandard) or without additional premium (standard), the Insurer reserves the right not to apply the exclusion as set out in Point (II)(2) above, limited only to the Pre-Existing Condition that has been properly and fully disclosed.
    b. Where the FAAKP application has been approved but the Insurer issues a document stating that the disclosed Pre-Existing Condition is permanently excluded from Insurance Benefits under the Terms and Conditions of the Policy (permanent exclusion), then the exclusion as set out in Point (II)(2) above shall apply, and the Insurer shall not pay any claims arising directly or indirectly from such disclosed Pre-Existing Condition, including any complications thereof.

Notes Specifically for Plan Standard:
*) Where the Insurer has renewed the Insurance Period, then from the first renewal date of the Insurance Period following the Coverage Effective Date, the exclusion for Specified Illnesss as set out in Exclusion Point II number 26 above shall no longer apply to subsequent Insurance Periods.

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GENERAL SUMMARY OF PRODUCT AND SERVICE INFORMATION (RIPLAY)

PT Asuransi Allianz Life Indonesia

Mr. Lutfi
(Insured are a Policyholder dan Premium Payor)
Entry Age: 30 years old at the time of purchasing Allianz Preferred Medical

Chosen Plan : Plan Premier

Premium : Rp18.828.000/year

Selection of Deductible:
Deductible Option 2

Payment Method Selection:
Autodebit via Savings Account

Claim Scenario Illustration

Mr. Lutfi was diagnosed with Chronic Kidney Failure in the second (2nd) year after purchasing the Allianz Preferred Medical Policy.

Mr. Lutfi underwent diagnostic examinations to determine the next course of treatment, and the associated costs were covered on an as-charged basis.

Sixty (60) days later, Mr. Lutfi was hospitalized and received Dialysis treatment for thirty (30) days at a Hospital.

Assumed costs incurred for Mr. Lutfi's treatment for Chronic Kidney Failure over a period of thirty (30) days

Benefits	Fees	Fees Total (Per 30 Days)
Bedroom (lowest single bed category)	Rp1.650.000/Days	Rp49.500.000/Days
Specialist Doctor Visits	Rp500.000/Days	Rp15.000.000/Days
Dialysis Treatment	Rp50.000.000/package	Rp50.000.000/package
Diagnostic Tests	Rp60.000.000	Rp60.000.000
Other Inpatient Expenses	Rp20.000.000	Rp20.000.000
Total Charges		**Rp194.500.000**
Approved Claim Amount		**Rp194.500.000**

Hospital Category	*Preferred Network*	*Other Network* (Asia *except* SG, HK, JP)	*Other Network* (SG, HK, JP, AUS)
Deductible (out-of-pocket costs)	Rp10.000.000	Rp20.000.000	Rp40.000.000
Paid by Allianz	Rp184.500.000	Rp174.500.000	Rp154.500.000

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GENERAL SUMMARY OF PRODUCT AND SERVICE INFORMATION (RIPLAY) PT Asuransi Allianz Life Indonesia

BENEFIT ILLUSTRATION

Scenario 1 – Claim Amount: Rp100.000.000

Plan		*Plan* Premier (*As Charged*)		
Claim in 1 Year Policy		Hospital Categories		
		Preferred Network	***Other Network*** (Asia *except* SG, HK, JP)	***Other Network*** (SG, HK, JP, AUS)
Claim	Total Eligible Claim	100.000.000	100.000.000	100.000.000
	Deductible (Out-of-pocket costs)	10.000.000	20.000.000	40.000.000
	Claim Paid by Allianz	90.000.000	80.000.000	60.000.000

Scenario 2 – Claims up to the Maximum Deductible Amount

Plan		*Plan* Premier (*As Charged*)		
Claim in 1 Year Policy		Hospital Categories		
		Preferred Network	***Other Network*** (Asia *except* SG, HK, JP)	***Other Network*** (SG, HK, JP, AUS)
Claim 1	Total Eligible Claim	5.000.000	5.000.000	5.000.000
	Deductible (Out-of-pocket costs)	10.000.000	20.000.000	40.000.000
	Claim Paid by Allianz	-	-	-
Claim 2	Total Eligible Claim	25.000.000	25.000.000	25.000.000
	Deductible (Out-of-pocket costs)	5.000.000	15.000.000	35.000.000
	Claim Paid by Allianz	20.000.000	10.000.000	-
Claim 3	Total Eligible Claim	100.000.000	100.000.000	100.000.000
	Deductible (Out-of-pocket costs)	0*	0*	10.000.000
	Claim Paid by Allianz	100.000.000	100.000.000	90.000.000

*) The Deductible payable by the Policyholder for the second and subsequent claims, after the maximum Deductible amount in one (1) Policy Year has been reached.

Scenario 3 –Claim calculation where the Insured undergoes inpatient treatment in Indonesia and claim calculation on a pro-rata basis

Plan	*Plan* Premier
Deductible for *Other Network* (Asia *except* SG, HK, JP)	a deductible of Rp20.000.000,-
Claim Amount Submitted	Inpatient treatment for ten (10) days in Indonesia. The Insured occupies a room one level higher than the nearest room category under the selected Plan, due to the unavailability of rooms corresponding to the Plan
Daily Cost Detail	
Bedroom Fee	Rp2.500.000,- / Days
Specialists Doctor Fee	Rp600.000,- / Days
Other Inpatient Expenses (Days 1 – 2)	Rp30.000.000
Other Inpatient Expenses (Days 3 – 10)	Rp100.000.000
Description	In accordance with the Policy provisions, if a room corresponding to the selected Plan is unavailable, the Insured may occupy a room one level higher than the nearest room category under the selected Plan, for a maximum of two (2) consecutive days. Therefore: • Treatment for Days 1–2 (2 days): covered on an as-charged basis • Treatment for Days 3–10 (8 days): covered on a pro-rata basis
Pro-Rata Claim Calculation	$= \frac{Entitled\ Room\ Rate}{Room\ Rate\ Utilizad} \times Total\ Charges\ \text{of}\ Eligible\ Claim\ Amount$ $= \frac{Rp1.650.000}{Rp2.500.000} \times \left(\left(8\ x\ (Rp2.500.000 + Rp600.000) \right) + Rp100.000.000 \right)$ = Rp82.368.000
Claim Details	
Total Claim Submitted	Rp161.000.000
Total Eligible Claim	Biaya Days 1-2: (2 x (Rp2.500.000 + Rp600.000)) + Rp30.000.000 Biaya Days 3-10 (Pro Rata): Rp82.368.000 Total = Rp116.068.000
Total Claim Amount Payable by the Policyholder	(Rp161.000.000 – Rp116.068.000) + Rp20.000.000 (Deductible) = Rp64.932.000
Claim Paid by Allianz	Rp161.000.000 – Rp64.932.000 = Rp96.068.000

Notes:

- SG, HK, JP, AUS : Singapore, Hong Kong, Japan, Australia
- The Deductible calculation scenario for the Extra Plan and Premier Plan is the same (for Preferred Network and Other Network – Asia excluding Singapore, Hong Kong, and Japan). However, the scenario for Other Network (Singapore, Hong Kong, Japan, and Australia) applies only if the Policyholder selects the Premier Plan.

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GENERAL SUMMARY OF PRODUCT AND SERVICE INFORMATION (RIPLAY)

PT Asuransi Allianz Life Indonesia

COMPLAINT HANDLING AND DISPUTE RESOLUTION SERVICES

1. Customer Complaint Handling

a. The Policyholder may submit a complaint either in writing or verbally to the Insurer through the complaint handling channels provided by the Insurer.

b. The Insurer shall follow up on such complaint within the following timeframes

i. For verbal complaints: within five (5) working days from the date the complaint is received by the Insurer (or such other timeframe as may be stipulated from time to time under regulations issued by the Financial Services Authority (Otoritas Jasa Keuangan / OJK)).

ii. For written complaints: within ten (10) working days from the date the supporting documents are completely received by the Insurer (or such other timeframe as may be stipulated from time to time under regulations issued by the Financial Services Authority (OJK)).

c. If certain conditions as stipulated under regulations issued by the Financial Services Authority (Otoritas Jasa Keuangan / OJK) apply, and upon prior notification to the Policyholder, the Insurer may:(i) extend the timeframe referred to in point (1)(b); or(ii) follow up on the complaint beyond the timeframe specified in point (1)(b).

d. Further information regarding the complaint handling channels and procedures is available to the Policyholder on the Insurer's official website.

e. In the event that no agreement is reached regarding the outcome of the complaint follow-up as referred to in point (1), the Policyholder may submit the complaint to the OJK for handling in accordance with its authority, or resolve the dispute arising from such complaint in accordance with the provisions set out in point (2).

2. Dispute Resolution Process

a. If a dispute arises between the Policyholder and the Insurer or any other party with an interest in the Policy, such dispute may first be resolved amicably through mutual deliberation to reach a consensus.

b. In the event that the dispute as referred to in point (2)(a) cannot be resolved and no agreement is reached, the Insurer and the Policyholder may resolve the dispute either through out-of-court settlement or through a competent court of law.

c. Out-of-court dispute resolution, as referred to in point (2)(b), shall be conducted through an Alternative Dispute Resolution Institution established by the Financial Services Authority (Otoritas Jasa Keuangan / OJK), including but not limited to the Financial Services Sector Alternative Dispute Resolution Institution, or any other authorized Alternative Dispute Resolution Institution designated by the OJK from time to time.

SERVICES, COMPLAINT HANDLING, and CLAIM PROCESSING

Should you have any questions or complaints regarding our products and/or services, please submit your inquiries and complaints through our Customer Center:

Address:
PT Asuransi Allianz Life Indonesia
Customer Lounge
World Trade Centre 6, Ground Floor
Jl. Jenderal Sudirman Kav. 29-31
Jakarta Selatan 12920, Indonesia

AllianzCare:
1500 136

Email:
contactus@allianz.co.id

Website:
www.allianz.co.id

PT Asuransi Allianz Life Indonesia is licensed and supervised by the Financial Services Authority (Otoritas Jasa Keuangan)

GENERAL SUMMARY OF PRODUCT AND SERVICE INFORMATION (RIPLAY)

PT Asuransi Allianz Life Indonesia

Important Notes:

- PT Asuransi Allianz Life Indonesia is licensed and supervised by the Financial Services Authority (Otoritas Jasa Keuangan / OJK), and its Marketing Personnel are licensed by the Indonesian Life Insurance Association.
- The Premium paid includes commissions for insurance agents/marketing personnel.
- A complete description of the insurance coverage is set out in the Policy. The insurance coverage is subject to the Exclusions specified in the Policy, being matters not covered under the Policy.
- The Insurer shall notify any changes to the benefits, fees, risks, terms, and conditions of this product and service through written notice or other methods in accordance with the applicable terms and regulations. Such notification will be provided at least thirty (30) working days prior to the effective date of the changes.
- Allianz Preferred Medical is an individual health insurance product issued by PT Asuransi Allianz Life Indonesia, and therefore PT Asuransi Allianz Life Indonesia is responsible for the contents of the Policy.
- You are required to read and fully understand this GENERAL SUMMARY OF PRODUCT AND SERVICE INFORMATION (RIPLAY) before agreeing to purchase the product, and you are entitled to raise any questions to the Marketing Personnel regarding this GENERAL SUMMARY OF PRODUCT AND SERVICE INFORMATION (RIPLAY).
- This GENERAL SUMMARY OF PRODUCT AND SERVICE INFORMATION (RIPLAY) does not constitute a contract or insurance agreement between PT Asuransi Allianz Life Indonesia and the customer, and therefore is not legally binding on either party. The customer shall be fully bound by all provisions set out in the Policy.
- This GENERAL SUMMARY OF PRODUCT AND SERVICE INFORMATION (RIPLAY) is provided for general informational purposes only. The complete terms and conditions of Allianz Preferred Medical are set out in the Policy. For further information, please contact the Insurer or your Marketing Personnel, or visit the official website at www.allianz.co.id. All products are designed to provide benefits to customers but may not necessarily be suitable for your specific needs. If you are unsure whether this product meets your requirements, it is recommended that you contact your Marketing Personnel.
- The Insurer reserves the right to decline any Policy application that does not meet the applicable requirements and regulations.

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