ALLIANZ HEALTH GROUP MEDICAL INSURANCE

Easy steps to use insurance services

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How you can use Allianz Health?

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Easy steps to use the insurance services

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1 HOW YOU CAN USE ALLIANZ HEALTH?

You have the right to use health goods and services on the territory of Bulgaria in our network of Contractual Partners or freely selected medical institutions and providers of health goods.

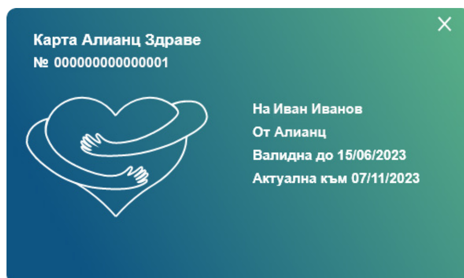
Digital platform Allianz Health

For your convenience, all processes of your insurance are managed online 24/7 through the digital platform. In it you can find:

- Your digital card with which you identify yourself in medical institutions – contractual partners;
- Full information about the Insurance coverage, limits and services;
- List of medical institutions - contractual partners of Allianz Bulgaria;
- Benefits Guide;
- Common questions and answers.

The digital platform allows you to:

- create a claim number, which is required when attaching documents for reimbursement of expenses for used medical services / purchased health goods;
- attach documents to an Insurance Claim;
- attach document check-up to reconcile highly specialised services or tests;
- monitor the status of your claim;
- make an appointment for examination through the **Superdoc** and **Easydoc** platforms;
- find the best price to buy medicine through **Aptechko.bg**.



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Assistance Center

The Customer Service Center – tel. → 0700 13 014 #3, is at your disposal 24 hours, 7 days a week, and can assist you if you need to use health goods and services, incl. specify the nature of the problem. Operators can refer you to a specific medical institution - a contractual partner, and coordinate with it the type, volume and scope of health goods and services that you are entitled to use.

Every working day from 9.00 to 17.30 (Monday – Friday), without public holidays, you can get information about the status of claims, incl. paid claims, and for your coverages and limits.

Through the Assistance Center you can get a claim number, which is required when attaching documents for reimbursement of expenses for used medical services / purchased health goods, outside the scope of the Subscription servicing.

In order to be identified by the Assistance Center as our client, you need to provide your names and PIN / PNF.

Types of insurance packages

As an insured person, depending on the agreed coverage and conditions for you, you can use the following options:

Subscription servicing

Payment of a fixed amount

Reimbursement of expenses

Second medical opinion

1.1 Subscription servicing

We provide health services through a network of medical institutions - contractual partners. It is necessary to identify yourself in the medical institution with the digital health card without the need for payment on the spot. We make payments directly to the medical institutions under the terms of the Insurance.

The subscription servicing is applicable to health modules "Outpatient Medical Care" and "Inpatient Medical Care".

Outpatient medical care

1. Book an appointment for examination with a suitable specialist doctor working in a medical institution - contractual partner under Allianz Health:
   - through the Allianz Health digital platform
   - through the platforms → **Easydoc** uʌu → **Superdoc**
   - on tel. → **0700 13 014 #3**
2. Visit the selected medical institution
   - show your digital health card at the registry office
   - examinations, tests, manipulations /upon appointment/
3. When using health goods and services outside the scope of subscription servicing, take all necessary medical and financial documents and proceed to → **item 3.2**. Reimbursement of expenses

Important!
If you have assigned highly specialized tests such as: MRI, scanner, endoscopic examinations (fibrocolonoscopy, gastroscopy, bronchoscopy), scintigraphy, as well as physiotherapy procedures, it is necessary to obtain approval from the Insurer. For this purpose, please contact our employee on tel. → **0700 13 014 #3**.

Inpatient medical care

If Inpatient medical care is needed (hospitalization)

1. Call us → 0700 13 014 #3
2. Upon admission to the hospital, show your digital card at the registry office
3. When using health goods and services outside the scope of subscription servicing, take all necessary medical and financial documents and proceed to → item 3.2. Reimbursement of expenses

Our Contractual Partners can be found on the Allianz Health digital platform, on our website → www.allianz.bg or get information about them by phone → 0700 13 014 #3.

In case of planned treatment in a hospital facility, you have the opportunity to provide us with a → Request for hospital care, filled in by you and your attending physician / representative of the hospital. The request shall be sent within 5 working days prior to the planned date of entry into the medical institution. Within 3 working days we will inform you about the type, volume and scope of health goods and services we can cover. Communication with us is made in writing by email → claimshealth@allianz.bg.

Important!
Always require medical documents for the services used under Subscription servicing, because you may need them in the process of Reimbursement of other goods and services that are outside the scope of cashless service.

1.2 Reimbursement of expenses

We refund the expenses you have incurred for purchased health goods and services under the terms of the Insurance, when they are not under Subscription servicing.

Reimbursement of expenses is applicable to health modules "Outpatient Medical Care", "Inpatient Medical Care", "Health Goods" and "Dental Care", if included in the Insurance Coverage.

When using medical services and / or health goods for a fee (outside the network of contractual partners of Allianz Bulgaria), it is necessary to request all medical and financial documents related to them.

Depending on your preferences, you can file a claim:

on → **www.allianz.bg**

in your digital platform Allianz Health

on tel. → **0700 13 014 #3**

1.2 REIMBURSEMENT OF EXPENSES

How to file a claim online

1. Make a claim online or by phone
2. On the mobile phone or email you will receive a message with the number of the filed claim and a link to the digital platform
3. Attach the collected medical and financial documents to the appropriate claim number
4. Enter and confirm your bank account
5. We will reimburse you the expenses under the terms and limits of your insurance within 15 working days from the date of the last document received.

If you wish, you can file a claim and send the documents in another way:
- by email: → **claimshealth@allianz.bg**;
- on paper by post/courier;
- on paper on the spot in an insurance office of Allianz Bulgaria;

It is mandatory to fill out a form → **Application for payment of indemnification**.

Deadlines

When submitting a claim for reimbursement of expenses for the purchase of health goods or use of services, please consider the following deadlines:
- Medicinal products purchased no later than 7 days from the date of their prescription;
- Corrective means (dioptric glasses) purchased no later than 60 days from the date of their prescription;
- Laboratory/instrumental studies carried out no later than 30 days from the date of their appointment;
- Physiotherapy on an outpatient basis, conducted within 60 days from the date of appointment;
- Rehabilitation in the conditions of hospitalization – up to 3 months after previous active hospital treatment.

All the necessary documents that you need to submit for reimbursement of expenses can be found at → **www.allianz.bg**.

1.2 REIMBURSEMENT OF EXPENSES

We refund the expenses incurred by you for purchased health goods and services until the relevant limit is exhausted and depending on the agreed copayment under your insurance.

Copayment

Copayment is the amount with which you participate in covering the expenses of health goods and services under the Insurance. It applies to goods and services included in the coverage, for which it is specified in your Insurance Certificate.

The amount of copayments is defined as a percentage of the value of health goods or services.

Example of 20% Copayment of the insured person

Type of expense	You pay	We reimburse you
Invoice for medicinal products	100 BGN	80 BGN
Invoice for dioptric glasses	150 BGN	120 BGN
Invoice for dressings	70 BGN	56 BGN

1.3 Payment of a fixed amount

Payment of a fixed amount is applicable to "Critical conditions and Second Medical Opinion" and "Childbirth".

How to file a claim

In case of a diagnosed Critical Condition or at Birth, follow these steps:

1. Request and collect all medical documents related to the case
2. Make a claim on → **www.allianz.bg**, the Allianz Health digital platform or tel. → **0700 13 014 #3**
3. On your mobile phone or email you will receive a message with the number of the filed claim and a link to the digital platform Allianz Health
4. Fill in the form → **Application for payment of indemnification**. Note the type of insured event – "Critical condition" or "Birth"
5. Attach the medical documents to the relevant claim number on the Allianz Health digital platform or by email: → **claimshealth@allianz.bg**, or send on paper by post or on-site to an insurance office of Allianz Bulgaria.
6. We will pay you a fixed amount under the terms and limits of your insurance within 15 working days.

According to the General Terms and Conditions of the insurance contract, you are entitled to receive a one-time fixed indemnification in case of diagnosis of Critical Condition, provided that it has arisen after a waiting period of 90 days from the beginning of your insurance coverage.

Second medical opinion

In case of diagnosed critical condition, in addition to the financial support, we also offer you the opportunity to get a second medical opinion. On the basis of medical records, an expert assessment is prepared by leading specialist physicians worldwide to verify the diagnosis and prepare a treatment plan. If necessary, a recommendation for appropriate treatment shall be provided.

1.3 PAYMENT OF A FIXED AMOUNT

The service is provided with the assistance of MediGuide International, LLC (MediGuide).

How can you use the Second Medical Opinion service?

1. Diagnosis of Critical Illness
2. You and/or your doctor can request the use of the service to the representative of MediGuide in Bulgaria - Fidelitas Assistance on tel. → 00800 2100 319 and follow the instructions
3. MediGuide will offer 3 clinics, classified as the best in the world in diagnosing and treating the specific disease, which can respond immediately to the inquiry
4. MediGuide completes and sends the full medical documentation to the clinic of your choice, where specialists will view your documents
5. Within 10 working days of providing the medical records to the respective clinic, you will receive a report on the initial diagnosis and a proposed treatment plan

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1.4 Prevention

Prophylactic examinations and tests help you monitor your health.

The services related to the prevention of your health cover examinations and tests related to the early detection of Diseases. The type, volume and scope of preventive examinations and tests are selected by your employer.

Your employer will inform you about the medical institution and the schedule for conducting preventive examinations and tests.

When visiting the hospital, identify yourself with an identity document and name your employer.

You will receive the results of Prophylaxis with a conclusion about your health condition in the manner agreed with your employer.

1.5 What else is important to know

Is it possible to refuse payment?

In accordance with the applicable **→ General Terms and Conditions of Allianz Health Group Medical Insurance**, we may refuse payment if:
- your health module limit has been exhausted;
- your condition is outside the scope of insurance coverage;
- The critical condition is diagnosed before the expiration of the waiting period;
- You have not substantiated the grounds and amount of your Insurance Claim;
- Your employer has not paid the due insurance premium or a consecutive contribution from it and has no valid insurance coverage;
- You prevent us from receiving information about your health condition and treatment by treating doctors, medical institutions, etc., necessary to clarify the basis and amount of the Insurance claim;
- there are other grounds provided for in the Insurance or the legislation in force.

See also our **→ Claims Settlement Rules**.

Exclusions from insurance coverage

We present you the exclusions to the insurance coverage according to the General Terms and Conditions, which will help you in using the insurance.

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2.1 General exclusions

We do not cover the costs for health goods and services resulting from a Disease or as a consequence of an Accident, which have arisen as a result of:

- war (whether declared or not) or, hostilities, invasion, foreign hostilities, military or occupation forces, civil war, riots, revolution, uprisings, disturbances, civil unrest, strikes, terrorism or others of a similar nature;
- impact of nuclear energy and radiation, except when nuclear energy is used for medical purposes; use of nuclear/biological/chemical weapons or substances; nuclear reaction, incl. explosion, contamination with radioactive products/ waste, or radiation;
- gas, chemical and other industrial accidents and hazards, breach of a dam wall or other emergencies;
- a pandemic recognized by the World Health Organization, incl. prophylactic examinations and tests in this regard;
- use of narcotic substances or their analogues - stimulants, toxic and doping agents and/or other intoxicants, incl anabolic hormones or those in the nature of doping or in case of drug addiction on your part;
- alcohol use; alcohol intoxication; alcohol dependence or alcohol exposure;
- committing a crime or administrative violation or attempted crime, as well as other violations of public order, qualifying as hooliganism, incl. and when the Insured Person has acted in a state of incapacity;
- detention by the law enforcement authorities in pre-trial detention or imprisonment;
- a fight deliberately caused by you, suicide attempt (deliberate); intentional self-injury/self-harm or deliberate exposure to danger except in cases of self-defense or saving human life or property;
- burning as a result of exposure to the sun, solarium, heat or frost as a result of cold, ice or other environmental factors;
- your participation in some sports, dangerous (extreme) activities, such as: hunting, rock climbing, mountaineering, spelunking (cave exploration), mountain biking, rowing (canoeing or kayaking), rafting, extreme sports (including but not limited to: skateboarding, parkour bungee jumping, base jumping and other jumping), equestrian sports, winter sports practiced off-piste, martial arts, motor and motorcycle sports, driving motor boats or jets, jet skiing, all kinds of aviation sports, including those related to flying, gliding, hang gliding, skydiving, sailing, scuba diving and diving, all kinds of competitions, including races, training or trials with cars, motorcycles, scooters and airplanes, including timed sports and the like;

- participation in events with experimental, scientific and/or research purposes;
- your failure to observe a regimen or treatment prescribed by a physician, use by the Insured Person of Medicinal products without a physician's prescription, manipulations performed by you or other persons who do not have the necessary professional qualification, as well as compliance with arbitrarily chosen dietary regime-prescribed dietary regimen;
- flying with an aircraft other than a ticket trip on a flight of scheduled airlines or with a recognised charter operator;
- catastrophic earthquakes, floods and other natural disasters.

2.2 SPECIAL EXCLUSIONS

We do not cover the costs for health goods and services used by you in connection with:

- diagnosis, treatment and follow-up of: infertility; polycystic ovaries; sexual dysfunction; obesity and metabolic syndrome; menopause; hair loss, seborrhea, acne, vitiligo, nail fungus (onychomycosis); AIDS, sexually transmitted diseases and their consequences;
- treatment and follow-up of: tuberculosis; epilepsy; osteoporosis; migraine; multiple sclerosis; functional nervous disorders; anorexia, bulimia, constipation; sleep apnea; chronic pain; mental illness, as well as additional care and special services in providing medical care to the mentally ill
- preparation and conduct of: assisted reproduction; gender reassignment; optional sterilization;
- quitting smoking or treatment of alcoholism/drug addiction, as well as their consequences;
- providing Emergency Medical Care;
- providing outpatient/inpatient care application of medical treatment, chemotherapy and radiation therapy, additional care and special services in case of oncological disease;
- treatment of congenital diseases or diseases acquired in childhood, leading to physical deformities or physiological deviations from normal parameters requiring constant treatment, as well as delay in physical growth and/or mental development.

We do not make payments under the Healthcare Module Critical Conditions and Second Medical Opinion:

- when the Critical Condition is considered essentially treatable through genetic

manipulation, substitution therapy, vaccination, or any other type of medical or other intervention;
- when the Critical Condition is the result of not sought or refused medical care;
- for Benign brain tumor in cysts calcifications, granulomas, malformations in or of the arteries or veins of the brain, hematomas and tumors of the pituitary or spine;
- for Blindness, if vision can be partially or completely restored as a result of an implant or other means;
- for Malignant tumor in the following cases: leukemia other than chronic lymphocytic leukemia if there is no generalized proliferation of leukemic cells in the bone marrow; tumors showing features of carcinoma in situ (including cervical dysplasia CIN-1, CIN-2 and CIN-3) or which have been histologically proven to be premalignant; all malignant tumors of the skin, unless there are metastases or the tumor is a malignant melanoma with a thickness of more than 1.5 mm, proven by histological examination by Breslow's method; non-life-threatening tumors, such as prostate cancer, which are described in the TNM classification as T1a and T1b or equivalent; papillary thyroid microcarcinoma; non-invasive papillary carcinoma of the bladder described as TaNoMo or equivalent classification; chronic lymphocytic leukemia milder than RAI Stage I or Binet Stage AI
- for Hearing loss, where, according to the general medical opinion, partial or complete hearing correction can be achieved by means of an aid, device or implant;
- for Speech loss, when, according to the general medical opinion, partial or complete correction of speech can be achieved by means of an aid, device or implant.
- for Stroke, for brain symptoms such as migraine, brain distress from trauma or hypoxia and cardiovascular disease affecting the eyes, the optic nerve or vestibular function..

2.3 OTHER EXCLUSIONS

We do not cover costs for health goods and services for:
- obligatory immunizations and obligatory treatment under the HA;
- chondroprotectors, medical cosmetics, sanitary materials, laxatives, as well as any other medical products not registered in Bulgaria under the MPHMA;
- contraceptives, except in cases where they are a means of treating a certain disease;

- medical devices and assistive devices/means of service and care/such as irrigators, inhalers, ice bags, breast pumps, electric pillows, medical thermometers, blood pressure monitors, as well as apparatus and aids for the care of the body;
- genetic testing and prenatal tests;
- positron emission tomography (PET scan);
- plastic, reconstructive and aesthetic corrections, cosmetic operations and other cosmetic health services and related preoperative examinations/consultations, as well as treatment of postoperative complications arising from them, except in cases of an Accident;
- removal of external skin formations and nevi;
- laser vision correction, cross-linking;
- hemodialysis, blood transfusion, organ and tissue transplantation, as well as their complications;
- voluntary abortion, including related tests;
- orthodontic and dental services, teeth whitening and related health goods;
- spectacle frames, sunglasses, lenses for glasses specially designed for the exercise of certain professions or for the performance of certain activities or actions;
- treatment that is not recommended/performed by a qualified physician, or is performed in an facility that is not registered under the MTFA, as well as if it is recommended/performed by a physician who does not have a recognized professional qualification for exercising activity in Bulgaria, including those invited for scientific exchange between medical establishments.

We do not cover costs for:

- examinations and tests for: insurance, presentation of Disability Expert Medical Committees, forensic examination
- health goods and services used before the entry into force of the Insurance Coverage, including when your claim or the expense documents for them are dated after the entry into force of the coverage;
- health goods and services used without specific complaints/symptoms of disease;
- health goods and services payable by the Ministry of Health, the NHIF, employers, assurers/insurers; municipal/public/private health program, financing schemes for medical expenses or other insurances, as well as when they are performed by you as a result of arbitrary refusal of the treatment carried out under any of the above options;

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- application of methods for diagnosis and treatment, which are not approved by the medical standards, as well as methods of non-traditional medicine, which do not comply with Ordinance No 7 of 1.03.2005 on the requirements to the activity of the persons, who exercise unconventional methods for favourable impact on the individual health;
- accommodation in a hospice or for transport, except for expenses for Specialized Medical Transport;
- issuing documents or transcripts receiving copies/records of tests on paper/ technical media, sending materials for tests from one medical treatment facility to another; translation and legalization of medical documents;
- health goods and services not related to the Disease being treated.

What are the responsibilities of the parties?

Here you will find information about the responsibilities of the parties during the term of the insurance

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Policyholder

What are the rights and obligations of the Insurer (your employer)

The Policyholder has the right:

- at any time during the term of the Insurance to request inclusion and exclusion of persons in the List of Insured Persons / List of Family Members;
- to receive summarized statistics on the Insurance and information on the movement of documents under a specific Insurance Claim;
- to transfer rights and obligations under the Insurance to another person only after obtaining the explicit written consent of the Insurer.

The Policyholder is not entitled:

- to request from the Insurer and to receive any information about the health status of the Insured persons;
- to create conditions for unlawful and unscrupulous use of health goods and services provided by the Insurer.

The Policyholder is obliged:

- to provide the information requested by the Insurer about himself and the applicants for insurance;
- to pay in full and on time the insurance premium;
- to fully and accurately inform the Insured persons about the conditions of the Insurance and about its subsequent amendments when affecting the Insured persons;
- upon termination of the Insurance to inform the Insured persons at the latest on the day following the day of termination.

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Insured

What are your rights as an insured?

You have the right:

- to receive from the Policyholder all the necessary information in connection with the exercise of your rights under the Insurance and to be notified in writing by him of changes to the Insurance that affect your rights and obligations;
- free choice of Healthcare Provider / Provider of health goods (incl. when contracted partner) on the territory of Bulgaria;
- when using health goods and services under the Health Modules "Outpatient Medical Care" and "Inpatient Medical Care" to freely choose the form of financial security, according to the agreed terms, coverages and limits.

You have no right:

- require healthcare professionals to perform diagnostic tests, manipulations or prescriptions of certain Medicinal Products that are not medically appropriate to your condition;
- to receive summarized statistical information on the performance of the Insurance or information about other Insured persons, except in the case of members of your family up to 18 years of age;
- to request changes to the Insurance.

What are your responsibilities as an insured?

You are obliged:

- to observe the order and manner of using health goods and services under the terms of the Insurance;
- to provide the Insurer with information in relation to your health;
- not to create conditions for unauthorized and unscrupulous use of health goods and services provided by the Insurer;
- provide a bank account to which payments on your insurance claims will be made;
- to submit all documents required by us related to an Insurance Claim;
- in case of Illness or Accident, make the necessary efforts to limit their consequences;
- identify yourself before the Contractual Partners with an identity document and

provide a digital Health Card;

- to personally use health goods and services and not to allow your rights under the Insurance for use of health goods and services to be exercised by third parties. In case of a breach of this obligation, you are obliged to refund us the damages paid in double amount. In this case, we may terminate your coverage;
- when we refuse payment to a Contractual Partner, you need to pay the relevant Contractual Partner the health goods and services you use. If, for any reason, we have paid the Contractual Partner, you are obliged to refund us the amount paid, together with legal interest, from the date of payment;
- not to use health goods and services if you are excluded from the List of Insured Persons, or the Insurance is terminated early.

Insurer

What are our rights as an insurer?

We have the right:
- at any time to make a change to the List of Contractual Partners;
- refuse to provide the information you request when it is contrary to the law or the terms of the Insurance;
- to check the documents and facts of each Insurance Claim and to require the submission of the necessary documents;
- to enter, store and process your personal data, incl. for your state of health;
- to check the medical expediency of the health goods and services you use;
- to require a medical examination to verify your diagnosis, treatment, delivered health goods and services within the deadline for adjudication of your Insurance Claim;
- to receive information about your health status.

What are our obligations as an insurer?

We undertake:
- to keep the List of contractual partners on our website up to date → **www.allianz.bg**;
- not to provide in any form, including to the Insurer, any information related to your health status, except as provided by law;
- to provide you with uninterrupted and free access to Allianz Health.

We cannot be held liable and no claims can be made to us if the Insurer has not fulfilled its obligations under the Insurance to you and therefore you have not been able to exercise your rights under it or have done so in a way that excludes our ability to fulfill our obligation to financially secure the expenses you incur.

Personal Data Protection

We process the personal data provided during and in connection with the conclusion, operation and termination of this Insurance, incl. when processing insurance claims, on the grounds and for the purposes specified in the Privacy Notice of Allianz Bulgaria Insurance JSC, available at: → **www.allianz.bg/gdpr/**.

3 WHAT ARE THE RESPONSIBILITIES OF THE PARTIES?

The Policyholder is obliged, before concluding the Insurance, to provide and during its operation to provide or indicate access to each Insured person to the Personal Data Protection Notice of Allianz Bulgaria Insurance Company.

The Policyholder is obliged to protect the trade secret of the Insurer by not making known to third parties, in any form, information related to the conclusion, content and / or performance of the Insurance or any information related to tariffs and price conditions and any other data and information about the Insurer that have become known to him in connection with the Insurance, as well as not to disclose to the Insured persons the price and other conditions that do not relate and are not related to the exercise of their rights.

The information that the Insurer receives about the Insured person under the Insurance is an insurance secret and may be provided to others only in the cases expressly specified by law and may be used only for the purposes of risk assessment, conclusion, maintenance of the Insurance and processing of Insurance claims and their payments.

Definitions and abbreviations

4

For your convenience, we apply the definitions and abbreviations in the General Terms and Conditions and this document

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A

Accident is any event that occurred during the Insurance Coverage Period, which resulted in bodily injury to the Insured Person, as a result of unforeseen, accidental and sudden influences of external origin. The event must not have been caused intentionally by the Insured Person, by their Disease or by a gradual physical or mental process. Cases of sprains, strains and tears of tissues, joints, tendons and muscles, caused for the first time by sudden exertion of one's own forces, are also recognized as Accidents.

Acute disease is a disease with a sudden onset, rapid progression of symptoms and short duration, manifested by intense, severe symptoms such as severe pain. Such a disease is expected to respond quickly to adequate treatment.

Aortocoronary bypass is a thoracotomy surgery performed to correct or treat cardiovascular disease.

Assistance Center is our Customer Service Center, which provides assistance 24/7 in case of need to use health goods and services (incl. clarifying the nature of the problem, referral to a Health Service Provider/Health Goods Provider and if possible, to make an appointment for examination and filing a claim. Information about claims, coverages and limits is provided every working day, Monday to Friday, 9.00 to 17.00, without public holidays. Using the services of the Assistance Center requires you to provide your PIN / PNF and full name. The Assistance Centre may give binding instructions for referral to a particular Contracting Partner and coordinate with it the type, volume and scope of approved health goods and services where relevant.

Assistive Devices are the devices used to support vital functions, prescribed by a physician and purchased during the validity of the Insurance. Assistive Devices are, for example, prosthetics for limbs, crutches, canes, wheelchairs, orthoses, elastic stockings, elastic bandages, catheters, collector bags and urinals.

B

Benign Brain Tumor is a life-threatening tumor that has symptoms of increased intracranial pressure, such as papilledema, mental symptoms, seizures, and impaired sensitivity. The tumor must require surgery for complete or partial removal, as far as possible, or to be treated with chemotherapy / radiation, or be considered inoperable and growing, and require palliative care.

Blindness is a clinically proven irreversible decrease in vision in both eyes as a result of a Disease or an Accident. Upon correction, visual acuity must be below 6/60 on the metric scale or 20/200 according to the Snellen test, or there must be a reduction in the visual field to 20 degrees or less.

C

Childbirth is a health service, expressed in the provision of medical assistance, health care and accommodation to the Insured Person in a medical treatment facility, on the occasion of the birth of a child.

Chronic Disease is a disease that has recurrent symptoms, clinical presentation and laboratory parameters or progressive development with possible remissions, but without a definitive cure or no known known treatment leading to cure or which disease requires maintenance treatment or requires long-term monitoring, consultation and adjustments in treatment.

Claims Ratio per Policyholder is calculated for one-year Insurance (without Healthcare Module PROPHYLAXIS) according to the following formula CR (%) = [(PIC+ NPIC): IP] x 100 (where: CR is the Claims Ratio as a

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percentage; PIC is the total amount of paid Insurance Claims under the Insurance; NPIC is the total amount of filed but not paid Insurance Claims under the Insurance; IP is the total amount of the Insurance Premiums under the Insurance. When determining the ratio, the amount of the claims under which the Insurer is entitled to recourse is not calculated.).

Coma is a state of unconsciousness with no response to internal or external stimuli, lasting without interruption more than 96 hours and requiring the use of life support systems. The coma must lead to a neurological deficit, causing a permanent and irreversible ability of the Insured to move from room to room on one level, or to eat independently, or to communicate with others through verbal speech, or the result of the Mini Mental Status Test to be below 16 points.

Contractual Partners are Health Service Providers and Health Goods Providers, with whom the Insurer has concluded contracts for Subscription for the provision of certain health goods and services.

Coordinator is an employee of the Contractual Partner, who in Subscription Servicing assists you in the use of health goods and services and the preparation of the necessary medical and financial documents. Copayment is the amount with which you participate in covering the costs of health goods and services under the Insurance. The type and size of the Copayment is determined in the Insurance Policy. Copayment can be applied in different amounts for the different Health modules and health goods and services.

Corrective Devices are the devices used to correct vital functions, prescribed by a physician and purchased during the validity of the Insurance. Corrective Devices are, for example, contact lenses or spectacle lenses. Coverage period is the period of Insurance coverage for one Insured person under the Insurance.

Coverage Period of the Insured Group is the Insurance Coverage Period for the persons included in the List of Insured Persons under the Insurance.

Customer Portal My Allianz is an internet-based system (platform) through which the Insurer provides services and content to registered users. The client portal My Allianz is loaded via a link from the website www.allianz.bg or by directly loading the website www.myallianz.allianz.bg.

D

Dental care is a system of preventive, diagnostic and treatment activities provided by dentists or dental care providers.

Dental Specialist is a qualified person with higher education in the specialty “Dental Medicine” and professional qualification “Dentist”, who has acquired a specialty and exercises his profession on the territory of Bulgaria in accordance with legislation in force.

Digital platform "Allianz Health" is an electronic platform through which you have access to information relevant to your insurance - period of insurance coverage, Insurance package and Insurance certificate, as well as for your family members who are up to 18 years old.

Disease is the set of subjective complaints and clinical manifestations of structural and functional injuries of the organism, diagnosed during the Insurance Coverage Period in a medical treatment facility and registered in an official medical document issued by this medical treatment facility. The date of onset of the disease is the date of its initial diagnosis.

E

Electronic Document is an electronic document within the meaning of Art. 3, item 35 of Regulation (EU) No 910/2014, namely: any content stored in electronic form, in particular text or sound, visual or audiovisual recording.

Electronic Statement within the meaning of Art. 2 of the EDETSA is a verbal statement presented in digital form through a commonly accepted standard for transformation, reading and presentation of information. The electronic statement may also contain non-verbal information.

Urgency Care Unit is opened in a licensed medical institution in accordance with Ordinance No 10 of 31.05.1994 on emergency medical care.

Emergency Condition is an acute change in human health that can lead to severe functional and morphological damage to vital organs and systems.

Emergency Medical Care includes all medical activities aimed at restoring acute life-threatening disorders and maintaining the vital functions of the body.

Emergency Medical Center is a medical treatment facility in which medical professionals, with the assistance of other staff, provide emergency medical care to sick and injured persons, including at home, at the scene of the accident and during transport until possible hospitalization.

Emergency medical department is a unit opened on the territory of a general hospital, which has the necessary qualified medical staff, equipment and conditions for providing the necessary volume of emergency medical care to any person in need of such.

F

Family member is your spouse or person living with you on a marital basis and your minor children, including children of one of you, adopted children or children in your care as guardians or guardians, until the age of 18 and, if they continue their education, until the age of 26, provided that the persons are registered at the same permanent address.

Fixed Sum Payment is a form of indemnification in which we pay you a fixed sum upon the occurrence of the conditions stipulated in the Insurance, regardless of the amount of the expenses for health goods and services.

Fraudulent Actions, Methods or Techniques are any actions or omissions, means or methods that may mislead, are misleading or maintain an existing misleading of the Insurer's representatives/employees regarding the occurrence of the Insured Event, the amount of the suffered damages or other circumstances that are significant for occurrence the right to receive an insurance sum or indemnification or to determine their amount.

G

Group of Policyholders are employers/assignors who are related parties under §1 of the Supplementary Provisions of the Commercial Act and the persons insured by them are considered to be from the same Insured Group.

H

Health card is individually provided by the Insurer to each Insured person a card in a digital form containing name, number and period of validity.

Health Goods Provider is a merchant registered under the Commercial Act, who has the right to supply, distribute or sell health goods in Bulgaria.

Health module includes defined by type, volume and scope health goods and services and a description of the applicable conditions, including the form of compensation, limits and sublimits of payments, Waiting periods and Self-participation. The health modules are "Outpatient Medical Care", "Inpatient Medical Care", "Critical Conditions and Second Medical Opinion", "Health Goods" and "Dental Care", grouped into the following Insurance packages – Comfort, Extra and Max. To each Insurance package can be purchased an additional Health Module Prophylaxis, which is available in three different variants.

Health Service Provider is a natural person or legal entity, registered under the MTFA and having the right to perform medical activity on the territory of Bulgaria, according to the legislation in force. For the purposes of these General Terms and Conditions, mental health centers, medical treatment facilities or separate parts thereof for the treatment of drug and alcohol addiction, hospices and facilities for medical and social care are not Health Service Providers.

Hearing Loss is irreversible hearing loss in both ears, with a hearing threshold above 90 decibels, as a result of a Disease or an Accident.

I

Implants are medical devices that are placed through surgery or other medical intervention in the human body and remain in it for a period longer than 30 days, which can be artificial lenses, stents, pacemakers, artificial joints, implants and other osteosynthetic devices.

Infertility is the inability to conceive, the inability to carry the pregnancy until the fetus becomes viable (miscarriage) and the non-viability of the newborn child.

Insurance claim is a written request to us for payment of incurred or made expenses for health goods and services covered by the Insurance.

Insurance is the insurance contract, which consists of these General Terms and Conditions, the insurance policy and its appendices, the Questionnaire for concluding the insurance, when applicable - Questionnaire-declaration of health status from the Insured Persons and their Family Members, and other written agreements between the parties, if any.

Insurance period is a period of one year for which the Insurance Premium is calculated. Insurance Sum is the maximum limit of our liability for the duration of the Insurance according to your Insurance package. Some of the coverage under the Insurance package has limits that are determined on the basis of a period of time (e.g. term of the Insurance), and other limits are determined on an event basis (e.g. travel, visit).

Insured event is the occurrence of a covered risk, consisting in the occurrence of costs from the use of health goods and services in connection with Illness or as a result of an Accident, or other contracted health goods and services, incl. in prophylaxis, Pregnancy and Childbirth.

Insured group is a group of at least 10 Insured persons, named in a list to the Insurance Policy, who are in an employment/service or other similar relationship with the same employer/assignor.

Insured Person is a natural person whose material goods are subject to insurance protection under the Insurance.

Intentional Exposure to Danger is a deliberate, willful and conscious act of the Insured Person, as a result of which they suffer damage to or create a real danger for damage to their health or physical integrity.

K

Kidney Failure is a condition characterized by chronic irreversible insufficiency of the function of both kidneys, as a result of which regular dialysis or kidney transplantation is required.

L

Life-threatening Malignant Tumor is a malignant tumor proven by histopathological evidence, which is characterized by progressive, uncontrolled growth, spread of malignant cells and invasion and destruction of normal and surrounding tissues. The tumor must require conservative treatment, surgery or palliative care.

List of contractual partners is an up-to-date list that is published on our website and in Allianz Health, to which you have permanent access. Regarding the Contractual Partners, name, address of activity, telephone number, email address, website are provided.

List of family members is an appendix to the Insurance Policy and includes Insured Persons who are the Members of your family and indicates their Insurance package. The list is prepared in our form and for each person with whom you are in the same family, it contains: three names, PIN / PNF, date of birth, gender, mobile phone number and email, current address, as well as your PIN / PNF and three names.

List of insured persons is an appendix to the Insurance Policy and includes Insured persons from the Insured group with an indication of their Insurance package. The list is prepared according to the Insurer's model and for each Insured person contains: full name, PIN / PNF, date of birth, gender, mobile phone number and contact email, location of work and current address.

M

Major Organ Transplantation includes an organ transplant from a donor to the Insured Person of one or more of the following organs: kidney, liver, heart, lung, pancreas or bone marrow.

Medical Care is a system of diagnostic, treatment and prevention activities provided by medical specialists and medical care providers.

Medical Examination is a set of methods for examining the patient's condition, including: case history, establishment of objective condition, physical and machine-assisted methods for examination of the health condition of the Insured Person, as well as complex assessment of the results of the clinical search, diagnosis and assignment of treatment. For the purposes of these General Terms and Conditions, activities performed by psychics, traditional healers and unqualified medical natural persons and legal entities are not medical examinations. The Medical Examination may also be performed at the patient's home in case of urgent indications.

Medical expediency refers to health goods or services that must be:
- of primary importance for the diagnosis or treatment of the patient's condition, illness or trauma;
- relevant to the symptoms, diagnosis or treatment of the patient's condition;
- relevant to the generally accepted current good medical practice, established medical standards and professional standards for medical care in the medical community;
- necessary for reasons other than providing convenience and benefit to the patient or his doctor;
- with proven curative value;

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- most appropriate by type and level/ category of the respective good and service;
- provided in an appropriate medical institution, an appropriate environment and an appropriate level of care with a view to treating the patient's condition;
- provided solely for an appropriate period of time.

Appropriate means taking into account the factors of 'patient safety' and 'economy'. When it comes to inpatient hospital treatment, medically necessary also means a diagnosis that could not be made, or a treatment that could not be carried out in a safe and effective manner outside the conditions of hospital stay.

Medical Second Opinion is a service provided by a leading medical center outside Bulgaria, in which a report is prepared remotely and on the basis of medical records, including an independent expert assessment by a specialist doctor in order to verify the initial diagnosis and treatment plan, and a recommendation for the most appropriate treatment for you.

Medical Supplies are medical devices, within the meaning of the MDA, necessary in the medical practice in carrying out diagnostic and therapeutic activities, used in the course of prevention, diagnostics and treatment, according to a given physician's prescription. These include all dressings, surgical needles and sutures, surgical cloths, transfusion systems, intravenous catheters, syringes, needles, catheters and other consumables related to the diagnosis and treatment of the Insured Person.

Medical Test is the application of methods for detection of pathological deviations from the normal physiological indicators of the organism, applied by qualified persons, authorized in accordance with the legislation in force to perform them. The results of medical tests should be reflected in an official medical document. The tests are prescribed by the attending physician according to existing medical indications.

Medicinal product is in accordance with the MPHMA. Medicinal products should be prescribed by a doctor and are in a direct causal relationship with the diagnosis of the Insured persons. For the purposes of the General Terms and Conditions are not medicinal products all herbs, synthesized herbal preparations, preparations with preventive action, food supplements, contraceptives, when the leading one is their contraceptive effect, specialized foods, biostimulants and medical cosmetics.

Myocardial Infarction (MI) is impaired blood supply to part of the heart muscle due to insufficient blood flow to the area. The MI must simultaneously meet the following criteria: typical central chest pain; diagnostic increase in specific cardiac markers typical of MI; new ECG changes for MI; evidence of reduction in left ventricular function, decreased ejection fraction or significant hypokinesia, akinesia or disturbances in wall movements as a result of MI.

P

Paralysis is a permanent and complete loss of function of two or more limbs as a result of trauma/disease of the spinal cord, limb meaning the whole arm/leg.

Period of insurance coverage is the period in which we bear the risk under the Insurance. Policyholder is a natural person or legal entity, party to the Insurance, who is an employer within the meaning of the Labor Code, assignor under a management /civil contract or under other type of contract from which a reasonable conclusion can be made about the relations between them and the persons, who are assigned to perform a certain type of activity/ work, such as, but not limited to - a contract of a lawyer in a law firm. Under the terms of the Insurance the Policyholder may also be an Insured Person.

Pre-existing Condition is a disease or related conditions of the Insured Person, for which one or more symptoms appeared before the beginning of the insurance coverage, regardless of whether it was established by a physician or was known only to the Insured Person or their Family Members. Any disease or related condition that is currently, has ever been or could reasonably be concluded to have been known to the Insured Person or their Family Members shall be deemed a pre-existing condition.

Pregnancy is the period from the date of initial establishment of conception to the date of Childbirth.

Pregnancy Monitoring is the conduct of certain examinations and tests performed to monitor the condition of the pregnant woman, the fetus and the development of the pregnancy.

R

Reasonable and Normal Costs are expenses for health goods and services performed according to the approved medical standard and the generally accepted current good medical practice, as the price of each used good/service must not exceed by more than 50% the average value of the respective agreed prices between the Insurer and its Contractual Partners for this good/service for the current calendar year.

Reimbursement of expenses is a form of indemnification in which we reimburse the expenses incurred by you for health goods and services purchased by you, under the conditions agreed in the Insurance.

Risk Assessment is a procedure of the Insurer, applied for the purposes of concluding the Insurance and providing the insurance coverage, which may also include a medical risk assessment.

S

Scope of health goods and services are the types of health goods and services to which you have access under the terms of the Insurance.

Severe burns are tissue burns from thermal, chemical or electrical agents causing third degree burns, on not less than 20% of the body surface, according to the Rule of Nines or the Lund and Browder chart of the body surface.

Specialist Physician is a qualified person with higher education in the specialty "Medicine" and professional qualification "physician", who has acquired a specialty and exercises his profession on the territory of Bulgaria in accordance with legislation in force.

Specialized Care is the assistance of a nurse, physical therapist or other qualified person appointed by a Specialist Physician, which aims to support the healing process.

Specialized Medical/Sanitary Transport is the transportation of the Insured Person, if necessary, from a medical standpoint, from their home or place of accident to a medical treatment facility or from one medical treatment facility to another medical treatment facility, carried out by a specialized motor vehicle with accompanying medical team/person on the territory of Bulgaria.

Speech Loss is a complete and irreversible loss of speech as a result of a Disease or an Accident. Speech Loss should continue for 12 months without interruption.

Stroke is an acute disturbance of blood flow to the brain as a result of a cerebrovascular accident, expressed in a neurological deficit, which leads to a permanent and irreversible ability of the Insured Person to move from room to room on one level, or

to eat unassisted, or to communicate with others through verbal speech, which changes were found no earlier than 3 months from the date of the Stroke. The Stroke must be unequivocally proven by computed tomography, magnetic resonance imaging or similar appropriate imaging tests for cerebral infarction or intracranial or subarachnoid hemorrhage.

Structural unit of the Insurer is our Head Office, located at the business address, telephone number, email address, Internet site, as well as each of our Main Representation and/or Representation.
Subscription servicing is a form of indemnification in which we provide the Insured persons with health goods and services provided by Contractual Partners under the terms of the insurance. The cost of the health services used is paid by the Insurer directly to the Contractual Partner.

Sum insured is the amount agreed between the parties and specified in the Insurance Policy, representing an upper limit of our liability.

Surgical treatment is the immediate treatment process, when surgical methods are used to correct pathological conditions of organs or systems, as well as the whole variety of surgical interventions, performed once or repeatedly, but interconnected at a specific time, reflected in the operative journal of outpatient or hospital units, involving surgical treatment.

T

Treatment is a medical procedure necessary to eliminate or alleviate the Insured Person's Disease or trauma.

U

Unconventional methods for influencing individual health are methods for diagnosis and treatment, applied by persons carrying out activity according to Chapter VI of the HA and Ordinance No 7 of 1.03.2005 on the requirements to the activity of the persons, who exercise unconventional methods for favorable impact on the individual health.

Urgent condition is any disease condition or exacerbated chronic disease that has led to discomfort of the person and is a prerequisite for seeking medical help and carries the risk of possible disruption of the morphological structure or suspension of the functional processes of one or several organs or systems in the human body. The urgent condition requires timely intervention by a medical specialist to clarify and diagnose this condition, take measures to manage the accompanying symptoms and syndromes (pain, nausea, vomiting, etc.) and subsequent initiation of treatment measures.

Urgent Medical Care is a medical activity for providing urgent medical care to sick and injured persons, whose lives are not directly endangered, but who need medical care quickly in order to prevent further development and complication of the Disease.

V

Volume of health goods and services is the amount of health goods and services provided that you have access to under the terms of the Insurance.

W

Waiting period is a period of time of entry into force of the Insurance Coverage, during which a certain coverage under the Insurance is not in force and we do not owe payment for certain health goods and services. In the case of Accident and renewal of expiring Insurance, no Waiting Period shall apply.

4 DEFINITIONS AND ABBREVIATIONS

For the purposes of the Insurance, the following abbreviations are used

Republic of Bulgaria	Bulgaria
National Health Insurance Fund	NHIF
Medical Devices Act	MDA
Commerce Act	CA
Health Insurance Act	HIA
Health Act	HA
Regulation (EU) No 910/2014 of the European Parliament and of the Council of 23 July 2014 on electronic identification and trust services for electronic transactions in the internal market and repealing Directive 1999/93/EC	Regulation (EU) No 910/2014
Insurance Code	IC
Medical Treatment Facilities Act	MTFA
Law on Medicinal Products in Human Medicine	ZMPHM
Electronic Document and Electronic Signature Act	EDESA

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