Allianz

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

Allianz Flexi Medical

An individual life insurance product giving comprehensive and flexible benefits in accordance with Your needs.

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 Personnels before deciding to purchase this Policy.

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

"You/Your/Policyholder" refers to the Individual 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 this Policy and whose name is specified in the Policy Data.

For more detailed definitions and information, you may refer to the Policy issued by Us.

What are the Benefits Provided by This Product?

In '000 Rupiah

Benefit	Description	Classic	Classic Plus	Essential Pro	Essential Plus	Elite Pro	Elite Plus
ACCIDENTAL DEATH BENEFIT		50,000	50,000	50,000	50,000	50,000	50,000
NON-ACCIDENTAL DEATH BENEFIT		25,000	25,000	25,000	25,000	25,000	25,000
INPATIENT CARE BENEFIT							
COVERAGE AREA		Indonesia	Indonesia	Asia, kecuali HKG, SG, JPN	Asia, kecuali HKG, SG, JPN	Asia + Australia	Asia + Australia
Inpatient Care and Surgery							
Room & Accommodation	No maximum day limit	The greater of the lowest-class room with 2 beds and an en suite bathroom and the Room Charge Limit	The greater of the lowest-class room with 1 bed and an en suite bathroom and the Room Charge Limit	The greater of the lowest-class room with 1 (one) bed (in Indonesia) / 2 (two) beds (outside Indonesia) and en-suite bathroom and the Room Charge Limit	The greater of the lowest-class room with 1 bed and an en suite bathroom and the Room Charge Limit	The greater of the lowest-class room with 1 (one) bed (in Indonesia) / 2 (two) beds (outside Indonesia) and en-suite bathroom and the Room Charge Limit	The greater of the lowest-class room with 1 bed and an en suite bathroom and the Room Charge Limit
	Batas Harga Kamar	700	1,300	900	1,300	1,100	1,650
Intensive Care Unit (ICU)		As Charged	As Charged	As Charged	As Charged	As Charged	As Charged
Surgery							
Prostheses and Implants							
Doctor Visit Fees							
Inpatient Care Miscellaneous Fees							
Pre-Inpatient Care Fees**	Per Policy year; Max. 60 days pre-Inpatient Care						
Post-Inpatient Care Fees**	Per Policy year, Max. 90 days post-Inpatient Care						
Outpatient Physiotherapy Care**	Per Policy Year; Max. 60 days pre-Inpatient Care Max. 90 days post-Inpatient Care						
Alternative Inpatient Care ("In-Home Care")**	Per Policy Year;	100,000	100,000	200,000	200,000	300,000	300,000
Additional Rehabilitation**	Per Policy Year; Max. 90 days after the end of the Inpatient Physiotherapy Care benefit	15,000	15,000	15,000	15,000	25,000	25,000
Traditional Medicine	Per Policy year, during Inpatient Care, Max. 90 days post-Inpatient Care	15,000 Max. 1,000 for medicine per Inpatient Care	15,000 Max. 1,000 for medicine per Inpatient Care	15,000 Max. 1,000 for medicine per Inpatient Care	15,000 Max. 1,000 for medicine per Inpatient Care	25,000 Max. 1,000 for medicine per Inpatient Care	25,000 Max. 1,000 for medicine per Inpatient Care
Inpatient Psychiatrist Consultation**	Per Policy Year, Max. 90 days post-Inpatient Care	15,000	15,000	15,000	15,000	25,000	25,000
Inpatient Care Daily Cash Benefit*	Per day; Max. 90 days per Policy year	350	650	350	650	550	850
Local Ambulance Fees		As Charged	As Charged	As Charged	As Charged	As Charged	As Charged

HKG, SG, JPN: Hong Kong, Singapore, Japan

*Payable to "Flexi Benefit" **Claims may only be made on a reimbursement basis

PT Asuransi Allianz Life Indonesia

Allianz Flexi Medical

Product Name
Allianz Flexi Medical

Product Type
Individual Health Insurance

Insurer Name
PT Asuransi Allianz Life Indonesia

Marketing Channel
Agency

Allianz

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ACCIDENTAL DEATH BENEFIT		50,000	50,000	50,000	50,000	50,000	50,000
NON-ACCIDENTAL DEATH BENEFIT		25,000	25,000	25,000	25,000	25,000	25,000
INPATIENT CARE BENEFIT							
COVERAGE AREA		Indonesia	Indonesia	Asia, excluding HKG, SG, JPN	Asia, excluding HKG, SG, JPN	Asia + Australia	Asia + Australia
CRITICAL ILLNESS CARE							
Dialysis Treatment**		As Charged	As Charged	As Charged	As Charged	As Charged	As Charged
Organ Transplantation Fees							
Organ Transplantation Donor**							
Cancer Treatment, including: Cancer Remission Examination & Lab test	Cancer Remission Treatment, Max. 5 years since the last active treatment						
Treatment for HIV/AIDS Infection	Per Policy year	15,000	15,000	15,000	15,000	15,000	15,000
Palliative Care	Per Policy year	250,000	250,000	250,000	250,000	250,000	250,000
EMERGENCY CARE BENEFIT							
Inpatient Care due to Emergency or Accident Outside the Coverage Area**	Applicable worldwide except the USA Within 48 hours since the Accident or Emergency occurs	As Charged	As Charged	As Charged	As Charged	As Charged	As Charged
Outpatient Care due to Emergency or Accident including Dental Care due to Emergency or Accident within and outside the Coverage Area**	Applicable worldwide except the USA Within 48 hours since the Accident or Emergency occurs						
Additional Outpatient Care due to Emergency or Accident**	Applicable worldwide except the USA Inpatient care within 30 days of Accident or Emergency.						
ADD-ON							
Durable Medical Equipment**	Per Policy Year; during Inpatient Care, until Maximum 90 days Post-Inpatient Care	15,000	15,000	15,000	15,000	15,000	15,000
Artificial Limbs**	Per Policy Year; during Inpatient Care, until Maximum 90 days Post-Inpatient Care	250,000	250,000	250,000	250,000	250,000	250,000
SERVICES							
Expert Medical Opinion		Available	Available	Available	Available	Available	Available
Medical Assistance							
Teleconsultation (Online Doctor Q&A) for Mental Health and Nutrition	12 times per Policy Year						
ANNUAL BENEFIT LIMIT		10,000,000	10,000,000	15,000,000	15,000,000	20,000,000	20.000,000
Deductible	Per Inpatient/Surgery;	15,000	15,000	20,000	20,000	25,000	25,000
Flexi Benefit Additional Facilities*	% Premium in the previous Policy Year period	1st Year: 5% 2nd Year: 10%, 3rd Year onwards 20%	1st Year: 5% 2nd Year: 10%, 3rd Year onwards 20%	1st Year: 5% 2nd Year: 10%, 3rd Year onwards 20%	1st Year: 5% 2nd Year: 10%, 3rd Year onwards 20%	1st Year: 5% 2nd Year: 10%, 3rd Year onwards 20%	1st Year: 5% 2nd Year: 10%, 3rd Year onwards 20%
Flexi Benefit	Claimable since the 3rd Policy year	Available as long as the requirements are met	Available as long as the requirements are met	Available as long as the requirements are met	Available as long as the requirements are met	Available as long as the requirements are met	Available as long as the requirements are met

HKG, SG, JPN: Hong Kong, Singapore, Japan.

*Payable to "Flexi Benefit" **Claims may only be made on a reimbursement basis

The Insurance Benefit for Basic Insurance under the Policy is as follows:

A. Inpatient Care or Surgery

Reimbursement of Inpatient Care or Surgery due to illness or Accident subject to the Limit in the Benefit Table and the Annual Benefit Limit in accordance with the selected Plan.

B. Critical Illness and Emergency Care Benefit

Reimbursement of the Critical illness Benefit fees refers to the Benefit Table in accordance with the selected Plan.

Reimbursement of the Emergency Care Benefit refers to the Benefit Table in accordance with the selected Plan.

C. Add-on

Reimbursement of the add-on fees such as Durable Medical Equipment and Artificial Limbs refers to the Benefit Table in accordance with the selected Plan.

D. Death Benefit

Accidental Death Benefit

We shall disburse the Accidental Death Benefit to the Beneficiary if the Insured passed away due to Accident. The Accidental Death Benefit amount is as specified in the Benefit Table.

Non-Accidental Death Benefit

We shall disburse the Non-Accidental Death Benefit to the Beneficiary if the Insured Party passed away due to reasons other than Accident. The Non-Accidental Death Benefit amount is as specified in the Benefit Table.

Flexi Benefit

We will extend Flexi Benefit benefits subject to the following terms and conditions:

a. We will create and manage a Flexi Benefit Account to collect Flexi Benefit Funds**;

b. Flexi Benefit Funds will be accumulated and credited to the Flexi Benefit Account in accordance with the following terms and conditions:

(i) If you opt for the electronic version of the Policy and Premium payment method by means of automatic debit through a credit card or savings account, 5% of the Premium amount paid will be credited to the Flexi Benefit Account;
(ii) If the Policy covers more than 1 Insureds, 5% of the Premium amount paid will be credited to the Flexi Benefit Account for each Insured;
(iii) If a claim for Inpatient Care Daily Cash has been approved by Us, the Inpatient Care Daily Cash (in accordance with the chosen Plan) will be credited to the Flexi Benefit Account; and/or
(iv) If the Policy is renewed in accordance with the Policy Terms and Conditions, and the terms and conditions of the Flexi Benefit Additional Facility set out under the "Flexi Benefit Additional Facility" below are satisfied.

Note:
*)Flexi Benefit Account is an account created and managed by the Insurer for each Policy to manage Flexi Benefit Funds.

**)Flexi Benefit Funds are funds provided by the Insurer solely for entry/crediting into the Flexi Benefit Account, and are designated for use by the Insured for any event meeting the terms and conditions set out in the Policy Terms and Conditions.

c. We shall also credit Flexi Benefit Funds as per the amounts set out below, contingent upon satisfaction of the following terms and conditions **("Flexi Benefit Additional Facility")**:
No Healthcare Services are performed by the Insured and no claims are submitted for Insurance Benefit (as referred to in the Policy Terms and Conditions) within a period of:

(i) 1 (year of the Insurance Period, 5% of the Premium amount paid during the Insurance Period before the Policy Renewal Date shall be credited to the Flexi Benefit Account;
(ii) 2 consecutive years of the Insurance Period, 10% of the Premium amount paid during the Insurance Period before the Policy Renewal Date shall be credited to the Flexi Benefit Account; and/or
(iii) 3 or more consecutive years of the Insurance Period, 20% of the Premium amount paid during the Insurance Period before the Policy Renewal Date shall be credited to the Flexi Benefit Account.

with the additional condition that:

(1) The Policy is renewed for the Insurance Period of the following year, and We will credit the Flexi Benefit Funds to the Flexi Benefit Account after the Policy Renewal Date;

(2) The Policy never lapses during the Insurance Period before crediting Flexi Benefit Funds to the Flexi Benefit Account. Specifically addressing points (ii) and (iii) of the Flexi Benefit Additional Facility, the Policy must never lapse during 2 3 years (or more) of consecutive Insurance Period (as applicable) before the Flexi Benefit Funds are credited to the Flexi Benefit Account;

(3) In the event that the number of Insureds in this Policy is more than 1 person, the crediting of Flexi Benefit Funds to the Flexi Benefit Account shall be based on each Insured meeting the terms and conditions of the Flexi Benefit Additional Facility, and as long as the Insured remains an "Insured" in the Policy Renewal Term of the following year; and

(4) If the Insured undergoes Healthcare Services but no claim is paid by Us because the amount of the claim is still within the Deductible limit; and/or the Policyholder uses Flexi Benefit Funds to pay for all fees of Healthcare Services for the Insured, the Insured shall be deemed to still meet the requirements of the Flexi Benefit Additional Facility.

d. Flexi Benefit Funds in the Flexi Benefit Account may only be used starting from the 3rd Policy Year, and are limited to the following purposes:

- Reimbursement of Outpatient costs incurred by the Insured;
- Payment of Excess claims and/or Deductible for Inpatient Care or Surgery that has previously been performed by the Insured; and/or
- Payment for online consultation with a Doctor through the Partner Company platform that has collaborated with the Insurer (as the Insurer informs from time to time), including the purchase of Medicines prescribed by the Doctor,

Provided that each Healthcare Service performed by the Insured above must meet the Medically Necessary requirements and other terms and conditions in the Policy. For avoidance of doubt, You and/or the Insured may not withdraw Flexi Benefit Funds for any reason.

If there is more than 1 Insured in the Policy:

- The accumulation of Flexi Benefit Funds in the Flexi Benefit Account based on point (b) of the Flexi Benefit above and Flexi Benefit Additional Facility shall be calculated for each Insured. If one Insured does not meet the requirements for the accumulation of Flexi Benefit Funds, this will not affect the accumulation of Flexi Benefit Funds for other Insured meeting the requirements; and
- The accumulated Flexi Benefit Funds may be used by all Insured under the Policy. Claims for Flexi Benefit Funds by one or more Insured will reduce the available Flexi Benefit Funds balance.

Note:

- After the Policy expires or is terminated for any reason (including due to the death of the Insured), all remaining Flexi Benefit Funds in the Flexi Benefit Account shall be forfeited and will not be remitted to the Policyholder.
- We will periodically inform You of the available Flexi Benefit Funds balance in Your Flexi Benefit Account through the method or means of communication that We determine.
- If, after We add or credit Flexi Benefit Funds to the Flexi Benefit Account, We find that the Flexi Benefit requirements are not met, We have the right to cancel the addition or credit.

Family Package

- Allianz Flexi Medical Policy may cover more than 1 Insured.
- If the Policy covers more than 1 Insured, additional Flexi Benefit Fund of 5% of the Premium amount paid will be credited to the Flexi Benefit Account for each Insured.

Requirements

- IThere is no limit to the maximum number of Insureds under 1 Policy as long as they met the Family criteria. (Family: Insured Parent, Spouse, Child, Older Sibling, Younger Sibling of the Policyholder)
- The selected plan shall be the same for all the Insureds
- Claim submission must attach valid supporting documents related to the relationship with the Policyholder.

Expert Medical Opinion

Expert Medical Opinion Scope of Services

The Expert Medical Opinion can be utilized by the Insured within the specified Limits outlined in the Benefit Table. This Expert Medical Opinion can only be sought by the Insured under the following circumstances:

a. The Insured seeks clarification or validation regarding a serious and intricate 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 illness and seeks information about alternative treatment options; and/or
d. The Insured requires an additional medical opinion regarding treatment.

For more information about Expert Medical Opinion Services, please access the following link https://alz.id/EMO

Medical Assistance

Medical Assistance Scope of Services

The following service may be provided to the Insured if the Insured passes away, suffers an Accident or suffers an Illness that occur during the coverage period of this Medical Assistance, provided that:

1. The Insured is travelling > 100 kilometres from their Place of Residence or when the Insured is abroad for a period not exceeding 90 days; and

2. The Insured must first contact the 24-Hour Emergency Assistance at the telephone number provided in the medical assistance card.

For more information about Medical Assistance, please access the following link https://www.allianz.co.id/layanan/customer-service/evakuasi-medis.html

Teleconsultation (Online Doctor Q&A) for Mental Health and Nutrition

The coverage under this Policy provides an access to teleconsultation (online Doctor consultation) that may be used by the Insured with:

- Clinical psychologists
- Psychiatrists
- Clinical nutrition specialists.

This benefit does not include prescription drugs and/or follow-up examinations referred by the Online Doctor.

Deductible

- The amount of the Deductible is calculated based on the following conditions:
  a. for each occurrence of Inpatient Care or Surgery for the same Illness or injury;
  b. based on Eligible Claim, and not calculated from the total claims submitted to Us; and
  c. after taking into account the Insurance Benefit that have been paid by other insurance companies, the Social Security Administrator (BPJS), or other parties providing similar coverage that is also covered by the Policy.

- a. If the amount of the Deductible is less than the Eligible Claim, We shall pay the Insurance Benefit in the form of the difference between the Eligible Claim (total fees of Healthcare Services approved by Us) and the amount of the Deductible; or
  b. If the amount of the Deductible is greater than the Eligible Claim, the Insurance Company will not pay any Insurance Benefit.

- You may not change effectiveness of this Deductible without any prior written consent from Us. If You apply to change the effectivity of the Deductible, We reserve the right to re-underwrite the risk and approve or decline the change request.

Summary of the Data

Product Type
Individual Health Insurance

Participant Entry Age (nearest birthday)
Minimum 18 years old

Insured's Entry Age:
(nearest birthday)1 month – 75 years old

Insurance Period
1 year and may be extended every year until the age of 100.

Currency
Rupiah.

Premium Payment Period
- Premium Payment Period is in accordance with the Insurance Coverage Period
- The amount of Premium shall increase in accordance with the age of the Insured during the policy renewal.

Premium Payment Method
- Monthly, quarterly, semi-annual and annual.
- Multiplier factor for Premium payment frequency.

Payment Frequency	Multiplier Factor
Annualy	100%
Semi-annually	52%
Quarterly	27%
Monthly	10%

Grace Period
45 calendar days from the last Premium Due Date.

Underwriting
Full Underwriting.

Waiting Period
- **Special Illness, HIV/AIDS**
  12 months*
- **Other illnesses**
  30 days*
- **No waiting period for Accidental care**

*) From the Coverage Effective Date, the date of Policy Reinstatement, or the date of written approval of the plan upgrade, whichever occurs later.

Elimination Period

Cancer
Cancer diagnosed within 12 months since the Coverage Effective Date; the Policy Reinstatement date; or the date of written approval of an increase in Insurance Benefit, whichever is later, will never be covered.

Risks

Credit Risk
Risks related to Our ability to meet our payment obligations to You/the Insured. We continuously maintain performance to exceed the minimum capital adequacy in accordance with applicable regulations.

Operational Risk
Risks related to Our operational processes, including system applications, as well as external events that may affect Our operational activities.

Economic and Political Condition Change Risk
Risk of changes in economic conditions and political stability, whether domestic or foreign, or changes in laws, policies and government regulations relating to the business world and that may affect the investment's performance and Our performance.

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

How to Apply for Your Policy?

- Complete the Individual Health Insurance Application Form (FAAKP).
- Sign a benefit illustration and/or Personal Summary of Product and Service Information (RIPLAY).
- Photocopy of the valid identity card of the prospective Policyholder and Insured (KTP/KITAS/KIMS) and complete other documents if necessary.

What Are Your Obligations as a Policyholder?

- You must completely and correctly answer all questions on the Individual Health Insurance Application Form (FAAKP). You are solely responsible for the accuracy and completeness of the data You provide to Us, as in the event of any error or omission in the data requested by Us may result in Your Policy being cancelled and We shall be released from any obligation to pay the Sum Assured, any claim, demand or any part thereof in any form or name, or to refund premium, whether now or later.
- You must read and understand the Individual Health Insurance Application form (FAAKP), benefit illustration page, and the General Summary of Product and Service Information (RIPLAY) as well as the Personal Summary of Product and Service Information (RIPLAY) before signing them.
- You must pay the Premium on time.

Are You Allowed to Cancel the Policy?

- You shall be entitled to cancel and return the Policy to Us if You do not agree with the terms and conditions stated therein within 14 calendar days from the date You received Your Policy.
- Upon cancellation and return of the Policy, We shall refund at least the amount of Premium that You have paid, minus fees, (if any), within a maximum of 7 working days from the date We receive the complete and accurate application for cancellation along with the required supporting documents and the application for cancellation has been approved by Us, and thereafter the Coverage shall automatically be cancelled from the Policy Effective Date. The deducting fee components include but are not limited to stamp duty and medical examination fees (if any).
- After the Cooling-Off Period as referred to in paragraph (1) of this Clause, You may terminate this Coverage for the Insured insured under this Policy and such termination shall be effective on the date of receipt of the termination letter or the date specified in the notice, whichever is later. There is no refund of Premium in the event that the Policy is terminated after the Cooling-Off Period.

Exclusions

I. We shall not be obligated to pay the Non-Accidental Death Benefit under this Policy if the Insured's death is directly or indirectly caused by any of the following events:

1. The Insured passed away by suicide within 1 (one) year from the Policy Effective Date or the date of the Policy reinstatement, (whichever is later).

2. The Insured passes away during the Insurance Period as a result of capital punishment by court, or intentionally committing or participating in a criminal act or an attempted criminal act, whether actively or not, or if the Insured passes away as a result of an insurance fraud committed by a party who holds or is participating in interest in this Policy.

II. We shall not be obligated to pay the Accidental Death Benefit under this Policy if the Insured's death is directly or indirectly caused by any of the following events:

1. Involvement in a duel, unless it is an act of self-defence.

2. Self-inflicted wound or suicide or attempted suicide whether or not physically and mentally fit, or

3. Criminal acts or attempted criminal acts or violations of law or attempted violations of law or resistance committed by the Insured during the arrest of any person (including the Insured) carried out by the authorities, or

4. Criminal act or attempted criminal act intentionally committed by You, the Insured or the person designated as Beneficiary, or

5. The Insured is involved in any flight other than as an official passenger or crew member of a commercial airline, whose flights are scheduled, regular and licensed, or

6. Risky occupation or profession of the Insured, for example in military, police, firefighter, mining or other high-risk occupations / professions, or

7. Sports or hobbies of the Insured that are dangerous in nature, such as auto racing, motorcycle racing, horse racing, hang gliding, mountain climbing, boxing, wrestling and other sports or hobbies that are dangerous and risky in nature, or

8. Accidents resulting from mental illness, illnesses affecting the nervous system, being drunk (the Insured being under the influence of alcohol), the use of narcotics and or illicit drugs.

If the Insured passes away as a result of any of the abovementioned reasons, We will only pay in the amount of Non-Accidental Death Benefit in accordance with the Benefit Table.

III. We shall not pay any Insurance Benefit for any Healthcare Service, care and/or treatments related to:

1. Care, treatment and/or Healthcare Service prior to the Effective Date of the Coverage.

2. All care, treatments and/or Healthcare Services related to any Pre-Existing Condition, including complications thereof.

3. Any care, treatment and/or Healthcare Service prior to end of the Waiting Period according to the following terms:
   a. Waiting Period for any Benefit (except for Specified Illnesses) is 30 days; and
   b. Waiting Period for HIV/AIDS treatment benefits is 12 months,

   unless the Illness, condition, or injury, medical condition or disability is a Pre-Existing Condition or other exclusions, where it will not be eligible for coverage under this Policy (even if Healthcare Services for the illness or disability is provided after the end of the Waiting Period);

4. Cancer where signs and symptoms have arisen, whether the Insured is aware of them or not, or that has been diagnosed and given care/treatment within 12 months since whichever is later from (i) the Effective Date of the Coverage; (ii) the Policy Reinstatement date; or (iii) the date of written approval regarding an increase in Insurance Benefit for the Coverage under this Policy by Us as specified in the Endorsement (if any) ("Elimination Period"), including additional care or treatment provided after the Elimination Period.*

5. Specified illnesses (whatever the cause, including Accidents), unless this Coverage has been in effect for 12 consecutive months since, whichever is later of (i) the Effective Date of the Coverage; (ii) the Policy Reinstatement date; or (iii) the date of written approval regarding an increase in Insurance Benefit for the Coverage under this Policy by Us as specified in the Endorsement (if any).The specified Illnesses include, among others:
   a. Bladder Stones in the Kidney, Urinary Tract/Bladder, Bile Duct/Gall Bladder;
   b. Heart, Heart Vascular and cerebral Vessel illness (example: heart failure, Coronary Heart Disease, Stroke);
   c. Cataract;
   d. Any kind of benign tumour/mass/cyst/polyp;
   e. Illness of the tonsils or adenoids and abnormal conditions of the nasal cavity, intranasal septum or turbinate, including the sinuses resulting in surgical intervention;
   f. Diabetes;
   g. Tuberculosis and all complications thereof;
   h. Thyroid Gland Disorders;
   i. Hypertension, Hyperlipidaemia (example: Hypercholesterol, Hypertriglyceridaemia)
   j. Chronic Kidney Failure;
   k. All kinds of Hernia, Intervertebral Disc prolapse;
   l. All kinds of haematological, autoimmune disorders;
   m. Haemorrhoids;
   n. All kinds of male or female reproductive system disorders, including but not limited to fibroids / myomas in the uterus; or
   o. Gastric ulcer (peptic ulcer)

For avoidance of doubt, if the specific illnesses included as the Pre-Existing Condition or other exclusions in this Policy is applicable, We shall not pay the Insurance Benefit in accordance with the specific Illnesses notwithstanding the Coverage has been effective for 12 consecutive months;

6. Any treatment, medication and/or Healthcare Service that is non-Medically Necessary and/or resulting in fees in excess of Reasonable Fees;

7. Mental, behavioural, psychological or neurological disorders, including but not limited to anxiety, anorexia, depression, stress, psychosis, neurosis, fatigue, physical psychiatric complications, psychogeriatric and physiological or psychosomatic manifestations, treatment when the Insured is under the influence of or involved in the use of narcotics, alcohol, psychotropic substances, poison, gases, or addiction to similar substances or Medicine other than those prescribed by a Doctor.

8. Pregnancy (pre/peri/post-pregnancy) including complications of pregnancy due to an Accident, miscarriage or childbirth, abortion, prenatal or postnatal care, or complications of dysfunction or deficiency, contraception, sterilization, methods of birth control, impotence testing or treatment, and all types of assistance with reproductive procedures, all hormonal therapy related to premenopausal syndrome, including all complications that occur.

9. Care and/or treatment for weight reduction or weight gain including all complications that occur.

10. Care and/or treatment related to cosmetics, including plastic surgery except for functional reconstructive plastic surgery that is Medically Necessary performed within 6 months of the date of Surgery performed before or in relation to the functional reconstructive plastic surgery procedure.

11. Eye examination, eye refractive disorders, including myopia, and/or purchase/rental of eyeglasses/lenses (including but not limited to non-monofocal lenses used as a result of cataract surgery), except for Lasik treatment with a refractive disorder of over 5 dioptres.

12. Regular physical examinations, Medical Check-Ups, or tests unrelated to the treatment or diagnosis of covered Illnesses/wounds.

13. Non-Medical Fees incurred not for direct medication to Illness/injury (non-medical fees), excluding administration fees.

14. Immunisation and vaccination, including care and/or treatments related to complications thereof.

15. Care and/or treatment including for complications related to:
    a. Congenital abnormalities. For the avoidance of doubt, congenital abnormalities may arise or manifest at any age, and are not limited to congenital abnormalities, the symptoms or complaints of which appear at, birth (birth defects). The determination of congenital abnormalities will refer to, among other things, the diagnosis of a Doctor and/or medical literature or journals (both domestic and foreign);
    b. Abnormalities and/or delays in growth and development; and/or
    c. Circumcision unrelated to Illness or Accident.

16. Medical care and/or treatment related to sexually transmitted Illnesses, sex change, sex reassignment or sexual Illness, including for complications thereof.

17. Family planning, including care and/or treatments related to complications thereof.

18. Care and/or treatment including for complications for:
    a. active involvement in war, riots, fights, or criminal acts,
    b. self-harm and attempted suicide; and/or
    c. criminal acts or attempted criminal acts or violations of law or attempted violations of law or resistance committed by the Insured during the arrest of any person (including the Insured) carried out by the authorities.

19. The Insured performs and/or participates in dangerous activities or sports (whether with remuneration/compensation or not) including but not limited to racing or speed competitions or contest (other than walking or swimming) or martial arts, potholing, rock climbing, mountain climbing, rope or aid climbing, diving at a depth of more than 30 meters, diving activities involving the use of respirators, sky diving, cliff diving, bungee jumping, BASE (Building Antenna Span Earth) jumping, paragliding, hang gliding and parachuting.

20. Care and/or treatments due to the Insured being a passenger or crew member in a flight other than as an official passenger or crew member of a commercial airline, whose flights are scheduled, regular and licensed, including for complications thereof.

21. Outpatient care except outpatient care that must be carried out by the Insured due to an Accident and Emergency condition.

22. All care and/or treatments related to dental conditions and complications thereof, except care and/or treatments performed as a result of Accidents. However, denture fitting, crown and tooth implant fitting for any reason including due to Accidents are excluded from coverage under this Policy.

23. Care and/or treatments that have been compensated by the Government, other health insurance, and/or other parties.

24. Experimental treatments, including unconventional drugs, use of drugs, medical technologies and/or procedures the effectiveness of which have not been proven under the existing medical practices, and which have not been approved by a recognized body in the country where the Insured is receiving care and/or treatment.

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GENERAL SUMMARY OF PRODUCT AND SERVICE INFORMATION (RIPLAY)

PT Asuransi Allianz Life Indonesia

Simulation/Product Illustration

Mr. Aris
Entry age of 30 years old, when buying
Allianz Flexi Medical

Selected plan	Premium	Selected the Deductible Feature
Essential Pro	Rp9.124.000 / year	

Mr Aris was diagnosed with liver cancer in the 2nd year after buying Allianz Flexi Medical Policy.

Mr Aris underwent a diagnostic examination to determine the next stage of treatment, the fees incurred were paid according to the bill.

60 days later, Mr, Aris underwent cancer treatment for 30 days at the hospital

The assumed fees incurred for the treatment of Mr. Aris' cancer treatment for 30 days

Benefit	Fees	Total Fees (30 days)
Room (lowest-class with 1 bed)	Rp1,100,000/day	Rp33,000,000/day
Doctor Visit	Rp500,000/day	Rp15,000,000/day
Chemotherapy	Rp50,000,000/pack	Rp50,000,000/pack
Radiotherapy	Rp60,000,000/procedure	Rp60,000,000/procedure
Inpatient Care Miscellaneous Fees	Rp20,000,000	Rp20,000,000
Total Invoice		Rp178,000,000

Rp178,000,000 – Rp20,000,000 Deductible
= Rp158,000,000 Protected by Allianz Flexi Medical

How to Submit a Claim?

Reimbursement Claim

Healthcare Services must be received by the Insured at one of the Hospitals listed in the Hospital And Clinic List but not included in Uncovered Hospitals/Clinics. We reserve the right to reject a claim if the Healthcare Service is received by the Insured at an Uncovered Hospital/Clinic.

Reimbursement Claim Documents

The Insured or You must submit the following documents for Health Service claim to Us:

a. 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));
b. Complete and correct Individual Health Insurance Claim Form signed by the Insured and/or You;
c. Medical Record form completed and signed by the attending Doctor with the original stamp/seal from the Hospital;
d. Proof of original payment for the treatment in the form of original receipts with fees details for each procedure and/or Healthcare Service
e. Copy of diagnostic supporting examination results;
f. Copy of prescriptions related to treatment;
g. Referral letter from the Doctor for care and treatment by a specialist Doctor, diagnostic tests, and physiotherapy;
h. Power of Attorney Form for the Disclosure of Medical Information and/or Data; and
i. Other supporting documents, if required.

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

We have the right to collect any additional documents / medical information/records from the Insured, You, Hospital and/or other parties related to the diagnosis and/or Healthcare Services provided to the Insured and/or Insured's data related to this Policy.

If the claim has been approved by Us, We will make payment to the Insured for the claim no later than 7 working days since the receipt by Us of complete and correct claim documents.

Pursuant to the provisions of the Policy, We shall be entitled to request the opinion of an independent Doctor towards the claim submitted by the Insured, including requesting the Insured to carry out a re-examination with a Doctor or laboratory designated by Us.

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 the Plan that You chose.

To use a Cashless Facility, the following provisions shall apply:

a. 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.
b. The Insured must present the Insurance Card and other forms of identification to the Healthcare Service Network when applying for Healthcare Services;
c. The Healthcare Service Network shall carry out a verification process with Us before providing Health-care Services;
d. You/the Insured and/or the Healthcare Service Network must provide medical information and/or data related to the Healthcare Service plan. 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 this Policy. After Our initial assessments:

   1. If the Healthcare Services to be provided are covered under the Policy, 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 treatment diagnosis is not covered or excluded under this Policy; or

   2. If We have not been able to assess if the Healthcare Services to be provided is covered under this Policy, 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 set out in the Policy Terms and Conditions.

Note:

i. Prior to the Insured being discharged from the Hospital, You and/or the Insured must pay all Healthcare Service fees not covered (Insurance Excess) under this Policy (including fees incurred due to the application of the Pro Rata Payment provisions as referred to in the Policy);

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 the Policy.

Death Benefit Claim

The submission of a claim of payment for Death Benefit 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 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 or accidental cause of death of 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 prepared thoroughly and correctly and signed by the Beneficiary (if the Insured passed away at home without treatment from a Doctor).
g. Copy of medical examination results related to the Policy/submission of this claim in connection with medical treatment, care and/or Health Services that have been carried out and/or received by the Insured.
h. Notification 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:

- The payment of the Death Benefit claim shall be disbursed within 14 business days from the date of Our approval of the Claim and the complete and correct claim form is received by Us
- A completed and correct claim form, duly signed, as well as other supporting documents in accordance with the provisions set out in the Policy and claim form must be received in Our Head Office in Jakarta no later than 60 days from the date of the occurrence of the risk. Delay in submitting a claim and/or claim documents shall not invalidate the claim, as long as the reason for the delay may be proven and is deemed reasonable.

Excess Claim

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

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

b. Upon Our receipt of the claim documents from the Hospital, We become aware that the Hospital did not charge or there is a shortfall when charging any Insurance Excess to You and/or the Insured.

Notes:
In the event of the aforementioned, we will charge You the Insurance Excess. You and/or the Insured must pay Us the Insurance Excess within 14 days of the date of the Insurance Excess. We shall not pay any Insurance Benefit and/or provide further Cashless Facility if We have not received the Insurance Excess after 14 days from the date We charged the Insurance Excess. If You and/or the Insured have not paid the Insurance Excess within 30 days from the invoice date of the Insurance Excess, We shall terminate Your Policy. Termination and cancelation of the Policy shall not release Your and/or the Insured's obligations to pay any amount outstanding to Us.

Complaint procedure and dispute resolution

1. Complaint Procedure

a. The Policyholder and/or the Insured may submit a complaint, either in writing or orally, to the Insurer via the designated complaint service line provided by the Insurer.

b. Insurer commit to addressing such complaint within the following timeframes:

(i) For verbal complaints: 5 business days from the date the complaint is received by the Insurer (or such other period as may be determined from time wto time by the regulations issued by the Financial Services Authority ("OJK")).

(ii) For written complaints: 10 business days from the date the complete supporting document is received by Us (or such other period as may be determined from time to time by the regulations issued by OJK).

c. In certain circumstances as set out in regulations issued by OJK, and with prior notification to the Policyholder and/or the Insured, the Insurer reserves the right to (i) extend the specified time limit in this point (1)(b); or (ii) address the complaint beyond the time limit specified in this point (1)(b).

d. Further information on the complaints handling and procedure channel is available to Policyholder and/or the Insured on the Insurer's official website.

e. Should disagreement persist regarding the resolution of the complaint as mentioned in this point (1), the Policyholder and/or the Insured retains the option to submit a complaint to OJK for resolution in accordance with OJK's authority or to resolve the dispute related to the complaint in accordance with the provisions of this point (2).

2. Dispute Resolution

a. In the event of a dispute between the Policyholder and/or the Insured and the Insurer or any other party of interest regarding the Policy, the dispute shall first be resolved through amicable discussions to reach a consensus.

b. In the event the dispute mentioned in this point (2)(a) cannot be resolved, and no agreement is reaches, the Insurer and the Policyholder and/or the Insured may settle the dispute by alternative dispute resolution outside of court or through a court of competent jurisdiction.

c. Alternative dispute resolution, as referred to in this point (2)(b) shall be conducted by an Alternative Dispute Resolution Institution designated by OJK, including but not limited to the Alternative Dispute Resolution Institution for the Financial Services Sector or other authorised Alternative Dispute Resolution Institutions determined by the OJK from time to time.

Service, Complaint Resolution and Claim

If you have any questions or complaints regarding our products and/or services, please contact Our Customer Center:

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

Corporate Number:
+62 21 2926 8888

Website:
www.allianz.co.id

AllianzCare:
1500 136

E-mail:
ContactUs@allianz.co.id

Allianz

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

- Allianz Flexi Medical is an insurance product of PT Asuransi Allianz Life Indonesia and has obtained approval from the Financial Services Authority (Otoritas Jasa Keuangan).
- PT Asuransi Allianz Life Indonesia is licensed and supervised by the Financial Services Authority (Otoritas Jasa Keuangan), and its Marketing Personnels hold the license from the Indonesian Life Insurance Association (Asosiasi Asuransi Jiwa Indonesia).
- This General Summary of Product and Service Information (RIPLAY) is not a contract or insurance agreement between PT Asuransi Allianz Life Indonesia and the customer, therefore it does not bind PT Asuransi Allianz Life Indonesia/-customer. Customers are fully bound by the provisions stated in the Policy.
- A comprehensive explanation of insurance protection may be found in the Allianz Flexi Medical Policy. The coverage is subject to Exclusions, which outline the specific circumstances or events that are not covered by the Allianz Flexi Medical Policy. The Premium paid includes the commission for the Marketing Personnel.
- We shall inform You of any changes in benefits, fees, risks, terms and conditions as set out in the Allianz Flexi Medical Policy no later than 30 working days before the effective date of such changes in benefits, fees, risks, terms and conditions.
- This General Summary of Product and Service Information (RIPLAY) is for general information purposes only. Complete terms and conditions are available in the Policy. For more detailed information, please contact us or Your Marketing Personnel, or visit our website at www.allianz.co.id. All Our products are designed to provide benefits to Customers, but they may not necessarily meet Your specific needs. If you are still unsure whether this product suits Your needs, we recommend that you contact Your Marketing Personnel.
- You are required to read and understand this General Summary of Product and Service Information (RIPLAY) carefully before agreeing to purchase the product, and you shall be entitled to ask the Marketing Personnel about any matters related to this General Summary of Product and Service Information (RIPLAY).
- We reserve the right to reject Your Policy application if it does not meet the required criteria and regulations.
- This General Information of Product And Service (RIPLAY Umum) is made in **Indonesian Language and English Language;** in the event of different interpretation between the text of **Indonesian Language and English Language**, the text of **Indonesiaan Language** shall prevail.

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