

GENERAL TERMS AND CONDITIONS FOR HEALTH (MEDICAL) INSURANCE „HEALTH AND VALUE“

SECTION I. GENERAL PROVISIONS

General information

Article 1. (1) UNIQA Life Insurance plc., hereinafter referred to as **Insurer**, under these General Terms and Conditions shall insure individuals, hereinafter referred to as Insured, in case of accident and/or disease for the risks and under the terms and conditions specified below. The health insurance shall be based on:

1. The provisions of Chapter 14, Section IV, Health (medical) insurance from the Insurance code and other regulations of the Bulgarian legislation, related to situations uncovered in these General Terms and Conditions;
2. These General Terms and Conditions (herein „The General Terms and Conditions“);
3. The terms and conditions about the amount, scope and territorial validity of the insurance coverage shall be specified in the Special Terms and Conditions;
4. The Special Terms and Conditions specified in the policy and all applications thereof (if any);
5. The insurance applicant's written statements set out in the insurance proposal and in all the remaining documents related to the specific case.

(2) The Group insurance contract shall comprise a description of the Special Terms and Conditions, and definitions that are adapted to the nature of the Group insurance coverage.

(3) Negotiation of terms and conditions other than the terms and conditions of any individual provisions herein shall be possible, by specifying the Special Terms and Conditions about the tariffs or by negotiating thereof in the insurance policy. In such cases they shall change or amend such provisions of the General Terms and Conditions.

Subject of the insurance

Article 2. Under these General Terms and Conditions, against payment of insurance premium, the Insurer shall take risks resulting from a disease, body injury upon accident, pregnancy and giving birth to the Insured person, related to the financial provision of certain medical services and goods, as well as fixed amounts within the scope, categories and limits set out in the Insurance Coverage section and the corresponding Special Terms and Conditions.

Concepts and definitions

Article 3. The concepts used herein and in the insurance contracts shall have the meaning as follows:

1. Insurer: UNIQA Life Insurance plc. – an insurance company registered as a personal data operator under No. 0053553, performing insurance activity by Insurance business

authorization No. 27/10.08.1998 and Additional insurance license No. 1031 – Ж3/ 24.10.2012, arranging and effecting the insurance.

2. Insured/Insured person: an individual for whom a risk shall be run by the insurance contract, who has placed a medical insurance or on whose behalf, according to his/her consent, the medical insurance contract has been entered into with the Insurer, and who shall be entitled according to the contract.

3. Insuring person: an individual or a legal entity, as well as any other organization, who, on behalf of or in the interest of the Insured and/or on his/her own behalf, shall place a medical insurance with the Insurer and shall undertake to pay the insurance premium through his/her own resources or by debiting the Insured's account.

4. Insurance contract: shall comprise these General Terms and Conditions, the insurance policy, an insurance proposal, a health questionnaire, a list of the Insured persons and Special Terms and Conditions and adds-on, if any issued.

5. Insurance policy: a part of the contract, comprising the names of the parties under the insurance contract, as well as addresses, insurance coverages, limits and provisions, the insurance premium, insurance periods, and the signatures of the parties under the insurance contract.

6. Add-on: an extraordinary part of the contract, comprising changes or amendments thereto, as well as the pertaining signatures thereunder.

7. Insurance coverage: any risks resulting from a disease, body injury upon accident, pregnancy and giving birth to the Insured person, related to the financial provision of certain medical services and goods, as well as fixed amounts within the scope, categories and limits set out in the Insurance Coverage section herein and the corresponding Special Terms and Conditions.

8. Limit of liability: the amount stated in the insurance policy, representing the upper limit of the Insurer's liability in case of insurance event under the insurance contract.

9. Insurance period: the period of twelve (12) month starting on the date stated in the insurance policy as a start date of the insurance contract.

10. Disease: an abnormal, according to the general level of development of medical science, state of body or mind.

11. Accident: an external event beyond the Insured person's will, suddenly affecting mechanically or chemically his/her body, thus resulting in a body injury. The events listed below, being beyond Insured's will, shall also be considered an accident:

11.1. drowning;

11.2. burn, liquid scald, consequence from a lightning strike or electrical shock;

11.3. poisoning from food, chemicals or gas/toxic fumes inhalation, except cases of gradual occurrence of such effects;

11.4. breaking of sound bones, bending of limbs, cricking or rupture of muscles, tendons, ligaments and capsules;

11.5. the insurance protection shall extend also to accidents caused by heart attacks and accidents caused by insults, except ones occurred as a result of influence of drugs and alcohol. In no case however, a myocardial infarction shall be considered an accident-originating consequence.

12. Medical treatment: a treatment or medical therapy shall be considered any medical or surgical procedure complying with the generally accepted rules of medical science, and suitable for relieving the symptoms of a disease, health improvement or preventing health worsening, or treatment of a disease and body injury upon accident for the purpose of restoring health.

13. Pre-existing diseases or conditions: shall mean any health conditions which is a consequence of a previously established disease or accident, or which needed a hospital treatment or medicaments prior to entry into force of the insurance contract, i.e. before the insurance start, which the Insured was aware of as of the moment of entering into the insurance contract or have not complied with any medical recommendations for medical condition establishment.

14. Chronic disease: shall mean an injury, disease or condition which:

14.1. no generally accepted means for treatment have been known for;

14.2. continues for an indefinite period and can have remissions;

14.3. requires a palliative treatment;

14.4. requires continuous monitoring, examinations and tests;

14.5. the person must be either rehabilitated or specially trained in order to cope with such disease;

14.6. results in a loss of performance.

15. Hospital: a healthcare institution established and registered according to the laws of the pertaining country for provision of treatment and medical therapy in a hospital environment to patients and persons injured in accidents.

16. Hospital treatment / Hospitalization: a stay in a hospital of the Insured person for a continuous period of at least 24 hours, according medical prescription for having an indispensable examination, treatment or monitoring performed.

17. Surgical intervention (operation): shall mean any medical procedure, performed by a specialized physician, through application of technical methods according to the professional medical standards, where the anatomical integrity of the body or any other internal organ is disrupted, and is implemented in order to provide a diagnosis or treatment to the Insured person, as a result of a disease or body injury. Such intervention must be documented by an operation protocol and epicrises.

18. Damage: the total amount of cost incurred for treatment of any body injury or disease.

19. Self-participation: the part of the expenses for which the Insured person shall remain liable under the terms and conditions specified in the insurance contract. The Insured person shall pay the self-participation per damage by himself/herself.

20. MedUNIQA SOS center: the insurance company's call center through which Insured persons shall contact Insurer's representatives, helping them upon insurance implementation in a way specified in the selected Special Terms and Conditions.

SECTION II. INSURANCE CONTRACT

Types of insurance contracts

Article 4. (1) Insurance contracts shall be of individual, family and group type.

1. Individual insurance contract – a contract providing

insurance to a single person. Under this kind of insurance the insuring can be either the Insured person or any other individual or legal entity. In the event that the insuring and the Insured are different persons, the Insured should provide his/her consent in writing in order for the contract to become effective. In the event that the Insured is a minor child, the proposal for insurance must be signed by its parent or guardian. The consent in writing shall be covered in the pertaining texts in the Insurance proposal.

2. Family insurance contract – a contract providing insurance to all the members of a family (spouses or life partners, and children).

Insuring can be either a family member or any other individual or legal entity. The Insured persons must submit their consent in writing to the Insured. In case of child of a minor age, the insurance shall be placed upon parents' consent. The consent in writing shall be covered in the pertaining texts in the Insurance proposal.

3. Group insurance contract – a contract providing insurance to a group of persons related socially or in any other way, which has been created preliminary for non-insurance purposes.

Form of the insurance contract

Article 5. (1) The insurance contract shall be entered into in writing and shall be documented by an insurance policy issued by the Insurer.

(2) The insurance proposal, the health questionnaire, any medical conclusions and results of the medical tests, the insurance policy, the General Terms and Conditions, the selected Special Terms and Conditions, the add-ons, the Special Terms and Conditions and all the remaining agreements in writing attached thereto, shall constitute an inseparable part of the insurance contract.

(3) The insurance contract and all the documents thereto shall be valid only when they are executed in writing.

(4) The insurance contract shall be deemed entered into when the insurance policy or a letter for coverage have been undersigned by the insuring and the Insurer.

Duration and termination of the insurance contract

Article 6. (1) The insurance shall be placed for a fixed period of 1 (one) year or longer, and for individual and family insurances the insurance start date shall always be the first day of the month following the month of the insurance proposal. The contract shall be extended for a further insurance period upon payment of the insurance premium, by considering the new age of the Insured person till reaching the maximum allowed age specified in the selected Special Terms and Conditions. The contract can be terminated by either party, upon no penalties or any other costs payable, by serving a notification of one month. The contract shall be effectively terminated as of the end of the current insurance period.

(2) Regardless of the insurance contract's validity period, the insurance will be terminated for any Insured person in case of:

1. death of the insuring person or declaration of bankruptcy or liquidation of the legal entity, where it is the contracting party, if within 30 (thirty) days after the insuring's death/insolvency declared the Insured persons have not negotiated with the Insurer any renewal of the insurance by specifying a new insuring person, except the Insured persons under contracts where the premium for the remaining part of the contract validity period has been fully paid;

2. death of an Insured person with respect to such person;

3. after the end of the month in which the Insured person has reached the age of 65, unless otherwise specified in the selected Special Terms and Conditions;

4. termination of the employment relationship or membership of the Insured being employed by the insuring person, or in case of no longer being a user of the services provided by the insuring, should this have been the reason for obtaining

a status of an Insured person to a group insurance contract;

5. occurrence of any other event specified according to the selected Special Terms and Conditions.

Start and end of the insurance coverage

Article 7. (1) The insurance contract shall enter into force at 00:00 h on the date specified in the insurance policy as a start date of the insurance, provided that the premium or the first installment thereof has been paid, unless otherwise specified.

(2) In the event that the first premium agreed has not been paid by the start date specified in the policy, the insurance contract shall become effective at 24:00 h on the date when the first premium agreed was fully paid.

(3) The insurance coverage and the Insurer's liability shall enter into force at 24:00 h on the expiry date of the pertaining period of delay, provided that the premium or the first installment thereof has been paid, unless otherwise specified. Regarding the coverages for which no periods of delay have been agreed, the Insurer's responsibility shall enter into force at 00:00 h on the date of entry into force of the insurance contract.

(4) The Insurer's liability shall be terminated as of the moment of the expiry of the 24-th hour of the date, specified in the policy as an insurance termination date, as well as in the event that the insurance has not been renewed under the provisions of Art. 6 (1) for a further annual insurance period or in other cases provided hereunder.

(5) The Insurer will not pay any indemnity for costs incurred as a consequence of a medical treatment or therapy, performed after the Insurer's liability has been terminated in compliance with Par. (4) of this Article, regardless of whether such treatment has begun during the validity period of the insurance contract.

Insurance contracting

Article 8. (1) Healthy persons shall be Insured with standard insurance risk. Persons with higher insurance risk shall be admitted for insurance under the provisions of Art. 10 hereof.

(2) Subject to insurance shall be persons of up to 64 years of age as of the date of insurance placement, unless otherwise specified in the selected tariff. The age of the Insured person shall be determined as a difference between the calendar year of the insurance start year and the year of birth.

Article 9. (1) The insurance contract shall be entered into on the basis of an insurance proposal in writing and a health questionnaire modelled by the Insurer.

(2) The health questionnaire shall be completed upon the first inclusion in the insurance.

(3) A health questionnaire shall be also completed in cases of restoration of a terminated contract or in case of contract renewal for a further insurance period, when more than 30 (thirty) days have elapsed between the date of insurance contract expiry/ termination and the date of its restoration.

(4) The insurance applicant must submit true data to the Insurer about his/her true age and health condition.

(5) The Insurer shall be entitled to demand from the party, for whom it has been found, based on the questionnaire, that an applicant represents a higher risk, to perform additional medical examinations and tests performed in order to obtain a complete picture of his/her health status upon insurance placement. The costs for such examinations and tests shall be at the expense of the insurance applicant.

(6) Prior to signing the insurance contract, the Insurer shall reserve his right to demand additional information in writing, which, at his own discretion, shall be necessary for risk assessment.

(7) The Insurer shall be entitled to include in the insurance with the increased premium, in the way specified in Art. 10 herein, a person, for whom on the basis of the health questionnaire has been found that present a higher risk. The Insurer shall also be entitled to refuse placing an insurance, to limit or to exclude

certain coverages for such a person, or to offer some special terms and conditions.

(8) After the insurance contract becomes effective, a new Insured person could be included in the coverage, as long as such a new person meets one of the following criteria:

1. is a spouse or life partner of the Insured. In such a case the Insured shall be provided with certain documents, such as marriage certificate, giving evidence that either spouse has become such after entering into force of the insurance contract, or documents giving evidence of the address registration of the Insured in case of life partners in a stable non-marital union;

2. is newborn child of the Insured, provided that the Insured has included all his/her children (if any) in the insurance coverage, and upon presenting the birth certificate to the Insurer, thus giving evidence that the child has been born after entry into force of the insurance contract, or a decision on adoption obtained by social services as an evidence that the child was adopted after entry into force of the insurance contract;

3. in case of group insurance, if the person acquires a status of new employee, or if he/she changes the working conditions being an employee of the insuring as user of services, or if he/she becomes a member of the insuring person's company.

(9) To acquire a status of Insured persons in cases described in Par. 8 of this Article, the insuring must notify the Insurer in writing and must submit the mentioned documents within 30 (thirty) days of change occurrence. The insurance coverage has the same scope as the coverage of the initially Insured person(s). In the event that the new Insured person is with a higher risk, the Insurer can either agree to insure him/her upon Special Terms and Conditions or turn down such insurance.

Acceptance for insurance at a higher risk

Article 10. (1) The Insurer shall be entitled to approve the acceptance to the insurance upon modified terms and conditions of a person who has been found to have certain health problems related to his/her previous or current health condition, which represent an increased risk for such a person.

(2) Standard risk shall be applied to a person who, as of the moment of questionnaire submission, does not have any diseases or body injuries, or has some at minimal risk in the Insurer's opinion.

(3) Higher risk shall be applied to a person with insignificant subjective physical or mental health problems and who is able to perform all his/her life and working activities combined with a periodical or regular medical treatment.

(4) The level of the higher risk in compliance with Par. (3) of this Article shall be determined by the evaluating physician, on the basis of the questionnaire data and according to the risk assessment procedure.

(5) Should the Insurer find out that a person presents a higher risk, the Insurer shall undertake, within ten (10) days on receiving the questionnaire, to send the insuring an insurance proposal in writing with the modified terms and conditions, and inform the insurance applicant thereof.

(6) The modified terms and conditions for entering into the insurance contract for the person at a higher risk can be as follows:

1. limitation or exclusion of a specific insurance coverage and/or disease, thereby considering the problems in the health condition or the consequences of the previous health condition;

2. application of special periods of delay for payment of indemnity for treatment under individual coverages specified according to the risk assessment procedure;

3. premium increase for the person at higher risk.

(7) Any exclusions of specific coverages for the person at a higher risk shall be specified in the policy.

(8) Should the insuring turn down in writing the proposed

modification of the contract provisions within ten (10) days on reception of a letter sent by the Insurer, the insurance proposal for such person at higher risk shall be deemed withdrawn.

Period of delay

Article 11. (1) Period of delay shall be the time period during which the Insurer shall not be liable in case of insurance event, regardless of the insurance contract in effect.

(2) A period of delay shall start on the start date of the insurance contract or on the start date of the insurance for a new Insured person, provided that the first premium due thereunder has been paid prior to that date, unless otherwise specified.

(3) In the event that the premium due was not paid prior to the start date of the insurance contract, the period of delay shall start at 24:00 h on the date of payment of the first premium thereunder.

(4) The total period of delay shall be 60 (sixty) days, except in the cases specified in Art. 11 (6) hereunder.

(5) No total period of delay shall be applied in the following cases:

1. treatment required by an accident. Abdominal or ventral hernias caused or worsened as a result of an accident, shall not be considered as consequences resulting from the accident, with the period of delay applicable in the same way as for diseases;

2. including a spouse in the scope of an existing insurance, when such insurance was valid at least three months and the insurance of the new person has been declared within one month after the marriage, with entering into force as of the first day of the month, following the month of notifying the Insurer;

3. including a newborn child in the scope of an existing insurance, when such insurance was valid at least three months and the insurance of a newborn child has been declared within one month after its discharging from hospital, with the insurance for the child effecting as from the 1st of the month following his discharge from hospital

4. In cases under Art. 11 (5), 2 and 3, the insurance coverage shall have the same scope as the coverage of the initially Insured person. If the new Insured person is in a higher risk, then the Insurer can either insure him/her upon special terms and conditions or turn down such insurance.

(6) Special periods of delay shall be specified either in the pertaining Special Terms and Conditions or in the policy.

(7) For diseases and accident consequences treated during the periods of delay, except in the cases under Article 11 (5), insurance coverage shall be granted after expiration of the periods of delay.

(8) In the event of upgrade to the Special Terms and Conditions providing a higher insurance coverage, the entitlement to the higher coverage shall start after the expiry of the new period of delay which shall be calculated with reference to the date on which the change has been negotiated.

(9) No new period of delay shall be applied in case of renewal of the insurance contract for a further insurance period, upon renewal of an expired fixed-term contract, as well as in the cases of restoration of a terminated contract, when less than 30 (thirty) days have elapsed between the date of insurance contract expiry/termination and the date of its restoration.

Insurance premium

Article 12. (1) The insurance premium shall be annual and shall be determined by the Insurer depending on the age and health condition of the Insured person, as well as according to the selected Special Terms and Conditions.

(2) When an Insured child reaches the age of 18, the premiums payable for adults shall be paid from the first day of the month.

(3) Depending on the terms agreed for payment of the insurance premium, the latter shall be paid in advance prior to

the start of each insurance period:

1. by annual premium for each insurance period;

2. by deferred payment by six-month, three-month or monthly installments. In such a case the Insurer shall be entitled to aggravate the deferred premium as of 1.02, 1.03 or 1.05 accordingly.

(4) The insurance premium is paid by the insurer or by any other person who has the legal right to pay the obligation in the amounts, currency and terms specified in the policy.

(5) The entire insurance premium or the first deferred installment thereof shall be paid at the conclusion of the insurance contract, unless otherwise agreed in the contract:

(6) Payment can be made in the following way: in cash or via a bank credit or debit card against a receipt issued by the insurer's application system, by cashless means via bank transfer to an account specified by the insurer or via an electronic payment system (E- pay or other), and in these cases the payment is considered to have been made on the day of verification of the insurer's account. All bank and other fees and commissions are for the account of the insurer.

(7) The current deferred installments of the insurance premium can be paid by means of expressly authorization of the Insurer by the Insured for collecting the deferred installments due by debiting the Insured's account through "Direct debit" cashless payment form. In such a case, upon maturity of a deferred installment, the latter shall be collected from the account specified by the Insured.

(8) In case of premature termination of the insurance according to Art. 6. (1) or in the case of exclusion of insured persons from the insurance contract, before the expiration of the insurance period provided for in the contract: the insurer is entitled to the corresponding premium only for the part of the insurance period during which he was covered. In case of premature termination of the insurance under Article 6. (1) or exclusion of Insured persons from the insurance contract, before the expiry of the insurance term specified in the contract:

Consequences arising from non-payment of a premium

Article 13. (1) In case of non-payment of the first premium due by the maturity date, the Insurer shall not be liable for any events occurred. Should the premium due be not paid till 24.00 h of the thirtieth day from the maturity date, the contract shall not take effect.

(2) In case of insurance renewal for a further insurance period, if the insurance premium due has not been paid till 00:00 h of the date specified as start of the new insurance period, the Insurer shall not be liable for any events occurred from the start of the new insurance year. Should the premium not be paid till 24:00 h of the thirtieth day from the maturity date, the contract shall be terminated.

(3) Should a current installment due of the deferred premium be not paid till 24:00 h of the fifteenth day of the installment's maturity date, the Insurer shall terminate the contract without sending a notification in writing to the insuring person.

(4) Should an insurance event occur during the waiting period related to premium payment under Article 13, Par. 1, and the premium has not been paid yet as of the date of insurance event's occurrence, the contract shall be deemed not effective and the Insurer shall not be liable to paying an indemnity.

(5) Should the premium be not paid in due time, the Insurer shall be entitled to accrue a default interest.

(6) Taking the insurer for insurance premium shall be repaid within three years, with effect from the pertaining maturity date.

SECTION III. INSURANCE COVERAGE

Insurance coverage

Article 14. (1) The insurances placed hereunder shall cover risks

resulting from a disease or accident of the Insured person, related to:

1. financial provision of certain health services and goods resulting from a disease or accident;
2. financial provision of health services and goods related to pregnancy and giving birth;
3. financial provision of goods and services for medical transportation, specialized care, palliative care, etc.;
4. payment of fixed amounts in relation to an accident, disease or giving birth, and any other risks mentioned in the insurance policy.

(2) The Insurer's liability shall be determined in the form of an individual insurance amount/limit of coverage, fixed one-off or regular payments and/or as volume and scope of health services and goods provided to the Insured person for a specified period, and shall be stated in the Special Terms and Conditions or the insurance policy.

Insurance event

Article 15. (1) An insurance event shall be an unpredictable future event upon which the Insured person, as a result of health worsening (by a disease or accident), shall undergo a medically grounded treatment which is a subject of the insurance contract, with the expenses of such treatment payable to a medical service provider and/or to the Insured person.

(2) Health worsening, as specified in Par. (1) of this Article, shall be certified by a licensed physician.

(3) Giving birth, including medical examinations needed for pregnancy monitoring, as well as the related necessity of medical treatment subject to medical prescription, shall also be considered an insurance event.

(4) The insurance event shall start with diagnosing of the disease or injury and shall end at the moment when there is no need of a further treatment from a medical point of view due to restoration and stabilization of the health condition, with no further improvement or worsening thereof guaranteed.

(5) The insurance event shall end with the termination of the insurance contract and/or exclusion of the Insured person from the policy, regardless of whether the treatment has ended or not.

(6) The type and the scope of the insurance coverage shall be described in the Special Terms and Conditions and the insurance policy.

Exception from the insurance coverage

Article 16. (1) The Insurer shall not be liable for:

1. in the event that the treatment has begun before the first entry into force of the insurance contract and is in progress as of the moment of entering into the insurance contract under which the Insured has acquired his/her status of Insured person, or the treatment continues after the termination of the insurance contract;
2. when the insurance event imposes a treatment, but the event itself has occurred as a result of a previous disease of the person, with such disease existing prior to the first entry into force of the insurance and not stated in the insurance proposal and/or health questionnaire upon insurance placement, or not explicitly negotiated in the insurance policy in case of group insurance;
3. chronic diseases occurred prior to insurance placement and any recurrences thereof, if not stated upon insurance placement;
4. examinations and tests performed without any medical necessity. Any expenses for examinations and tests in cases where the Insured person has obtained a medical conclusion "clinically healthy" shall be at the Insured's expense;
5. treatment of fertility problems in men and women,

contraception, fertilization, vasectomy, venereal diseases, sexually transmitted diseases, change of sex or any other form of sex-related condition, infertility and any condition related thereto, or any form of assisted reproduction;

6. termination of pregnancy (abortion) and any consequences thereof, if performed due to psychological or social reasons, except cases of spontaneous abortion, ectopic pregnancy, abortions due to medical reasons or stillbirth;

7. finding any donor organs, as well as for any costs incurred for removing a donor organ from the donor and/or for the donor organ itself, and/or any transportation costs for delivery thereof, as well as all administrative costs related thereto;

8. any voluntarily performed operations and/or treatment, implantations or corrective medical and technical procedures performed, such as:

8.1. operations and procedures performed voluntarily, therapies and/or operations, which are not indispensable for medical reasons;

8.2. cosmetic and plastic operations and the consequences thereof, performed with aesthetic purpose, except operations for eliminating gross injuries as a result of an accident;

8.3. dental aesthetical therapies and the consequences thereof, except operations for eliminating gross injuries as a result of an accident;

8.4. having lipomas, atheromas, nevuses and warts voluntarily removed, and any health services used for cosmetic purposes;

8.5. circumcision, except when performed for medical reasons.

9. hospitalization, due to endangering of their own or other personality, and admission in homes (retirement homes, hospices) specialized for care of people of old age or palliative care (retirement homes, hospices);

10. services or therapies performed at hydro- and SPA establishments, slimming clinics and/or environmentally friendly lifestyle, health farm or other similar institutions, as well as stationary, rehabilitation-specializing (SPA centers), sanatoriums and other kinds of establishments registered as healthcare ones;

11. homecare which is not taken under medical control, and any measures for geriatric and rehabilitation treatment and treatment pedagogy;

12. therapeutic procedures for treating addictions of any kind, diseases and accidents (consequences thereof) occurred or worsened as a result of abuse with alcohol, drugs, opiates, stimulants, anabolic hormone or other substances of doping nature, or a treatment deteriorating as a result of abuse with the above, and any measures and treatment of such addictions;

13. slimming therapy or program, operations for implantation of intragastric balloons, advices from nutrition specialists, nutrition trainings courses;

14. rejuvenating therapies;

15. reimbursement of costs for treatment performed by persons lacking the pertaining medical license; physicians, dentists or persons of any other medical professions, or in specific healthcare institutions (or departments thereof). For Insured persons, this shall be valid for treatments performed after they have been notified thereof. For all insurance events having occurred beforehand, an insurance protection shall be provided by the end of the third month from the date of notification.

16. health services and medicaments which have not been prescribed by a licensed physician, or which have not been assigned for the purpose of providing a medical treatment to the Insured;

17. stationary treatments in the healthcare institutions or departments thereof, specified in Art. 20 (4);

18. compulsory immunizations according to the immunization calendar;

19. hospital treatment in a healthcare institution, hospital, department or any similar stationary institutions for mental diseases treatment, except the specialized neurological and neurosurgical departments thereof.

20. examinations and tests for purposes of insurance, fees for examinations by Invalidity Committees, forensic-medical expertise, AIDS/HIV tests (except for pre-surgery preparation), administrative fees for issuing documents and document copies, for obtaining records for tests performed (CD, DVD), issued by healthcare institutions, costs for examinations and tests related to issuing medical certificates;

21. care or medical treatment resulting either directly or indirectly from the Human Immunodeficiency Virus (HIV) or any diseases related thereto, including the Acquired Immune Deficiency Syndrome (AIDS) are the AIDS-related complex (ARC) and any other similar infections, diseases, injuries or medical states, arising from such conditions, regardless of the cause thereof;

22. congenital abnormalities.

(2) Should the treatment exceed the necessary scope or should the treatment costs exceed the normal and common costs, the Insurer shall be entitled to reduce the reimbursement to the proper amount. This shall be also valid for medical auxiliary tools.

(3) The Insurer shall be entitled, in some justified cases, to exclude from the insurance protection a treatment provided by specific physicians, dentists or persons practicing any other medical professions, or in specific health institutions (or departments thereof). For Insured persons, this shall be valid for treatments performed after they have been notified thereof. For all insurance events having occurred beforehand, an insurance protection shall exist by the end of the third month from the date of notification.

Article 17. (1) The Insurer shall not be liable should the insurance event occur as a result of:

1. war, attack, hostilities, military activities, terrorist acts, civil war, sabotages, terrorism and vandalism, mutinies, revolutions, rebellions, military or any other kind of coup d'état and active participation of the Insured persons in public order offense or committing crimes under the Penal Code;

2. health damage upon intentional exposure to a hazard (except upon attempt for saving a human life), intentional self-injury, suicide or an attempt for such, as well as entering into an affray or mob rule (except in cases of proven self-defense);

3. non-compliance with medical recommendations;

4. influence of alcohol, drugs or opiates, including any accidents occurred after consumption thereof;

5. natural disasters (for example, volcanic eruption, earthquakes, etc.);

6. ionizing radiations or radioactive contamination of any other kind of radioactive waste from nuclear fuel combustion, i.e. any radioactive, toxic, explosive or dangerous properties of nuclear facilities or components thereof.

(2) The Insurer shall not be liable in case of indemnity claim based on false data.

(3) The Insurer shall be entitled to exclude a person from the insurance, should such person be found out to have been submitted misleading or false statements, i.e. has concealed some important circumstances affecting the insurance contracting, as well as any person not fulfilling the obligations specified herein.

(4) In the event that the treatment exceeds the necessary scope or the treatment costs exceed the normal and common expenses, the Insurer shall be entitled to reduce the reimbursement to the proper amount. This shall be also valid for medical auxiliary tools.

Insurance payments

Article 18. (1) The type and scope of the insurance coverage

shall be described in the Special Terms and Conditions and the insurance policy in the form of:

1. Lump sums;
2. compensations;
3. a combination of both.

(2) Insurance payments shall be provided by:

1. payment of a fixed, agreed in advance insurance sum or a part thereof;
2. reimbursement of costs incurred for health services and goods used by the Insured person;
3. granting the Insured person the use of health services and goods by health service providers and medical goods suppliers with whom the Insurer has entered into a contract.

Indemnities for outpatient treatment

Article 19. (1) The Insured person shall be free to choose a healthcare institution, physicians and dentists who are licensed for independently pursuing their medical profession. In case of medical necessity during an insurance event, the costs for acquisition of a couple of physicians in relation to the treatment being carried out, shall also be reimbursed.

(2) The costs for home visits by a physician shall be paid as long as the Insured person's condition does not allow him/her to pay a visit to the physician.

(3) Any transport costs incurred by a physician for paying a visit to an Insured person at any other location shall be reimbursed, as long as there is no other established physician where the Insured person is domiciled. No costs incurred by the Insured person's travel to a physician shall be reimbursed.

(4) In case of performing the treatment by a spouse, parents or children of the Insured person, only the proven material costs shall be reimbursed, with no remuneration for the treatment performed.

(5) The need for physiotherapy and rehabilitation shall be established by a specialized physician performing the treatment of the main disease, and the treatment shall be performed by a physician-specialist licensed to perform such services in a registered healthcare institution. In such cases no additional costs related to home visits shall be reimbursed.

(6) Subject to reimbursement shall be the costs for any medical auxiliary tools (therapeutic tools) prescribed by a physician, such as: glasses, contact lens, hernia bondage belts, limb prosthetics, hearing aids, orthopedic corsets, orthopedic insoles and orthopedic accessories for shoes, supports and corsets. No expenses for medial facilities and auxiliary tools, such as irrigators, inhalers, ice bags, breast pumps, oral showers, electric pillows, medical thermometers, blood pressure measuring devices and auxiliary tools providing body care and patient care.

In the event that the Insurer has reimbursed some costs for medical auxiliary tools, a new indemnity claim can be made only after the common period of wear and tear has elapsed, unless such early purchase has been made due to medical reasons.

Insurance indemnities for hospital treatment

Article 20. (1) Hospital treatment shall include the costs for medical treatment or therapy performed in a healthcare institution or departments thereof, which is registered as hospital, where the Insured occupies a bed for the purpose of medical treatment for more than 24 continuous hours.

(2) The hospitalization shall not be deemed necessary for medical reasons, if only based on the lack of opportunity for home care provision or any other personal requirements of the Insured.

(3) A stationary treatment due to dental treatment and dental prosthetics, as well as interventions by dental and jaw surgery shall be deemed necessary from medical point of view as long

as due to medical reasons no outpatient treatment is possible.

(4) Hospital treatment shall not include Insured person's accommodation at:

1. healthcare institutions for non-hospital treatment, even when the needed examination, monitoring or treatment requires a short-term hospitalization of up to 48 hours;
2. healthcare institutions that are mainly rehabilitation-centered;
3. healthcare institutions for addiction treatment;
4. mental health hospitals;
5. holiday houses, slimming homes, sanatoriums and SPA-centers;
6. residential care homes and hospices.

(5) Expenses for hospital treatment (and the pertaining daily allowances for hospitalization) in case of stationary treatment under Article 20, Par. 1 in healthcare institutions or department for lung diseases and tuberculosis treatment shall be granted up to the fifth week of the treatment, provided that the Insurer approves such a treatment in writing prior to the start of the fifth week of the treatment.

(6) The Insurer cannot refuse providing coverage upon a stationary treatment performed in healthcare institutions under Article 20 (4), if the hospital treatment's urgency does not allow a visit to a healthcare institution under Article 20 (1) or obtaining of a written approval by the Insurer before the treatment start.

Medical transportation

Article 21. (1) In case of needed transportation of an Insured person to a hospital for treatment due to medical reasons, and in case of needed transportation from hospital to home, the expenses for ambulance, train or taxi shall be reimbursed, provided that the transportation and hospitalization complies with a medical prescription.

(2) In case of outpatient treatment, no travel expenses incurred by the Insured person shall be reimbursed.

Special provisions

Article 22. (1) 'Costs for surgical treatment' shall mean the professional fees of the operating surgeon, anesthesiologist, operation assisting physicians, operation nurses and other kinds of support staff, including the preliminary and subsequent treatment before and after the operation, as well as the material expenses separately included in the bill, except the costs for equipment replacing organs or supporting the function thereof.

(2) In case of operations performed simultaneously, the operation with the highest rank according to the tariff shall be fully paid. Each subsequent operation performed in different operation halls or fields, shall be paid for up to 50%, while each subsequent operation performed in the same operation field shall be paid for up to 25 % of its price.

(3) 'Expenses for radio therapy' shall mean the professional fee of the attending physician and the assistant, the costs for use of equipment and other costs for materials, as well as any other costs related thereto.

(4) The costs for medicines purchased from a pharmacy and prescribed by a physician within the treatment shall be reimbursed. No costs for treating water and mineral water, medical wines, food products and supplements, tonic products, geriatric products, medical cosmetics, laxative products and slimming products, vitamins, contraceptives and all unregistered medicines shall be reimbursed.

Payment of insurance indemnities

Article 23. (1) Insurance indemnities shall be paid to the Insured or to the medical aid provider who has delivered the medical services and goods to the Insured person according to the

agreed in the insurance policy and the Special Terms and Conditions under which the insurance has been placed.

(2) The Insurer shall consider the party who has submitted the original documents for the treatment as entitled to obtain the insurance indemnity, unless otherwise specified in the insurance contract.

(3) The Insurer shall pay an insurance indemnity on the basis of paid up original invoices or hospitalization certificates, and shall reserve the right to request an evidence for invoice payment. The treatment related documents shall comprise the first name and the last name, the address and date of birth of the person treated, diagnosis, treatment period, information about the treatment performed and the services provided, any medicaments prescribed, tests prescribed, visus change, etc. The Insurer shall be entitled to request from the policy holder any additional documents, and to verify the medical documentation submitted and use all the information for establishing the insurance event and the indemnity amount.

(4) For dental treatment, the medical documents shall comprise a clear description of the treated or replaced teeth by using the standard dentist form. In case of pulpitis treatment and dental surgery a radiographic image must be submitted. In the event of a more extensive intervention by the dentist or on Insurer's request, the document shall also cover the dental status.

(5) Certified copies of the medical documents and originals of the payment documents shall be submitted, which, after payment, shall come into Insurer's ownership. Unless otherwise specified, any possible costs related to issuing the necessary documents and the costs for translation into a foreign language, shall be borne by the Insured.

(6) In case of insurance event, and upon coverage existing under the same risk provided by another Insurer or securer, the Insurer's responsibility shall be proportional to the ratio between the limit agreed in the policy of UNIQA Life Insurance plc. and the total limit for the same risk under all insurance and assurance contracts. In such a situation, the Insured must notify the Insurer about the existing contracts, so that the Insurer would coordinate the payments with other Insurers and/or securers.

(7) Any costs incurred in foreign currency shall be converted according to the reference rate of the Bulgarian National bank, valid as of the day of the cost payment by the Insured from abroad. The Insurer shall pay the insurance indemnity in Bulgarian currency to the Insured upon submission of the original documents.

(8) Any insurance indemnity claims cannot be assigned or transferred without the Insurer's consent.

(9) The Insured person must submit the documents necessary for evidencing of an insurance event occurred. The Insurer shall examine and consider only the initially submitted and the additionally requested documents. Any additionally submitted documents identical to the initially submitted ones, but varying in content, shall not be examined by the Insurer. In the latter hypothesis the Insurer shall be entitled to bring a matter of false document issue before the competent organs.

(10) In case of insurance event the Insurer shall be entitled to request any information necessary for establishing the insurance event or the scope of the liability for indemnity payment. Evidences which the Insured person cannot be made available to as a result of existing regulatory impediments or lack of legal opportunity shall not be requested.

(11) If the Insured breaches the liability for submitting the information under Art. 23 (10), the Insurer shall be exempted from the obligation of indemnity payment, however the provisions under Art. 23 (12) shall also be considered. The obligation for information submission shall comprise also an obligation the Insured person to be examined upon Insurer's request by a physician specified by the Insurer.

(12) In cases where an exemption of the Insurer from liability

of indemnity payment upon breaching an obligation to the Insurer is agreed, the legal consequence agreed shall not occur, unless such breaching is intentional or resulting from gross negligence.

Cost coverage guarantee

Article 24. (1) The insuring or the Insured must request from the Insurer a guarantee in advance for coverage of the treatment costs, should this be specified in the pertaining special terms and conditions in the following cases of:

1. stationary hospital treatment, daily stationary and daily clinical treatment;
2. repatriation of corpses.

(2) The guarantee in advance for cost coverage shall be obtained from the MedUNIQA SOS center by ordinary mail or via electronic mail.

(3) To obtain a guarantee, a request in writing to the MedUNIQA SOS center shall be sent, with the pertaining medical documentation attached thereto, as well as information about the hospital where the treatment shall be performed.

SECTION IV. RIGHTS AND OBLIGATIONS UNDER THE INSURANCE CONTRACT

Obligation for pre-contractual declaration of circumstances

Article 25. (1) Upon entering into the insurance contract, the insuring, or the Insured correspondingly, must submit true information about the age and the health condition of the Insured person, and declare in a clear and comprehensive manner all circumstances which are known to them and are of significance for taking the risk. 'Significant' shall refer to all the risk circumstances that could affect the Insurer's decision to enter into the contract under the agreed conditions or to enter into the contract at all. In case of doubt, a circumstance for which the Insurer has asked explicitly and in writing shall be deemed significant.

(2) Any complaints, diseases or consequences from an accident occurred prior to entering into the insurance contract shall be stated by the insuring, or by the Insured respectively, prior to entering into the insurance contract. Such diseases and accident consequences can be included in the insurance protection under special terms and conditions (higher premium, special periods of delay, etc.).

(3) Regarding treatment of diseases and accident consequences stated by the insuring, or the Insured respectively, prior to entering into the insurance contract the insurance protection can be only excluded by an explicit written declaration by the Insurer.

(4) Should it be found out that the insuring or the Insured person has provided false data about the health condition of the Insured person or has concealed or withheld a circumstance which the Insurer, upon being aware of, would not have placed the insurance, the Insurer shall be entitled to:

1. terminate the contract within a period of one month from becoming aware of the circumstance;
2. to refuse full or partial payment of insurance compensation if the event is causally related to the inaccurately declared or concealed circumstance.

When a circumstance has had an impact only to increase the amount of damages, the insurer cannot refuse payment, but can reduce it according to the ratio between the amount of the premium paid and the premium to be paid according to the actual insurance risk.

(5) Termination of the contract by the Insurer shall be declared by sending a written notification to the insuring.

(6) In case of premature termination of the insurance contract, the Insurer shall be entitled to the premium for the insurance period elapsed as of that moment, unless otherwise specified

by the Special terms and conditions or special provisions.

(7) In case of termination of the insurance contract, the Insurer shall be responsible for the insurance events occurred prior to the date of contract termination, as long as the circumstance in respect of which the obligation for notification has been violated has had no influence on the occurrence of the insurance event or on the amount of the indemnity.

(8) The Insurer cannot terminate a contract due to violation of the obligation for disclosure of information by the insuring/ Insured at the moment of contract entering, if three years have elapsed since that moment.

Obligation for notification during the insurance period

Article 26. The Insured/Policyholder shall notify the Insurer in writing in the presence of other valid insurances covering the same risks for which a claim for payment of compensation has been made. In this case, the Insurer's liability is in such a proportion as the insured amount under the concluded insurance refers to the total insured amount of all insurances.

Changes in the insurance contract

Article 27. (1) Any reduction of the insurance coverage (exclusion of an Insured person, change in the Special Terms and Conditions under the insurance, etc.) shall be settled in compliance with Art. 6 (1).

(2) The Policyholder has the right to request an extension of the insurance coverage (inclusion of an additional person, change of special insurance conditions, etc.), starting from the first day of each month. Any amendments to the insurance contract are made by issuing a new contract signed by the Insurer and the Insured.

SECTION IV. FINAL PROVISIONS

Taxes and fees

Article 28. (1) Any government charges and taxes due under the insurance contract shall be determined according to the Bulgarian laws as of the relative moment of their occurrence and shall be at the Insured's expense.

(2) The Insurers shall also be entitled for providing some additional services, such as: entering new data and amendments in the contract, entering changes in the insurance policy, issuing duplicates, etc., to collect the pertaining official administrative fee. The amount of the fee shall be determined by the Insurer and shall be paid prior to service provision.

(3) All postal charges paid up by the Insurer for notifying the Insured of outstanding premiums or any other liabilities shall be reimbursed to the Insurer by the insuring.

Claims against third parties

Article 29. (1) If, for an insurance event, along with the claim to the Insurer, the Insured has a similar right of indemnity claim to a third party Insurer after the indemnity has been paid, the rights of the Insured with respect to the proportional part of the indemnity, according to Art. 392, Par 1 of the Insurance Code, shall be transferred to UNIQA Life Insurance plc. to the amount of the indemnity paid and the normal costs incurred for the evaluation thereof.

(2) In the event that the person entitled to a claim has already received a compensation for the expenses incurred from third parties liable to indemnity payment, or on the basis of other insurance contracts, the Insurer shall be entitled to consider such compensation upon performing his obligation.

(3) The provisions of Art. 29 (1) and (2) shall not apply for indemnities payable without any proofs of expenses.

(4) The Insurer's obligation for reimbursing costs whose partial reimbursement through a public legal Insurer/securer can be claimed by a person entitled to such a claim, shall come when such person has satisfied the indemnities being his liabilities.

(5) If the person entitled to a claim waives of such a claim

against third parties, or makes such waiver to guarantee his claim without the Insurer's consent, the Insurer shall be discharged from the obligation for compensation, in so far as the Insurer could obtain a compensation from such claim or right.

Notifications under the insurance contract

Article 30. (1) For the sake of validity, all statements and notifications submitted by the insuring shall be in writing. Written statements can be made in any legible form, including via fax, by electronic way, etc.

If a submitted declaration lacks either a handwritten signature or a secure electronic signature, the Insurer can request that the statement be additionally submitted, with a handwritten (original) signature put thereon. The deadline for statement submission shall be deemed complied with, if the request for additional submission of a statement is replied to in the required form and within a reasonable period.

(2) In case of change in the name of the insuring or the Insured person, or of the address specified in the insurance policy, the insuring must within one week notify the Insurer thereof.

(3) In case of entering into the insurance contract with a legal entity as a party under the insurance contract, the provisions of Art. 30 (2) shall become effective upon change in the registered office and the name of such legal entity.

(4) The insured is obliged to notify the insurer of any change in his name, company or name, or address for correspondence, which are specified in the insurance contract or in other documents provided to the insurer. In the event that he fails to fulfill this obligation or provides false information, any written statement by the insurer sent by him to the address of the insurer last declared to the insurer shall be deemed to have been served and received by the insurer with all the provisions of the law or in contract legal consequences

Additional provisions, time-barring and arbitration

Article 31. (1) The contractual relations between the insuring, the Insured persons and the Insurer shall be settled by the provisions of the insurance contract, these General Terms and Conditions, the Insurance Code, the Obligations and Contracts Act and the Commercial Code.

(2) The insuring must explain the Insured persons their rights and obligations under the insurance contract, and to make them aware of these General Terms and Conditions.

(3) For any miscalculated or incorrectly paid installments of the insurance premium by the Insured, as well as for any out-of-time received premiums and indemnities, the Insurer shall not be liable to paying any interests.

(4) Any disputes occurred under the insurance contracts between the Insurer, on the one hand, and the insuring or the Insured, on the other hand, shall be settled voluntarily. In cases where such disputes cannot be settled voluntarily, they shall be settled through judicial proceedings by a competent Bulgarian court.

(5) All the rights resulting from the insurance contracts entered into shall be time-barred upon expiry of five years from the date of the insurance event occurrence.

Complaints procedure

Article 32. The Insured shall be entitled to, being unsatisfied by the volume and the quality of the services delivered, lodge a complaint in writing with the Insurer. The Complaint management policy of UNIQA Life Insurance plc. is published at the company's internet site www.uniqa.bg.

Changes in the General Terms and Conditions

Article 33. (1) These General Terms and Conditions shall be amended or modified but such changes shall be only effective to a particular insurance contract, when based on a written agreement between parties, covered in the insurance policy or in an add-on thereto.

Article 34. Regardless of the remaining clauses of the insurance contract, the Insurer will not provide insurance coverage and/or pay an indemnity if such a provision conflicts with specific economic, financial or any other restrictions or sanctions, including embargoes imposed in accordance with a resolution issued by the UN Security Council, European Union or under the national legislation of the Republic of Bulgaria. The above restriction shall also be applied in the cases where such economic, trade or financial sanctions or embargoes have been imposed by the USA or other countries, insofar as they are not in conflict with the EU legislation of the national legislation of the Republic of Bulgaria.

By entering into force of these General Terms and Conditions the validity of the General Terms and Conditions under health (medical) insurance, effective since 01.06.2011, amended on 09.10.2012, amended on 04.04.2016 shall be terminated.

These General Terms and Conditions have been adopted by a decision of the Managing Board of UNIQA AD Insurance Company on 27.07.2022, and shall become effective on 01.10.2022.

The Insurer's management address is:

UNIQA Life Insurance plc

Sofia 1000, 18 Todor Aleksandrov blvd.

The Insurer/ Insured or any Third beneficiary, who have not been satisfied with the response to their applications related to the insurance contract, can contact the Financial Supervision Commission, the institution responsible for the surveillance and control of insurance business, in order to protect the rights of the Insured and strengthening the stability of the insurance market.

The address of the company is: 1000 Sofia, 16 Budapeshta Str.

The undersigned, _____,
hereby declare that I have been provided with a copy of these General Terms and Conditions, consisting of 11 (eleven) pages, I have made myself familiar with the content hereof, and I accept it.

Date: _____

Signature: _____