General Terms and Conditions for Group Medical Insurance "Allianz Health"

I. Subject of the insurance

Under these General Terms and Conditions for Group Medical Insurance "Allianz Health", ZAD Allianz Bulgaria, hereinafter referred to as the "Insurer", against paid insurance premium assumes certain insurance risks related to the health and physical integrity of the Insured Persons.
The medical insurance under these General Terms and Conditions is carried out in compliance with the principles of equality of the parties, good will, good faith, responsibility for one's own health, free choice of a Health Service Provider or Health Goods Provider by the Insured Persons.

II. Insured person

1. An Insured Person from the Insured Group may be aged from 18 to 65, provided that they are not placed under full interdiction.

2. An Insured Person who is a Family Member can be aged from 0 (newborn child) to 65 years, provided that they are not placed under full interdiction. The insured Family Members are Insured Persons within the meaning of these General Terms and Conditions, unless otherwise expressly stated.

3. The age of the applicants for insurance is determined at the beginning of the month preceding the conclusion of the Insurance or their inclusion in the List of Insured Persons.

4. Upon additional agreement between the Insurer and the Policyholder and against paid additional premium, under the conditions of increased risk, persons who do not meet the age requirements under item 1 and item 2 of this Section may be insured.

5. An Insured Person may have only one active insurance under these General Terms and Conditions.

III. Insurance packages. Healthcare modules

1. Depending on the agreed Insurance Package, the Insurer covers the expenses of the Insured Person for:

- health goods and services resulting from a Disease or as a consequence of an Accident and/or
- other agreed-upon health goods and services, including those related to prophylaxis, Pregnancy and Childbirth, and/or
- goods and services related to their health care resulting from a Disease or as a consequence of an Accident, including Specialized Medical/ Sanitary Transport and Specialized Care.

2. The coverage of expenses for health goods and services under the Insurance can be done through:

2.1. Cost Reimbursement of the Insured Person;

2.2. direct payment to a Contractual Partner for the health goods and services provided to the Insured Person. Upon reaching an explicit agreement with the Insurer, direct payments of sums may be made to a Health Service Provider/Health Goods Provider, who is not a Contractual Partner;

2.3. Fixed Sum Payment to the Insured Person, regardless of the expenses incurred by them.

3. Depending on the agreed Insurance Package, the parties to the Insurance may agree:

- a maximum Insurance Sum (sub-limit) for different health goods and services or Healthcare Modules, or
- a specific volume or scope of health goods and services offered for a certain period.

4. The Insurance provides coverage under Insurance Packages, which the Policyholder chooses upon its conclusion from the following options:

Insurance package Healthcare modules	Comfort	Extra	Max
Outpatient medical care	✓	✓	✓
Hospital medical care	✓	✓	✓
Critical conditions and medical second opinion	✓	✓	✓
Health goods		✓	✓
Dental care			✓
Prophylaxis* * (additional option to each Insurance package)			

Note:

The table of Healthcare Modules, which is Appendix No. 1 to these General Terms and Conditions, contains a detailed description of:

- The Healthcare modules and the possible sizes of the insurance amount included in the Insurance packages, and
- the preventive examinations and tests offered in the Prophylaxis Healthcare module;

The conditions applicable under the Insurance (including insurance sums, scope of preventive check-ups and tests) are agreed in the insurance policy.

5.1. Healthcare Module Outpatient Medical Care

Outpatient medical care is the provision of health goods and services in an outpatient setting by medical treatment facilities for outpatient care, in accordance with the Health Act (HA), Medical-Treatment Facilities Act (MTFA) and medical standards, in accordance with the health condition of the Insured Person. The health goods and services are used due to a health problem of the Insured Person, which does not require inpatient hospital treatment.
Medical examinations with freely selected Specialists, routine and highly specialized medical examinations and manipulations are covered, appointed on medical indications by a specialist doctor, incl. physiotherapy procedures.
This module includes health goods and services, related to normal or high-risk Pregnancy Monitoring, described in these General Terms and Conditions, up to a certain amount, incl. costs for a package service offered by a medical treatment facility, one and only if "Pregnancy monitoring" is agreed in the insurance policy.
Home visits and care are covered by medical indications, described in a medical document, and are not considered necessary on medical indications if they are based only on personal requirements of the Insured Person.
Dental services are not covered under the Healthcare module Outpatient Medical Care.

5.2. Healthcare Module Hospital Medical Care

Hospital medical care is the hospital stay and the entire range of health goods and services, provided by medical treatment facilities for hospital care, in accordance with the HA, MTFA and medical standards, in accordance with the health condition of the Insured Person. The health goods and services are used due to a health problem of

the Insured Person, which requires Hospital treatment.
Services additionally requested by the Insured Person in accordance with the Ordinance for exercising the right of access to medical care and other health goods and services, which are not included in the scope of the basic package of health activities guaranteed by the NHIF budget, are covered. Certain services on the occasion of rehabilitation are also covered under this module, only if it is a continuation of Hospital treatment, covered by the Insurance and if they are provided by Specialized Rehabilitation Hospitals. The Insurance Sum under this module does not include the value of outpatient procedures, clinical procedures and clinical pathways paid by the NHIF in respect of health insured persons within the meaning of the HIA, while in case the Insured Person and their Family Members are uninsured within the meaning of the HIA, the Insurer provides limited in volume health goods and services, according to the Table of the Healthcare Modules. Hospital medical care is not considered necessary for medical reasons if it is based only on the lack of opportunity for home care or other personal requirements of the Insured Person.
In case of Childbirth during the Insurance Coverage Period, regardless of the scope and volume of services used and medical assistance provided, the Insurer pays a fixed sum to the Insured Person, once for the duration of the Insurance, according to the selected Insurance Package.
Dental services are not covered under the Healthcare module Hospital Medical Care.

5.3. Healthcare Module Critical Conditions And Medical Second Opinion

Critical Conditions are: Benign brain tumor, Blindness, Coma, Aortocoronary Bypass, Myocardial infarction (MI), Kidney failure, Life-threatening malignant tumor, Hearing loss, Speech loss, Major organ transplantation, Paralysis, Stroke and Severe Burns. In case of a Critical Condition diagnosed after the expiration of the Waiting Period, the Insurer pays once for the duration of the Insurance a fixed sum to the Insured Person, according to the terms of the respective Insurance Package and the Insured Person has the right to use the Medical Second Opinion service regarding this condition. The service is provided with the assistance of MediGuide International, LLC (MediGuide), which maintains a list of leading medical centers outside Bulgaria, which are available to prepare a Medical Second Opinion. To request the use of a service, the Insured Person and/or their treating physician should contact MediGuide's partner in Bulgaria - Fidelitas Assistance. MediGuide identifies the medical centers with expertise in relation to the diagnosed Critical Condition and the Insured Person and/or their treating physician select the medical center from which they wish to receive a Medical Second Opinion. The collected and completed medical documents are sent to the medical center, which prepares its report within 10 working days after receiving all necessary medical documents. In order to use the Medical Second Opinion service, it may be necessary to transfer and process personal data of the Insured Person outside the European Economic Area under the conditions of the current legislation on the protection of personal data and measures taken to protect personal data that ensure an adequate level of data protection.

5.4. Healthcare Module Health Goods

This module covers the costs of the Insured Person for Medicinal Products, Assistive Devices, Corrective Devices, Medical Supplies for Outpatient Medical Care and for Medicinal Products for Dental Care. If the Insurer has reimbursed the costs of Assistive Devices, a new claim for indemnification may be filed after the expiration of the usual period of wear and tear, except in cases

when, for medical reasons, an earlier purchase is required.
During the term of the Insurance, the Insurer reimburses one-time expenses for prescription glasses, prescribed by an ophthalmologist in a medical-treatment facility, purchased from opticians registered under the HA and provided that the vision correction is at least 0.5 diopters. Contact lenses for vision correction are covered when they are prescribed by an ophthalmologist in a medical-treatment facility with a minimum correction of 0.5 diopters within the relevant limit. In cases where the Insured Person is prescribed dioptric correction for only one eye, the costs for both lenses or contact lenses are covered. The cost for antireflective lenses for glasses without diopters are not covered.
In order to be reimbursed for Medicinal products, incl. homeopathic products and food supplements, it is necessary for them to be prescribed by a qualified Specialist or by the general practitioner of the Insured Person. Medicinal products, homeopathic products and food supplements must be distributed in accordance with Bulgarian legislation in force and be purchased from a pharmacy in Bulgaria, registered under the Medicinal Products in Human Medicine Act (MPHMA).
The Insurer does not reimburse expenses for Medicinal Products and Medical Devices that are paid on a legal basis by the NHIF or another person, as well as those that are not permitted for use in Bulgaria. Expenses for medical devices are reimbursed only if they are purchased from medical treatment facilities and medical establishments under the MDA. The Insurer reimburses the expenses of the Insured Person for the difference from the amount, which is partially paid by the NHIF or by the other person for Medicinal Products and Medical Devices up to the amount of the respective limit under the Insurance.

5.5. Healthcare Module Dental Care

The health goods and services are used due to a health problem of the Insured Person, which requires Dental Care related to the control of the condition of the oral cavity, preventive, therapeutic, surgical and orthopedic activities are covered.
This module covers expenses for dental treatment according to medical indications, provided to the Insured Person in the form of outpatient or inpatient hospital treatment within a separate limit, specified in the Table of Healthcare Modules. Hospital medical care due to dental illness and dental prosthetics, as well as interventions through dental surgery are considered necessary for medical reasons only when outpatient treatment is not possible for medical reasons.

5.6. Healthcare Module Prophylaxis

This module covers health goods and services related to early detection of Diseases, and the type, volume and scope of prophylactic examinations and tests are determined in the insurance policy. The health goods and services are used once and the agreed limit for an Insured Person under this module is outside the aggregate limit under their Insurance Package. The Insurer and the Policyholder agree on a schedule for conducting prophylactic examinations and tests at a medical treatment facility designated by the Insurer, as the period for conducting them may not exceed the term agreed with the Policyholder. The Policyholder declares the period in which he wishes the prophylactic examinations and tests of the Insured Persons to be carried out, not later than 30 days after the conclusion of the Insurance.
Within 14 days before the period of the prophylaxis, the parties shall form a preliminary schedule, which shall contain information about the minimum and maximum number of Insured Persons, which may be registered on the same day and in the same settlement. Within 7 days before

the prophylaxis, the parties shall form a final schedule, which shall contain the specific dates and settlements for conducting the prophylactic examinations and tests, as well as a named list of the included Insured Persons. The Insurer may set additional (back-up) dates for conducting prophylactic examinations and tests for the Insured Persons, who for objective reasons were unable to attend the main dates. The number of these persons may not be more than 10% of the total number of the Insured Persons under the respective Insurance. The Policyholder organizes the attendance of the Insured Persons, and the obligation of the Insurer for conducting the prophylactic examinations and tests is considered fulfilled in the cases in which the Insured Persons do not attend them. For the persons included in the List of the Insured Persons after the prophylaxis, no prophylactic examinations and tests are organized outside the main and additional (back-up) dates. The Insured Persons must inform the employees at the Registry of the medical treatment facility that the purpose of their visit is to conduct prophylactic examinations and tests, to identify themselves through an identity document and to indicate the Policyholder. Based on the performed prophylactic examinations and tests, the Insured Persons receive information about their health condition in a manner agreed in the insurance policy.

6. There may be a Waiting Period for certain coverages under the Insurance, which is explicitly stated in the insurance policy.

7. The Insurer covers expenses that are Reasonable and usual, and are incurred solely and exclusively in connection with healthcare goods and services that are included in the type, volume and scope specified in the coverage under the Insurance, that are medically appropriate and that are provided by Healthcare Service Providers/Healthcare Goods Suppliers. If the expenses do not meet these requirements, the Insurer has the right to refuse payment or reduce the amount of indemnification or payment. The Insurer does not cover other direct or indirect, material or non-material damages, losses, lost profits and others that are the result of Disease, Accident, Prophylaxis, Pregnancy and Childbirth.

8. The insurer owes payment of fixed sums or indemnification only for the risks and up to the limits specified in the insurance policy, but not more than the amounts of the Limit Prices of Health Goods and Services. All limits in the insurance policy are for one Insured Person for the term of the Insurance, unless the parties agree otherwise. Each payment made to an Insured Person reduces its Insurance Sum for the respective Healthcare Module and/ or the sub-limit for a health product or service, when such is provided.

9. Insured persons under the Insurance are only those who are included in the List of the Insured Persons and for whom the due insurance premium has been paid in time. Changes (inclusion or exclusion of persons) in the Lists of Insured Persons shall be made with an additional agreement (annex), which shall specify the Coverage Period of the Insured Person, which may not be longer than the term of the Insurance, their Insurance Package and its corresponding insurance premium.

10. For the term of the Insurance, the transfer of the Insured Group or the Insured Person from one Insurance package to another is not allowed.

IV. Exclusions from coverage

1. General exclusions

1.1. The Insurer does not cover the costs for health goods and services resulting from a Disease or as a consequence of an Accident

of the Insured Person, 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 of the Insured Person;
- 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 of the Insured Person by the law enforcement authorities in pre-trial detention or imprisonment;
- a fight deliberately caused by the Insured Person, suicide attempt (deliberate), intentional self-injury/self-harm of the Insured Person or deliberate exposure to danger, except in cases of self-defense or saving human life or property;
- burn/frostbite due to exposure to sun/tanning beds, heat, cold or other environmental factors;
- participation of the Insured Person in the following sports, dangerous (extreme) activities, such as: hunting, rock climbing, mountaineering, spelunking (cave exploration), mountain biking, rowing (canoeing or kayaking), rafting, other 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 of the Insured Person in events with experimental, scientific and/or research purposes;
- failure of the Insured Person 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 the Insured Person or other persons who do not have the necessary professional qualification, as well as compliance with arbitrarily chosen dietary regime;
- flying with an aircraft other than as a passenger on a flight operated by scheduled airlines or with a recognized charter operator; - catastrophic earthquakes, floods and other natural disasters.

2. Special exclusions

2.1. The Insurer does not cover the costs for health goods and services used by the Insured Person in connection with:

- diagnosis, treatment and follow-up of: infertility; polycystic ovaries; sexual dysfunction; ovarian or testicular dysfunction; menopause; obesity and metabolic syndrome, including metabolic

disorders; food intolerance; 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/Hospital 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.

2.2. Under the Healthcare Module Critical Conditions and Medical Second Opinion, the Insurer does not make payments:

- 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.

3. Other exclusions

3.1. The Insurer does 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 of the Insured Person;
- 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;
- complex tests for the diagnosis of allergies such as ALEX and others of this type;
- the "Androflor", "Femoflor" and intestinal microbiome tests;
- 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, crosslinking;
- 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;
- examinations and treatment prescribed by a nutritionist.

3.2. The Insurer does not cover costs for:

- examinations and tests for: insurance, presentation of National Expert Medical Committee or Disability Expert Medical Committees, forensic examination;
- health goods and services used before the entry into force of the Insurance Coverage, including when the claim of the Insured Person 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 the Insured Person as a result of arbitrary refusal of the treatment carried out under any of the above options;
- application of methods for diagnosis and treatment, which are not approved by the medical standards, as well as methods of nontraditional 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 favorable impact on the individual health;
- accommodation of the Insured Person in a hospice or for transport, except for expenses for Specialized Medical/Sanitary 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 for which the Insured Person is treated.

V. Territorial coverage

1. The Insurer provides insurance coverage for the expenses under Section III of these General Terms and Conditions, incurred on the territory of Bulgaria.

VI. Conclusion, entry into force and term of the insurance. Amendment of the insurance

1.1. This is a group insurance and it is concluded by a Policyholder who meets the requirements of these General Terms and Conditions.

1.2. On the basis of a Questionnaire-declaration of health status (a model form) from the person, applying for insurance, a medical risk assessment is made for:

- Insured Persons from an Insured Group up to 25 persons, incl.;
- all Family Members.

1.3. No medical risk assessment is made for Insured Persons from an Insured Group over 25 persons. The Insurer reserves the right to require the submission of a Questionnaire-declaration of health status from the persons applying for insurance, when it deems it necessary.

1.4. Before concluding the Insurance, as well as during its validity, the Insurer has the right to receive detailed and accurate information about the age, sex, health condition of the Insured Person. Upon an insurance claim, the Insurer has the right to access all medical documentation in connection with the health condition of the Insured Person, and may request it from all persons storing such information, including in accordance with the MTFA, HIA and HA.

2. The insurance is concluded on the basis of a Questionnaire for concluding the insurance (a model form), filled in by the Policyholder and submitted to the Insurer, in which all significant circumstances, of which he is aware or should be aware, and which are relevant to the risk, should be fully and comprehensively disclosed.

2.1. If the Policyholder has knowingly declared inaccurately or concealed a circumstance, in the presence of which the Insurer would not have concluded the Insurance or would not have included a certain person in the List of Insured Persons, if he knew about this circumstance, the Insurer may terminate the Insurance or terminate coverage for a certain Insured Person. This right can be exercised within 1-month period from learning of the circumstance. In this case, the Insurer retains the paid part of the premium and has the right to demand its payment until the termination of the Insurance, respectively until the termination of the coverage for a certain person.

2.2. If the knowingly inaccurately declared or concealed circumstance is of such a nature that the Insurer would have concluded the Insurance, or would include a certain person in the List of Insured Persons, but under other conditions, he may request its amendment, or the provision of other coverage for that person. This right may be exercised within 1-month period from learning of the circumstances. If the Policyholder does not accept the offer for amendment of the Insurance within 2-week period from the receipt of the offer, the Insurance or the cover for the designated person shall be terminated. In this case, the Insurer retains the paid part of the premium and has the right to demand its payment until the termination of the Insurance.

2.3. When in the cases under item 2.1. and item 2.2. of this Section an Insured Event occurs, the Insurer may refuse to pay in whole or in part an insurance indemnification or a sum only if the incorrectly declared or concealed circumstance has affected the occurrence of the event. When the circumstance has affected only the amount of damages, the Insurer may not refuse payment, but may 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.

2.4. Items 2.1.-2.3. of this Section shall also apply if the Policyholder has concluded the Insurance through a proxy or at the expense of a third party and the concealed circumstance was known to the Policyholder or his proxy, respectively to the third party.

2.5. If at the conclusion of the Insurance the circumstances under item 2 of this Section were not known to the parties, each of them may, within 2-week period from their knowledge, propose an amendment to the Insurance. If the other party does not accept the offer within 2-week period from its receipt, the offering party may terminate the Insurance, of which it shall notify the other party in writing. If the Insurance is terminated, the Insurer shall reimburse the part of the paid premium, which corresponds to the unexpired term of the Insurance.

2.6. When in the cases under item 2.5. of this Section an Insured Event occurs before the amendment or termination of the Insurance, the Insurer may not refuse payment of an insurance indemnification, but may 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.

2.7. During the validity of the Insurance, the Policy-holder is obliged to announce to the Insurer all new circumstances for which the Insurer has asked a written question at the conclusion of the Insurance. The announcement of the circumstances must be made immediately after learning of them. In case of failure to fulfill this obligation, the respective consequences under item 2.1.-2.6. of this Section shall apply.

3. Together with the Questionnaire for concluding the insurance, the Insurer provides a List of Insured Persons (including a List of Family Members, when applicable), which the Policyholder is obliged to keep up to date within the term of the Insurance.

4. The List of Insured Persons (including the List of Family Members, when applicable), the Insurance Packages, the amounts of Copayments, the Waiting Periods must be indicated in the insurance policy.

5. Immediately after concluding the Insurance, the Policyholder is obliged to provide to each Insured Person all the information he has received from the Insurer regarding the conditions of the Insurance and which is necessary for the exercise of their rights. The Policyholder is obliged to provide or indicate access to each Insured Person to the Users' Guide, these General Terms and Conditions, their Insurance Package and Insurance Coverage Period, the List of Contractual Partners.

6. Immediately after concluding the Insurance, the Insurer sends a text message to the mobile phone number of the Insured Person indicated under the Insurance with a link to Allianz Health.

7. Family Members can be insured only for the same insurance coverage as the Insured Person with whom they are in the same family. Their insurance can be carried out not later than 1 month from the conclusion of the Insurance, provided that their insurance coverage is terminated together with the coverage of the respective Insured Person with whom they are in the same family. For

Family Members the Healthcare module Prophylaxis is not offered.

8. For the insurance of the Family Members, a List of Family Members to the Insurance is prepared or individual insurance policies are concluded, under which the Insured Persons from the List of the Insured Persons are Policyholders.

9. The Insurance is concluded for a period of one year, unless the parties agree on another shorter term. The Insurance Coverage Period shall enter into force on the day and time specified in the insurance policy, provided that the entire premium due, or the first installment thereof in case of payment in installments, has been paid, unless otherwise agreed.

10. The Coverage Period of the Insured Person may be shorter than the Coverage Period of the Insured Group, when this Insured Person is included in the List of Insured Persons (List of Family Members, when applicable) after the beginning of the Insurance Coverage Period or if excluded from the relevant list before the end of the Insurance Coverage Period.

11. Any amendment or supplement to the Insurance shall be made by mutual agreement between the parties with the conclusion of an additional agreement (annex) to the insurance policy.

12. The Policyholder is obliged to provide the data on the persons he wishes to include or exclude from the List of Insured Persons (List of Family Members, where applicable), notifying the Insurer through an Application for adjustments regarding Insured Persons (a model form).

13. The Coverage Period of the Insured Person, additionally included in the List of Insured Persons (List of Family Members, when applicable), shall enter into force at 00.00 on the date agreed in the annex to the insurance policy, provided that the insurance premium has been paid for it, and expires together with the Insurance Coverage Period under the Insurance.

14. The Coverage Period of an Insured Person who is excluded from the List of Insured Persons (List of Family Members, where applicable), shall be terminated going forward as of 24.00 on the date agreed in the annex to the insurance policy. The insurance premium due for this person is calculated for the period of their coverage.

VII. Termination of the insurance

1. The Insurance is terminated upon the expiration of the term for which it was concluded.

2. The Insurance can be terminated early:

2.1. by each of the parties with 1-month written notice to the other party without penalties or other costs;

2.2. unilaterally by the Insurer and without notice in the cases of non-payment of the insurance premium or a subsequent installment thereof under item 6.3 in connection with item 7.1 of Section IX of these General Terms and Conditions.

2.3. by mutual agreement of the parties;

2.4. in case of insolvency or liquidation of the Policyholder under the CA;

2.5. in other cases provided for in these General Terms and Conditions or IC.

3.1. The Insurer may exclude an Insured Person from the List of Insured Persons and terminate their insurance coverage unilaterally and without notice in case of established Intentional Exposure to Danger of the Insured Person.

3.2. Upon death of the Insured Person, their insurance coverage is automatically terminated.

4. The financial relations between the parties to the Insurance shall be settled as of the date of its termination, unless the parties agree otherwise. The Policyholder owes the respective insurance premium until the date of termination of the Insurance. When the Insurance is terminated by mutual agreement or with 1-month written notice and if the insurance premium is paid in full, the Insurer shall refund to the Policyholder the part of the premium corresponding to the period from the date of termination to the end of the term of the Insurance.

5. Notwithstanding the provisions of item 2.1 and item 4 of this Section, if the Policyholder unilaterally terminates the Insurance and the Insurer has fulfilled its obligations under the Healthcare Module PROPHYLAXIS in respect of more than 33% of the Insured Persons, the Policyholder shall pay the insurance premium for this module in full until the end of the term of the Insurance.

6.1. If the Insurance Claim is fraudulent or if Fraudulent Actions, Methods or Techniques are used in its filing, as well as if the Insured event is intentionally caused by the Policyholder/Insured Person or their representatives/employees, all claims filed and unpaid under the Insurance shall be rejected by the Insurer, and the person who perpetrated these acts or omissions will be given over to the competent authorities.

6.2. Upon submission of false and inaccurate information, use of false or forged documents and documents with false content, in order to illegally receive Insurance Sum or indemnification under the Insurance, the Insurer has the right to refuse payment and terminate unilaterally the Insurance or insurance coverage for the Insured Person, as all paid premiums remain for the Insurer's benefit as a penalty.

6.3. The Insurer has the right to delay the payment of the Insurance Sum or indemnification, in compliance with the legally defined deadlines, if there are doubts about the right to receive the Insurance Sum or indemnification until the receipt of the necessary evidence to the contrary. If criminal or administrative proceedings have been initiated regarding or in connection with the Insured Event or the insurance legal relationship, as well as in cases of civil litigation before a court affecting the insurance legal relationship or the payment of the Insurance Sum or indemnification, the Insurer has the right to defer payment until the completion of the proceedings with a valid act that has entered into force and in compliance with the statutory deadlines, which does not limit the right of individuals to seek their rights through legal proceedings.

7. In case the due insurance premium or the first installment thereof is paid and the Insurer terminates the Insurance before the entry into force of the Insurance Coverage Period, the Insurer shall refund the paid insurance premium/ installment, reduced by a penalty of 5% of the insurance premium.

VIII. Insurance sum

1. The Insurance Sum is determined by the Insurer in the official currency of Bulgaria per Insured Person, according to the agreed Insurance Package, and is indicated in the insurance policy.

2. The expenses of the Insured Person for used health goods and services, which exceed the amount of the Insurance Sum under their Insurance Package or the respective limits for Healthcare Module and health goods and services, as well as the expenses for used health goods and services, other than those

agreed under the Insurance, are at their expense.

3. When reimbursing expenses for used health goods and services, which are covered in the form of Cost Reimbursement, Copayment of the Insured Person may be applied. The amount of the Copayment and the health goods and services to which it applies are specified in the insurance policy.

4. All changes regarding the Insured Person, leading to an increase in the amount of the Insurance Sum, limits, sub-limits or coverage under the Insurance, shall enter into force at 00.00 on the day specified in the annex, provided that the due Insurance Premium is paid for them, unless otherwise agreed.

IX. Insurance premium

1. The insurance premium is the amount of money, which is determined by the Insurer depending on the conditions of the Insurance on the basis of the Insured Person. The amount of the insurance premium under the Insurance is calculated annually in the official currency of Bulgaria and is indicated in the insurance policy.

2. The insurance premium is paid in a single payment upon concluding the Insurance. The parties may agree to pay the annual insurance premium in separate installments, and the terms for their payment shall be indicated in the insurance policy. The insurance premium is paid in the official currency of Bulgaria to the bank account of the Insurer.

3. In case of single payment or payment in installments of the Insurance Premium, its equalization shall be made on the basis of the number of the Insured Persons in each month of the term of the Insurance, as the equalization shall be performed in the order and manner agreed in the insurance policy. As a result of the equalization, the Insurer collects or refunds insurance premium.

4. The Policyholder owes a tax of 2% on the Insurance Premium, according to the Insurance Premium Tax Act. The due taxes and the possibilities for using tax relief in connection with the payment of insurance premium, respectively the receipt of insurance indemnification under the Insurance, are determined according to the Bulgarian legislation in force at the respective moment of occurrence of the tax liability.

5. Each of the parties may request an increase/decrease of the insurance premium or termination of the Insurance in compliance with the requirements of the IC and these General Terms and Conditions, if during the term of the Insurance the insurance risk significantly increases/decreases or the terms and conditions of the Insurance change.

6. In case of non-payment of a subsequent installment of the insurance premium, the Insurer may:

6.1. reduce the total Insurance Sum under the Insurance for the Insured Person, respectively to the part of the unpaid premium;

6.2. amend the terms and conditions of the Insurance;

6.3. terminate the Insurance.

7.1. The Insurer may exercise one of the rights under item 6.1 and item 6.2. of this Section not earlier than 15 days, and under item 6.3. - respectively 30 days from the date on which the Policyholder has received a written notification from the Insurer. The written notification shall be deemed served and the Insurance shall be terminated automatically when the Insurer has chosen the right under item 6.3. of this Section and it is explicitly

stated in the insurance policy that it will be considered terminated after the expiration of a certain period from the due date of the subsequent installment, which may not be shorter than 30 days. In the cases under sentence two, an additional explicit written statement by the Insurer to the Policyholder is not required.

7.2. The partial payment of the due insurance premium under the Insurance or subsequent installment thereof shall be considered full non-payment and if the Policyholder does not pay in full within 30 days of the due date, the Insurance shall be terminated at 00.00 on the 30th day. In this case of termination of the Insurance, the Insurer does not owe a refund of the insurance premium received until the moment of termination, but owes payment of the costs for used or purchased health goods and services by the Insured Persons until the date of termination of the Insurance.

8. In the case a person is excluded from the List of Insured Persons/List of Family Members, but despite the exclusion (due to the Insurer's failure to fulfill its obligations under the Insurance) that person has used healthcare goods and services and an insurance indemnification or sum has been paid for them, The Insurer does not owe a return to the Insurer of the one-time paid insurance premium for that person, and in case of an agreed deferred payment, has the right to demand and receive from the Insurer the full amount of the insurance premium payable for that person until the end of the Insurance term.

9. The Insurer has the right to increase the insurance premium when the Claims Ratio under the Insurance after the 6th month from its conclusion exceeds 25%.

X. Rights and obligations of the parties

1. Rights and obligations of the Insured Person:

1.1. The Insured Person has the right to:

- receive from the Policyholder all the necessary information in connection with the exercise of their rights under the Insurance and to be notified in writing by the Policyholder about amendments in the Insurance, which affect their rights and obligations;
- free choice of Health Service Provider/ Health Goods Provider (including when they are a Contractual Partner) on the territory of Bulgaria;
- when using health goods and services under Healthcare modules Outpatient Medical Care, Hospital Medical Care and Dental care to freely choose the form of financial settlement in accordance with the agreed conditions, coverage and limits.

1.2. The Insured Person does not have the right to:

- require medical specialists to perform diagnostic tests, manipulations or prescriptions of certain medicinal products that are not medically necessary in view of their condition;
- receive summarized statistical information on the implementation of the Insurance or information on other Insured Persons, except in the cases of Family Members under the age of 18;
- request changes in the Insurance.

1.3. The Insured Person is obliged:

- to observe the procedure and the manner of using the health goods and services, according to the Insurance;
- to provide the Insurer with information in connection with their health condition;
- not to establish conditions for illegal and unscrupulous use of the health goods and services provided by the Insurer;
- not to use health goods and services after their exclusion from the List of Insured Persons/List of Family Members or upon early termination of the Insurance;

- to provide a bank account to which the payments on the Insurance Claims are made;
- to submit all documents required by the Insurer, related to an Insurance Claim, in the manner specified by the Insurer;
- in case of a Disease or an Accident to make the necessary efforts to limit the consequences thereof;
- to identify himself before the Contractual Partners with an identity document and provide a Health Card;
- to personally use the health goods and services and not to allow their rights under the Insurance for use of health goods and services to be exercised by third parties. In case of an established statutory violation of this obligation, the Insured Person shall owe the Insurer a refund of the paid indemnification in double amount. In such case, the Insurer may terminate the coverage for this person and does not owe a refund of the paid insurance premium.
- to refund to the Insurer the amounts paid to the Contractual Partner in the cases under item 3 of Section XII of these General Terms and Conditions.

2. Rights and obligations of the Policyholder:

2.1. The Policyholder has the right:

- at any time from the term of the Insurance to declare inclusion and exclusion of persons to the List of the Insured Persons/List of Family Members;
- to receive summarized statistical data on the Insurance and information on the processing of the documents on 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.

2.2. The Policyholder does not have the right:

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

2.3. The Policyholder is obliged:

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

3. Rights and obligations of the Insurer:

3.1. The Insurer has the right

- before concluding the Insurance, to perform a risk assessment, incl. medical assessment and on this basis to accept or refuse its conclusion;
- to refuse to include a person in the List of Insured Persons/List of Family Members;
- at any time to make a change in the List of Contractual Partners and in the Limit Prices of Health Goods and Services;
- to refuse to provide the requested information to the Policyholder or the Insured Person, when this contradicts the law or the conditions of the Insurance;
- to check the documents and facts on each Insurance Claim and to require the presentation of the necessary documents;
- to enter, store and process the data regarding the Insured Persons and their health condition;
- to require the performance of a medical examination of the Insured Person for verification of the diagnosis, treatment, delivered health goods and services within the period for ruling on the Insurance Claim;

- to verify the medical necessity of the health goods and services used by the Insured Person;
- to receive information about the health condition of the Insured Person;
- to receive the agreed insurance premium in due time;

3.2. The Insurer is obliged:

- to maintain on its website an up-to-date Lists of Contractual Partners and Limit Prices of Health Goods and Services;
- not to provide in any form, including to the Policyholder, any information related to the health status of the Insured Persons, except in the cases provided by law;
- to provide the statistical information requested by the Policyholder for the paid sums and indemnifications;
- to provide uninterrupted and free access of the Insured Person to Allianz Health.

3.3. The Insurer may not be held liable and no claims may be made against him in case the Policyholder has not fulfilled his obligations under the Insurance to the Insured Person and therefore the latter has not been able to exercise their rights thereunder, or they have done so in a way that excludes the possibility of the Insurer to fulfill its obligation for financial settlement of the incurred expenses.

XI. Use of health goods and services

A. General provisions for the use of health goods and services

1. The Insurance may cover all or part of the health goods and services required by the Insured Person, which may not lead to a restriction or change in the physician's prescription regarding the type, volume and scope of the health goods and services necessary for the diagnosis, treatment and follow-up of a certain health problem of the Insured Person, which are determined by the attending physician, according to the generally accepted current good medical practice, approved medical standards and professional standards for medical care in the medical community. The Insured Person has the right to decide which and how many of the prescribed health goods and services they wish to use, accepting all the consequences of this decision, as the prescriptions of the attending physician and the decisions of the Insured Person do not lead to an obligation of the Insurer to provide all prescribed and/or used health goods and services.

2. The Insured Persons have the right to use the agreed health goods and services without restriction in Bulgaria, to freely choose a treating physician and a medical treatment facility in compliance with the conditions of the Insurance and in accordance with their Insurance Package.

3. The Insurer is not responsible for the quality and terms in which health goods and services are provided by the Contractual Partners, as it is not a provider of such. In case of problems, the Insurer may assist in clarifying the reasons for them, as far as the terms of the contract with the respective Contractual Partner allow.

B. Use of health goods and services with Subscription

4. A Subscription is applied to modules Outpatient Medical Care, Hospital Medical Care and Dental care. Under the terms of the Subscription, the Insured Person does not owe payment to the respective Contractual Partner for the used health goods and services included in their coverage under the Insurance. With each Contractual Partner, the Insurer negotiates the health goods and services that are provided to the Insured Persons and the Specialist Physicians to perform them. With some Contractual Partners there is a certain Coordinator, and if

there is no such person designated, the Insured Persons should contact the Registry.

5. If there is a need to use health goods and services under the modules Outpatient Medical Care, Hospital Medical Care and Dental care, the Insured Person can contact a Contractual Partner to book an appointment or visit him directly, as well as use platforms for booking classes (including Allianz Health may provide links to such), or contact the Assistance Center for assistance. When the person has contacted the Assistance Center, the call is logged. The Assistance Center can ensure the booking of an appointment during or after the end of the telephone conversation with the Insured Person.

6. The use of health goods and services, beyond the express instructions given by the Insurer or the volume and type previously approved by him, shall be paid by the Insured Person.
Health goods and services, in an amount exceeding the agreed amounts in the insurance policy or which are not included in the insurance coverage, are paid by the Insured Person.

Subscription servicing on Health modules Outpatient Medical Care and Dental care

7. When visiting Contractual Partner, the Insured Person informs the Coordinator/Registry about the booked appointment for examination and their desire to use goods and services under the Insurance through Subscription. The Insured Person shall be identified by an ID and shall present the Health Card. The Coordinator/Registry checks the up-to-datedness of the Insurance and the coverage of the Insured person based on the information provided by him. The Coordinator/Registry can check the coverage by calling the Assistance Center.

8. After using the health services, the Insured Person is obliged to check and sign all necessary medical and other documents certifying the used health services, their diagnosis, examinations, prescribed treatment.

9. If the Insured Person is assigned with highly specialized Medical examinations and manipulations, such as MRI, scanner, endoscopic examinations (fibrocolonoscopy, gastroscopy, bronchoscopy), scintigraphy, as well as physiotherapy procedures, the same must receive prior written approval from the Insurer, and for this purpose an insurance claim should be filed with the Insurer. The Insured Person may contact the Assistance Center for instructions regarding the approval procedure.

Subscription servicing on module Hospital Medical Care

10. In case of planned treatment in a medical treatment facility for hospital care under the module Hospital Medical Care, which is a Contractual partner, the Insured person identifies himself before the Coordinator/Registry by an ID and presents a Health Card. The Coordinator/Registry carries out the communication with the Insurer regarding the confirmation of the insurance coverage, the type and volume of the contracted services.

11. Prior admission in the medical facility, the Insured person may provide the Insurer with a Request for Hospital Medical Assistance (by template), filled in by the person and the treating physician/representative of the medical facility. The request is sent to the Insurer before the planned date of admission. Within 3 working days after notification, the Insurer shall inform the Insured Person of the type, volume and scope of the health goods and services that will be covered under the terms of the Insurance.

C. Use of health goods and services with Cost Reimbursement

12. Cost Reimbursement applies to Healthcare Modules: Outpatient Medical Care, Hospital Medical Care, Health Goods And Dental Care, as the Insured Person pays for the used goods and services out-of-pocket and subsequently submits an Insurance Claim to the Insurer.

13. The Insurer covers Cost Reimbursement in the cases when health goods and services are used, which under the terms of the Insurance are covered only in the form of Cost Reimbursement or are used in medical treatment facilities, which:
- are not Contractual Partners, including when the Insurer has paid directly to such medical treatment facilities under explicit agreement;
- are Contractual Partners, but these goods and services are not agreed for provision in the form of Subscription by them;
- are Contractual Partners, but these goods and services are performed by a Specialist Physician, who is not included in the contract between the Insurer and this Contractual Partner.

14. When the Insured Person has personally used and paid for health goods and services of a Contractual Partner, which are covered by the Insurer in the form of Subscription by the respective Contractual Partner, the Insurer shall reimburse the Insured Person within the agreed limits for Cost Reimbursement for the respective goods and services, but not more than 70% of the price, paid by the person for the used health goods and services.

D. Use of health goods and services with Fixed Sum Payment

15. Fixed Sum Payment as a form of compensation is applied under the Health module Critical Conditions and Medical Second Opinion and in case of Birth under the Healthcare module Hospital Medical Assistance, under the procedure of Section 12 of these General Terms and Conditions.

XII. Payments by the insurer

A. Payment by the Insurer for Subscription

1. Under Subscription servicing the Insurer shall reimburse each Contractual Partner for the health goods and services provided by him to the Insured Persons, in accordance with these General Terms and Conditions and the contract concluded between them.

2. The Insurer shall reasonably refuse full or partial payment to a Contractual Partner for health goods and services used by the Insured Person under Subscription, when:

- the amount for the health goods and services exceeds the respective limit for the Insured Person;
- the health goods and services are excluded under the Insurance or are outside the scope of coverage for the Insured Person; - the health goods and services are used outside the Coverage Period of the Insured Person;
- the Policyholder has not paid the due insurance premium or a subsequent installment of it and there is no valid insurance coverage for the person;
- the Contractual Partner has not coordinated in advance with the Insurer on the use of health goods and services, in cases where such is necessary;
- the health goods and services are outside the explicit instructions given by the Insurer to the Contractual Partner or the volume and type approved in advance;
- the Insured Person prevents the Insurer from receiving information about their health condition and treatment provided by treating physicians, medical treatment facilities, etc., necessary to clarify the grounds and amount of payment to the Contractual Partner;

- there are other grounds provided for in the Insurance or the legislation in force.

3. When the Insurer refuses payment under item 2 of this Section, the Insured Person shall be obliged to pay to the respective Contractual Partner for the health goods and services used by them, and if for any reason the Insurer has paid to the Contractual Partner, the Insured Person owes to the Insurer a reimbursement of the amount paid, together with the statutory interest, from the date of payment.

B. Payment by the Insurer for Cost Reimbursement

4. In case of Cost Reimbursement, the Insurance Claim is filed by the Insured Person, their legal representative or by a duly authorized person, through an Application for payment of indemnification (a model form) at any Structural Unit of the Insurer, by mail at address: 16 Srebarna Street, PO Box 1407, Lozenets district, Sofia or through digital platform Allianz Health. Any written correspondence with the Insured Person regarding the filed claim, incl. notifications, invitations and opinions shall be sent to the address indicated by them in the Application for payment of indemnification. The Insured Person must attach to the application all necessary financial and medical documents for the used health goods and services.

5. The Insured Person must substantiate the grounds and amount of their Insurance Claim. In order to submit an insurance claim online, the Insured Person must have an INN, which is obtained through Allianz Health or the Assistance Center.

5a. The insurance claim and accompanying documents are submitted:

5a.1. in electronic form - by attaching to Allianz Health according to the relevant INN;

5a.2. on paper - at any Structural Unit of the Insurer.

5b. When the insurance claim is submitted according item 5a.1., the term for its examination starts from the date of attachment of the documents. When the insurance claim is submitted according item 5a.2., the term for its examination starts from the date of its receipt by the Insurer.

5c. Inquiries regarding an insurance claim can be made by calling the Assistance Center every working day from Monday to Friday from 9:00 a.m. to 5:30 p.m., excluding public holidays, according to the received INN.

6. In order to establish the merits and amount of the due payment for each Insurance Claim, the Insurer has the right to request from the Insured Person any information, as well as additional medical and financial documents. All costs related to the preparation and submission of the necessary documents are at the expense of the Insured Person.

7.1. All documents attached to the Insurance Claim must meet the following requirements:

- the financial documents must meet the requirements of the Bulgarian legislation and be issued in the name of the Insured Person, as each good and service must be listed in detail (by type, number and price) and must be indicated as a separate item;
- the medical documents must be drawn up (including signed and stamped) according to the samples and instructions for the respective document and contain the required information (for individualization and description of the provided health goods and services, including medical history, diagnosis, description of the objective condition, assigned examinations and treatment, etc.);
- the prescription must be issued not earlier than the date of the examination and by

the physician who performed it, containing the required information: name, signature and seal of the physician, city and date of issue, name of the patient, age and address;
- the dates of the financial documents must not precede the date of the medical documents;
- the medical document with which they are prescribed and the prescription for them must be attached to the invoice for purchased Medicinal Products, in cases when they are not described in detail and with dosage in the medical document.

7.2. the documents can be submitted in a copy and the Insured Person is responsible for keeping them in the original. The Insurer may require their submission in original within 12 months from the submission of the Insurance Claim.

7.3. with the Insurance Claim, according to the specific case, the Insured Person submits the necessary medical and financial documents for proving the grounds and amount of the used health goods and services:

7.3.1. medical document (for performed medical examination, assigned examinations and treatment), as it can be an outpatient card, medical referral (Form MH No 119 98) or another official medical document with the requisites of an outpatient card;

7.3.2. a prescription for the prescribed medicines or assistive services, if they are not specifically recorded in a medical document (outpatient card or another document containing the same details);

7.3.3. invoice/other primary accounting document under the Accounting Act, accompanied by a fiscal receipt/receipt/document for non-cash payment or other official document containing financial information;

7.3.4. discharge summary from a medical treatment facility;

7.3.5. medical document containing results, reading and conclusion from the performed medical tests;

7.3.6. a document certifying the need for Specialized Medical/Sanitary Transport, issued by the treating physician;

7.3.7. for dental care - X-ray, before surgical services, before and after treatment of pulpitis and periodontitis; outpatient card with the performed activities included. No X-ray is required for children under 18 years of age and for pregnant women. A document certifying the full dental status of the Insured Person must be submitted with the first submitted claim related to dental care;

7.3.8. stickers/packaging for purchased prescription glasses/contact lenses;

7.3.9. stickers/packages/barcodes for used supplies and medical devices or an official document from a medical treatment facility, which has performed the operative intervention, certifying their use;

7.3.10. for Pregnancy Monitoring: medical documents for examination and establishment of pregnancy; results, reading and conclusion from conducted tests; medical record for pregnancy monitoring and financial documents. In case the Insured Person uses a package service offered by a medical treatment facility, the Insurer reimburses the person the price paid up to the limit under the Insurance, and the Insured Person is obliged to submit detailed written information from the medical treatment facility for number of examinations and types of tests included in the package service.

7.3.11. for physical therapy/kinesitherapy: medical document for recommended physical therapy/ kinesitherapy by a physician - specialist in the profile of the disease; medical document for performed

examination and appointed by a physician - specialist in physical therapy, physical therapy / kinesitherapy with number and type of procedures; card with appointed and performed physical therapy/kinesitherapy procedures;

7.3.12. for additionally requested services (improved living conditions, additional services related to the stay in the medical treatment facility, selection of a physician or a team of medical specialists) for treatment in a medical treatment facility for Hospital care: medical documents for treatment; official documents to certify the use of additionally requested services and medical justification for their need (if any);

7.3.13. for services related to rehabilitation, used in specialized hospital treatment facilities, epicrisis from previous inpatient treatment in the last 3 months with appointment of rehabilitation;

7.3.14. other documents certifying the date, reason and circumstances under which the Insured event occurred or certifying the medical expenses incurred.

8. The Insurer checks the insurance claim and the documents attached to it and up to the amount of the relevant Sum Insured reimburses the incurred costs according to the type, volume and scope of the coverage under the Insurance, deducting the agreed Copayment of the Insured Person and applies the corresponding amount of the Limit Prices for healthcare goods and services. The Insurer has the right to check the circumstances announced by the Insured Person regarding the used health goods and services, to request medical documentation from all persons who keep it, as well as to prepare an expert opinion.

9. In case the Insured person does not submit all required documents to the Insurance Claim or some of the submitted documents do not meet the requirements regarding their details or are incomplete and do not provide the Insurer with sufficient data to make a decision on the Insurance Claim, the Insurer has the right within 45 days from the receipt of the claim, to request in writing the Insured Person to submit the necessary documents.

10. In case the Insured Person does not submit the required documents, the Insurer shall give a reasoned decision on the merits and the amount of the claim, not later than 6 months from the date of its filing.

11. Within 15 working days after receipt of all necessary documents, the Insurer determines and pays the amount of the insurance indemnification or sum or reasonably refuses its payment.

12. According to the technical possibility the Insured Person may track the status of each Insurance Claim via a link to Allianz Health or in the Customer portal My Allianz. The Insured Person has access to the following information on each Insurance Claim: date of notification of the Insurer, respectively receipt of INN, amount of the claim, approved amount for payment, refused amount for payment and grounds for refusal, amount paid and date of payment.
The Insured Person may monitor the status of all payments made to Contractual Partners for health goods and services used by them on Subscription.

13. The Insurance Claim and the documents attached to it shall not be returned to the Insured Person, including in case of full or partial refusal to pay, except upon explicit written request from the Insured Person to the Insurer. The documents are returned to the Insured Person with a certificate of delivery or another method, certifying the acceptance and transfer, and their copies remain with the Insurer.

14. The insured person has the right to claim reimbursement only of the expenses incurred and the goods and services used during the period of validity of the Insurance for:

14.1. Medicinal products prescribed by a physician, when purchased no later than 7 days from the date of their prescription (the date of issuance of the prescription). If long-term treatment is necessary, compliance with the 7-day period is not required for subsequent purchases, if a medical document reflects a treatment period longer than 1 month and the date of discharge is no earlier than 6 months;

14.2. Auxiliary or Corrective means prescribed by a physician, when purchased no later than 60 days from the date of their prescription;

14.3. Clinical-laboratory and instrumental tests prescribed by a physician, when they are carried out no later than 30 days from the date of their appointment;

14.4. Medically indicated physical therapy performed within 60 days of the appointment;

14.5. Rehabilitation in conditions of inpatient treatment, started no later than 3 months after the end of active treatment.

15.1. In the event of an Insurance Claim for Cost Reimbursement for Medicinal Products prescribed and purchased in quantity necessary for treatment for a period longer than 30 days, the Insurer shall cover only that part of the costs corresponding to the quantity of Medicinal Products necessary for treatment until its filing.

15.2. No costs are covered for medicinal products or medical devices purchased through online sales and from retail shops that do not comply with Bulgarian legislation in force.

16. The Insurer reimburses costs only for health goods and services that have been used and/or purchased during the term of the Insurance and within the agreed limits, but not more than the amounts of the Limit Prices of Health Goods and Services.

17. The Insurer refuses Cost Reimbursement for health goods and services used by the Insured Person when:

- the health goods and services exceed the respective limit for the Insured Person;
- the health goods and services are excluded under the Insurance or are outside the scope of coverage for the Insured Person;
- the health goods and services are used outside the Coverage Period of the Insured Person;
- the Insured Person has used health goods and services from a person who is not a Health Service Provider/Health Goods Provider under the Insurance;
- the Insured Person has not substantiated the grounds and amount of their Insurance Claim;
- the Policyholder has not paid the due insurance premium or a subsequent installment of it and there is no valid insurance coverage for the person;
- the Insured Person prevents the Insurer from receiving information about their health condition and treatment provided by treating physicians, medical treatment facilities, etc., necessary to clarify the grounds and amount of payment to the Insurance Claim;
- there are other grounds provided for in the Insurance or the legislation in force.

17a. The Insurer refuses to reimburse the costs of healthcare goods and services used by the Insured Person in the part exceeding the amounts of the Limit Prices of Healthcare Goods and Services.

18. The procedure and the manner for filing the Insurance Claims and for payment of Insurance Sums/indemnifications under the

Insurance are regulated in the Rules for the activity on settlement of insurance claims for Group Medical Insurance "Allianz Health", which together with the model forms of the Insurer under these General Terms and Conditions are published on the website of the Insurer.

C. Fixed Sum Payment by the Insurer

19. For Fixed Sum Payment, the Insurance Claim is filed by the Insured Person, their legal representative or by a duly authorized person, through an Application for payment of indemnification. The following shall be attached to the application:
- for Childbirth: discharge summary for the birth;
- for critical conditions and medical second opinion - medical documents proving the diagnosis of the condition.

20. The Insurer refuses Fixed Sum Payment to the Insured Person when:
- the respective limit for the Insured Person has been exhausted;
- the condition of the Insured Person is outside the scope of its coverage;
- the Critical Condition was diagnosed before the end of the Waiting Period;
- the Insured Person has not substantiated the grounds and amount of their Insurance Claim;
- the Policyholder has not paid the due insurance premium or a subsequent installment of it and there is no valid insurance coverage for the person;
- the Insured Person prevents the Insurer from receiving information about their health condition and treatment provided by treating physicians, medical treatment facilities, etc., necessary to clarify the grounds and amount of payment to the Insurance Claim;
- there are other grounds provided for in the Insurance or the legislation in force.

D. General provisions for payments by the Insurer

21. The Insurer has the right to require the submission of documents other than those specified in these General Terms and Conditions in order to verify the scope and volume of health goods and services used by the Insured Person and the accuracy of information provided at the conclusion of the Insurance, information about the health condition of the Insured and for clarification of the Insured Event. The Policyholder, the Insured Person and the Health Service Providers/Health Goods Providers are obliged to submit, at the request of the Insurer, all data and information stated in the previous sentence, which are known to them, as well as to assist the Insurer in clarifying all the circumstances and facts relevant to establishing the grounds and amount of the claim.

22. The Insurer has the right to request an additional (control) examination of the Insured Person, in view of diagnostic clarification or assessment of the prescribed therapy. This type of examination is performed by exception, after notifying the person of the time and place of the examination, and the costs are at the expense of the Insurer. In the absence of confirmation of the diagnosis/therapy or in case of refusal by the Insured Person to perform such examination, the Insurer has the right to refuse full or partial payment of amounts for the respective health goods and services.

23. In case of death of the Insured Person, after receiving health goods and services, the Insurer reimburses the costs or pays the amounts due for them to the entitled - Contractual Partners or legal heirs, based on submitted documents. In case of payment to the legal heirs, they need to present a Certificate of heirs and a bank account

number to which the payment should be made.

24. The Insurer makes payments upon Cost Reimbursement and Fixed Sum Payment to a bank account explicitly indicated by the Insured Person.

XIII. Economic sanctions limitation clause

1. The Insurer shall not be required to provide coverage or pay insured sums/indemnities which coverage, insured sums/indemnification would expose the Insurer to a sanction, prohibition or restriction under United Nations resolutions or trade or economic sanctions, laws or regulations of the European Union, the United Kingdom of Great Britain and Northern Ireland or the United States of America.

2. This Insurance does not provide coverage and does not provide for the payment of insured sums/compensation for the cases in which the insurance coverage and/or the payment of insured sums/compensation would put the Insurer in violation of the above-mentioned economic sanctions.

3. In the cases of item 1 and item 2 above, the Insurer has the right to refuse the payment of insured sums/compensation and/or to terminate the Insurance, and these cases supplement all other grounds for refusal to pay insured sums/benefits and grounds for termination of the Insurance.

XIV. Protection of personal data. Confidentiality

1. The Insurer processes the personal data provided during and on the occasion of the conclusion, operation and termination of this Insurance, incl. when processing insurance claims, on the grounds and for the purposes specified in the Personal Data Protection Notice of ZAD "Allianz Bulgaria", available at: www.allianz.bg/gdpr/.

2. The Policyholder is obliged before the conclusion of the Insurance to provide and during its validity to provide or indicate access of each Insured person to the Privacy Notice of ZAD "Allianz Bulgaria".

3. The Policyholder is obliged to keep the trade secret of the Insurer, without disclosing to third parties, in any form, information related to the conclusion, content and/or execution of the Insurance or any information related to tariffs and price conditions and any other data and information about the Insurer, which have become known to him in connection with the Insurance, as well as not to make available to the Insured Persons, the price conditions and other conditions of it, which do not apply and have no relation to the exercise of their rights.

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

XV. Complaints

1. Users of insurance services can file complaints at any stage of their service:

- in writing - in each Structural Unit of the Insurer;
- by mail - at the address: 16 Srebarna Str., p.c. 1407, Lozenets district, Sofia;
- to the e-mail address for complaints: cm@allianz.bg
- on the website www.allianz.bg via the contact form in the "Contact us" section.

When submitting the complaint, the sender is required to indicate up to date address (and/or e-mail address) for feedback, to

which he will receive a written response from the Insurer.

2. The procedure for filing and reviewing complaints regarding insurance claims is in accordance with the Rules for the activity on settlement of insurance claims by Group medical insurance "Allianz Health", which are available on the website www.allianz.bg.

3. Within the statutory term, the Insurer shall send a motivated written answer to the filed complaint.

4. On the territory of Bulgaria, disputes related to the provision of insurance services may be resolved out of court in proceedings on Alternative Dispute Resolution before the Sectoral Conciliation Commission of the Consumer Protection Commission (address: Sofia 1000, Vrabcha Str. No. 1, floors 3, 4 and 5; tel. 02/ 9330 588; website www.kzp.bg; email address: adr.ins@kzp.bg)

5. All inquiries, requests, complaints and/or objections regarding the processing and/or consideration of the Insurance Claim of the Insured Person shall be filed in writing, and the Insurer shall be obliged to respond within the term specified in the IC. In case the Insurer, for his part, needs to send an inquiry to a third party or the state body should rule on the case, the Insurer shall notify the respective person that it will respond definitively after receiving the respective answer.

XVI. Applicable law. Jurisdiction

1. The contractual relations between the Policyholder, the Insured Persons and the Insurer are regulated by the terms and conditions of the Insurance and the Bulgarian legislation in force. The Bulgarian legislation in force shall apply to the issues not settled in the Insurance.

2. Disputes arising in connection with the insurance legal relationship are resolved in good will, and in case of failure to reach an agreement - by a competent Bulgarian court.

XVII. Subrogation. Limitation period

1. With the payment by the Insurer under the Insurance, in the cases in which the insurance risk is realized as a result of the guilty conduct of a third party, the Insurer assumes the rights of the Insured Person against the person causing the damage up to the amount of the paid indemnification.

2. The Insured Person is obliged to assist in any way for the realization of the Insurer's rights.

3. The waiver of the Insured Person of their rights against third parties has no force against the Insurer regarding the possibility for the latter to exercise his rights.

4. The rights and obligations under the Insurance in connection with Insurance Sums or indemnifications shall be repaid with a limitation period of 5 years, as of the date of occurrence of the Insured event.

XVIII. Correspondence addresses. Messages

1.1. The correspondence address of the Insurer and the Policyholder shall be indicated in the insurance policy. The address of management of the Insurer and the Policyholder shall be considered as a correspondence address, unless the parties agree otherwise.

1.2. The contact details of the Insured Person (mobile phone number and e-mail address) are indicated in the List of Insured Persons.

2.1. The Policyholder is obliged to notify the Insurer of any change in its name, company

name or appellation or correspondence address, which are indicated in the insurance policy or in other documents provided to the Insurer. In case the Policyholder fails to fulfill this obligation or provides incorrect information, any written statement by the Insurer sent by him to the address of the Policyholder, last announced to the Insurer, shall be deemed served and received by the Policyholder with all legal consequences provided by law or in the Insurance.

2.2. The Insured Person is obliged to keep up to date with the Insurer his contact details (mobile phone number and e-mail address), which are considered to be a correspondence address within the meaning of the IC.

3. The Policyholder may also indicate to the Insurer an e-mail address and mobile phone number of his employee(s) to whom the Insurer should send electronic messages and/or text messages for due insurance premiums, early termination of the Insurance and others. The Policyholder is obliged to notify the Insurer of a changed mobile phone number or e-mail address. In case the Policyholder does not notify the Insurer in writing about the change, the messages sent to the mobile phone numbers/e-mail addresses announced to the Insurer shall be considered delivered and received by the Policyholder with all legal consequences provided by law or in the Insurance.

4.1. Any change of the correspondence address of the Policyholder under item 1.1. and of the data under item 3 of this Section shall be made after submission of a written Application for change by the Policyholder, accompanied by the certifying documents required by the Insurer. The Application for change can be submitted:

- in each Structural Unit of the Insurer;
- by mail - at the address: 16 Srebarna Str., p.c. 1407, Lozenets district, Sofia;
- to the e-mail address: health@allianz.bg

4.2. Updating the contact details of the Insured Person (mobile phone number and e-mail address) is not considered a change in the Insurance and the Insured Person may update them through the Policyholder or in person. The Insured Person may update their contact details personally with the Insurer, as item 2 of Section XVIII of these General Terms and Conditions does not apply, and they should submit a written Application for change:

- in each Structural Unit of the Insurer;
- by mail - at the address: 16 Srebarna Str., p.c. 1407, Lozenets district, Sofia.

XIX. Additional provisions

1. The Insurer assumes that if the Policyholder has expressed his explicit consent in the insurance policy and/or other written agreements between the parties that:

1.1. the legal force of the electronic signature and of the advanced electronic signature is equivalent to that of the handwritten signature of the person making statements on the occasion of the Insurance; and

1.2. he wishes to be an addressee of Electronic statements within the meaning of Art. 5 of the EDETSA on the occasion of the Insurance, in the cases when the written form of notification under the Insurance is obligatory, according to the IC, the notifications between the parties under the Insurance may be made also through the use of electronic signature within the meaning of Art. 3, item 10 of Regulation (EU) No 910/2014 or of an advanced electronic signature within the meaning of Art. 3, item 11 of Regulation (EU) No 910/2014.

2. The Insurer assumes that if the Insured Person has expressed their explicit consent in "Allianz Health" that:

2.1. the legal force of the electronic signature and of the advanced electronic signature is equivalent to that of the handwritten signature of the person making statements on the occasion of the Insurance; and

2.2. he wishes to be an addressee of Electronic statements within the meaning of Art. 5 of the EDETSA on the occasion of the Insurance, In the cases when the written form of notification under the Insurance is obligatory, according to the IC, the notifications may be made also through the use of electronic signature within the meaning of Art. 3, item 10 of Regulation (EU) No 910/2014 or of an advanced electronic signature within the meaning of Art. 3, item 11 of Regulation (EU) No 910/2014.

XX. Definitions and abbreviations

1. For the purposes of these General Terms and Conditions for Group Medical Insurance "Allianz Health", the following definitions are used:

- **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.

- **Allianz Health Digital Platform (Allianz Health)** is an electronic platform used by the Insurer, through which the Insured Person accesses via the Internet information on the Insurance for the individual Insurance Coverage Period, Insurance Package and insurance certificate. Each time when Allianz Health is accessed current information about the Insured Person and their Family members up to 18 years of age is displayed. Allianz Health provides access to these General Terms and Conditions, the Users' Guide and the List of Contractual Partners and possibility of obtaining an INN.

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

- **Assistance Center** is a contact Call center of the Insurer, which provides services to the Insured Persons 24/7, assisting them in case of need to use health goods and services (including clarifying the nature of the problem, referral to a Health Service Provider/Health Goods Provider and, if possible, making an appointment for an examination) and receiving an Individual Notification Number. Information on the status of claims, incl. paid claims, as well as information on coverage and limits for the Insured Person, is provided every working day from Monday to Friday from 9.00 to 17.30, without public holidays. The use of the Assistance Center services requires the provision of a personal identification number (PIN)/personal foreigner's number (PFN) and full name of the Insured Person. The Assistance Center may give binding instructions for referral to a specific Contractual Partner and coordinate with it the type, volume and scope of approved health goods and services, where applicable.

- **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.

- **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.

- **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 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 a Contractual Partner who assists in the use of health goods and services by the Insured Person and the preparation of the necessary medical and financial documents for the Insured Person when using Subscription.

- **Copayment** is the amount with which the Insured Person pays out-of-pocket for the expenses for health goods and services under the Insurance. The type and amount of the Copayment of the Insured Person is determined in the insurance policy. The Copayment can be applied in different amounts for the different Healthcare 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.

- **Cost Reimbursement** is a form of indemnification in which the Insurer reimburses the expenses incurred by the Insured Persons for health goods and services purchased by them under the conditions agreed in 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.

- **Coverage Period of the Insured Person** is the Insurance Coverage Period for one Insured Person 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.

- **Dental care** is a system of preventive, diagnostic and treatment activities provided by physicians – specialists in dental medicine or dental care providers.

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

- **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.

- **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.

- **Emergency Care Unit** is a unit opened on the territory of a multi-profile 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.

- **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 Unit** can be opened in a licensed medical treatment facility, according to Ordinance No 10 of 31.05.1994 for emergency medical care.

- **Family Member** is a spouse or a person living on a marital basis with the Insured Person, and their minor children, including children of one other spouses or cohabitants, adopted children or children in their care as guardians or custodians, up to the age of 18, and if they continue their education - up to the age of 26, provided that the persons are registered at the same permanent/current address.

- **Fixed Sum Payment** is a form of indemnification in which the Insurer pays to the Insured Person 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.

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

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

- **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.

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

- **Healthcare Module** includes health goods and services defined by type, volume and scope, and a description of the applicable conditions, incl. form of indemnification, payment limits and sub-limits, Waiting Periods and Copayments. The Healthcare Modules are Outpatient Medical Care, Hospital Medical Care, Critical Conditions And Medical Second Opinion, Health Goods and Dental Care, grouped in the following Insurance Packages - Comfort, Extra and Max, and offered in different levels. An additional Prophylaxis module can be purchased with each Insurance Package.

- **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.

- **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.

- **Individual Notification Number (INN)** is a unique number, which is generated by the information system of the Insurer, after the person uses the relevant functionality in Allianz Health to obtain INN or contacts the Assistance Center for the purpose of making an insurance claim regarding health goods and services used. The INN is sent as a text message to the mobile phone number or e-mail address of the Insured Person, indicated to the Insurer at the conclusion of the Insurance or subsequently in compliance with the provisions of these General Terms and Conditions, and is displayed in Allianz Health.

- **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 from the Insured Person to the Insurer for payment of incurred or made expenses for health goods and services covered by the Insurance.

- **Insurance Coverage Period** is the period in which the Insurer covers the risk under 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 the period for which the insurance premium is calculated, which period is one year.

- **Insurance Sum** is the amount of money agreed upon between the parties and specified in the insurance policy, representing the upper limit of the Insurer's liability.

- **Insurance Sum per Insured Person** is the maximum limit of the Insurer's liability per Insured Person for the term of the Insurance according to their 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 the basis of an event (e.g. travel, visit).

- **Insured Event** is the occurrence of a covered risk, expressed in the occurrence of expenses for the use of health goods and services in connection with a Disease or as a result of an Accident or other agreed-upon health goods and services, incl. for prophylaxis, Pregnancy and Childbirth.

- **Insured Group** is a group of at least 10 Insured Persons, listed by name in the insurance policy, who are in employment/civil contract or other similar legal 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.

- **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.

- **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 a current list, which is published on the website of the Insurer and in Allianz Health. The information about Contractual Partners contains their name, address of activity, telephone number, email address, website.

- **List of Family Members** is an appendix to the insurance policy and includes Insured Persons, which are Family Members with indication of their Insurance Package. The list is prepared according to a sample of the Insurer and contains for each person: full name, PIN/PFN, date of birth, sex, mobile phone number and e-mail address for contact, place of work and current address, as well as PIN/PFN and full name of the Insured person with whom they are in the same family.

- **List of Insured Persons** is an appendix to the insurance policy and includes Insured Persons from the Insured Group with indication of their Insurance Package. The list is prepared according to a sample of the Insurer and for each Insured Person contains: full name, PIN/PFN, date of birth, sex, mobile phone number and e-mail address for contact, place of work and current address.

- **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 Necessity** refers to health goods or services that must be:
  - essential for the diagnosis or treatment of the patient's condition, disease or trauma;
  - consistent with the patient's symptoms, diagnosis or treatment;
  - in accordance with the generally accepted current good medical practice, established medical standards and professional standards for medical care in the medical community;
  - required for reasons other than providing convenience and benefit to the patient or their physician;
    - with proven medical value;
  - most appropriate by type and level/category of the respective good and service;
  - provided in an appropriate medical treatment facility, an appropriate environment and an appropriate level of care for the treatment of the patient's condition;
  - provided only for an appropriate period of time.

Necessity means taking into account the factors of "patient safety" and "cost effectiveness".
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 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.

- **Limit prices for health goods and services** are the maximum allowable prices for certain health goods and services that the Insurer reimburses when Reimbursing expenses. The current Limit prices and types of health goods and services are published on the Insurer's website and in Allianz Health.

- **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 according to the MPHMA. The medicinal products should be prescribed by a physician and have a direct causal connection with the diagnosis of the Insured Persons. For the purposes of these General Terms and Conditions, all herbs, synthesized herbal preparations, preparations with preventive action, food supplements, contraceptives, when their contraceptive action is the leading cause, specialized foods, biostimulants and medical cosmetics are not Medicinal Products.

- **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.

- **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.

- **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.

- **Reasonable and Usual 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.

- **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.

- **Scope of health goods and services** are the types of provided health goods and services to which the Insured Persons have access under the terms of the Insurance.

- **Medical Second Opinion** is a service provided by a leading medical center outside Bulgaria, offered by the Insurer, whereby a report is prepared remotely and on the basis of medical documentation, including an independent expert assessment by a specialist in order to verify the initial diagnosis and treatment plan of the Insured Person and an expert recommendation for the most appropriate treatment.

- **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.

- **Physician - Specialist** 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, outside of emergency conditions, 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 the Headquarters located at the address of management, as well as each General Representative, Representative and/or liquidation and claims processing unit of the Insurer.

- **Subscription** is a form of indemnification in which the Insurer ensures the provision of the agreed health goods and services to the Insured Persons through Contractual Partners, under the conditions agreed under the Insurance, as the Insurer makes payments directly to the Contractual Partner.

- **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.

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

- **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 or exacerbated chronic disease that has led to discomfort and is a prerequisite for seeking medical help and carries the risk of possible disruption of the morphological structure or cessation of functional processes of one or more organs or systems in the human body. The Urgent Condition requires swift intervention by a medical specialist to clarify and diagnose this condition, take measures to control the accompanying symptoms and syndromes (pain, nausea, vomiting, etc.) and subsequent treatment.

- **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.

- **Users' Guide** is a document provided by the Insurer, which contains information on the Insurance, relevant for the Insured Persons and which Users' Guide is not part of the Insurance.

- **Volume of health goods** and services is the quantity of provided health goods and services to which the Insured Persons have access under the terms of the Insurance.

- **Waiting Period** is the period of time from the entry into force of the insurance coverage, during which only a certain coverage under the Insurance is not in force and the Insurer does not owe payment for certain health goods and services. In the event of an Accident and upon renewal of an expiring Insurance, a Waiting Period does not apply.; e-mail address: adr.ins@kzp.bg

2. The following abbreviations are used for the purposes of the Insurance:

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 Regulation (EU) identification and trust services for No 910/2014 electronic transactions in the internal market and repealing Directive 1999/93/EC	Regulation 910/2014
Insurance Code	IC
Medical Treatment Facilities Act	MTFA
Medicinal Products in Human Medicine Act	MPHMA
Electronic Document and Electronic Trust Services Act	EDETSA

XXI. Appendices

Appendix No 1 Table of Healthcare Modules.

XXII. Final provisions

§ 1. These General Terms and Conditions may be supplemented or amended on the basis of a written agreement between the parties, reflected in the insurance policy, its appendices or in additional agreements (annex).

§ 2. These General Terms and Conditions have been adopted by Resolution No 20 of the Management Board of Joint Stock Insurance Company Allianz Bulgaria dated 28.05.2020, changed by Resolutions No 62/14.12.2020, No 32/19.07.2022., No 31/20.04.2023. and No 05/04.02.2026.

For the Insurer

_____

Date

_____

I, the undersigned

_____

_____ ,

as the Policyholder/representing the Policyholder, declare that I have received a copy of these General Terms and Conditions, I am familiar with them and I accept them. I undertake to provide or indicate access to each Insured Person to these General Terms and Conditions.

For the Policyholder

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