

## Health insurance conditions

№	Name	Health insurance conditions
1	Parties to the contract	<p><b>Insurer:</b> JSC "Insurance Company Unison" (Registered No. 404393152);</p> <p><b>Insurer:</b> an individual who has concluded this insurance contract with the Insurer for his own benefit or for the benefit of third parties and who is obliged to pay the insurance premium;</p>
2	Subject of the contract	The subject of this contract is the obligation of the insurer, in exchange for the payment of the insurance premium by the insured, to compensate for the damage caused by the insured event, in accordance with the procedure and amount specified in these terms and conditions and the insurance policy.
3	Definition of terms	<p><b>3.1. "Insured"</b> - a natural person aged 1 to 65 years, for whom insurance is provided;</p> <p><b>3.2. "Family member"</b> - a spouse, child/children. The relationship must be confirmed by documents provided for by the legislation of Georgia.</p> <p><b>3.3. "Family package"</b> - the minimum number of family members (spouse up to 65 years and children up to 18 years) within the package is 3 (three), the package selected for all family members, the validity period of which begins on the same date, and the premium is determined by the number of family members and the agreed discount, if any.</p> <p><b>3.4. "Age restriction"</b> - natural persons up to 65 years of age are subject to insurance. Within the framework of family insurance: spouses up to 65 years of age and children/children from 1 to 18 years of age;</p> <p><b>3.5. Foreigner</b> - a person who is not a citizen of Georgia and a stateless person with status in Georgia;</p> <p><b>3.6. Stateless person</b> – a person whom no state considers as its citizen in accordance with its legislation;</p> <p><b>3.7. Electronic card/insurance policy</b> – a card placed on the official website of the insurer <a href="http://www.unison.ge">www.unison.ge</a> in the user's personal account – ("My account") is a confirmation of insurance carried out on the basis of the contract. The electronic card provides for a specific service limit, the insurer's co-participation percentage, coverages, co-payments, etc. A person is considered insured only under the insurance conditions determined in accordance with the package intended for him/her;</p> <p><b>3.8. "Medical institution"</b> – an institution operating on the territory of Georgia, which is granted the right to carry out medical activities in accordance with the requirements of the legislation of Georgia;</p> <p><b>3.9. "Insured event"</b> - an event specified in this Agreement, upon the occurrence of which the Insurer is obliged to pay insurance compensation;</p> <p><b>3.10. "Accident"</b> - a sudden, unforeseen, unexpected event caused by the influence of visible external forces independent of the will of the Insured and the result of which is the death of the Insured, temporary or permanent limitation of his working capacity;</p>

- 3.11. **“Total (full) insurance period”** - the period of time during which the insurance provided for in this Agreement is valid;
- 3.12. **“Individual insurance period”** - the period of time during which the insurance coverage is valid for a specific Insured;
- 3.13. **“Limit”** - the maximum amount of the insurer’s liability, which is determined in the electronic card, in accordance with the full insurance period and is subject to proportional reduction according to the individual insurance period.
- 3.14. **“Sublimit”** - part of the limit, which determines the maximum amount of compensation for a specific service;
- 3.15. **“Insurance coverage area”** - the geographical area of the insurance. This insurance is valid only on the territory of Georgia, excluding occupied territories.
- 3.16. **“Provider”** - a medical institution in contractual relations with the insurer, which provides the insured with the provision of medical services specified in the contract according to medical indications, the list of which is the subject of an individual agreement and is attached to this agreement as an appendix
- 3.17. **“Medical indication”** - a health condition that requires medical intervention (treatment or research) prescribed by a licensed physician in accordance with established medical practice in the country and the world, based on guidelines/protocols;
- 3.18. **“Full (total) insurance premium”** - the total cost of the full insurance period payable by the insurer in accordance with the insurance package chosen by the insurer/insured
- 3.19. **“Individual earned premium”** - calculated for a specific date within the framework of the total insurance period as the amount of the proportional premium for the period of time that has elapsed from the start of the individual insurance period of a specific insured person to the specified date;
- 3.20. **“Individual unearned premium”** – calculated for a specific date within the general insurance period as the amount of the premium proportional to the time remaining before the expiration of the individual insurance period of a specific insured;
- 3.21. **“Total earned premium”** – the sum of individual earned premiums taken for a specific date within the general insurance period.
- 3.22. **“Total unearned premium”** – the sum of individual unearned premiums taken for a specific date within the general insurance period.
- 3.23. **Waiting period** – the period calculated from the beginning of the insurance period and during which the insured is not reimbursed by the insurer for any service costs or specific service costs, in accordance with the terms of the contract.
- At the same time  
Notwithstanding 3.1.18; 3.1.19; 3.1.21; The calculation of the premium to be paid by the insurer/insured under the conditions specified in the clauses, as well as the terms and conditions of this agreement Subject to the strict observance and consideration of the conditions specified in other clauses of the Terms and Conditions, in the event of premature termination of the insurance, the premium to be returned to the insurer/insured by the insurer is calculated (in the case of the insurer – according to the relevant general insurance period, and in the case of the insured(s) – according to the relevant individual insurance period) by dividing the total premium determined by the insurer and agreed upon between the parties, by the number of months determined by the general and/or individual insurance period.

		<p><b>3.24. Basis for determining the amount of the insurance premium:</b> - The main grounds for determining the insurance premium provided for in these Terms and Conditions are:</p> <ul style="list-style-type: none"> <li>- Structure of the insurance package;</li> <li>- Number of declared (insured) persons;</li> <li>- Prices of medical services;</li> <li>- State regulations of Georgia;</li> <li>- Duration of the insurance period;</li> <li>- National currency exchange rate (according to the data of the National Bank of Georgia)</li> <li>- Consumer Price Index in the field of healthcare published by the National Bureau of Statistics of Georgia;</li> <li>- Loss ratio (the accumulated loss of the period compared to the premium earned for the corresponding period);</li> </ul> <p><b>3.25. "Co-payment"</b> - the part of the cost of medical services paid by the insured, which is not reimbursed by the insurer;</p> <p><b>3.26. "Reporting month"</b> - the month counted monthly during the validity of the contract, according to the date of signing this contract.</p> <p><b>3.27. "Reporting day"</b> - the last calendar day of the reporting month.</p> <p><b>3.28. "Double insurance"</b> - if the insured, in this type of insurance, is a beneficiary of another, one or more insurance companies, then the loss will be compensated jointly and severally between the insurers, in which JSC "Insurance Company Unison" will participate in proportion to the extent of its liability, with the assumption that the total insurance compensation should not exceed the actual damage.</p>
4	Subject of insurance	<b>Health insurance</b>
5	Insurance coverages	<p><b>5.1. Personal/family doctor services</b> - includes consultation of the insured by a personal doctor on the basis of a personal doctor, preparation of a medical questionnaire for each insured and monitoring of the health status, if necessary, issuing a referral for prescribed and planned outpatient services. Opening a hospital sheet in accordance with medical indications;</p> <p><b>Note:</b> The location of the family doctor and the provider outpatient institution are selected when purchasing insurance. The location can be changed only once during the insurance period no later than 1 (one) month after the start of the insurance period.</p> <p><b>5.2 Disease prevention</b> - includes the following consultations and examinations for preventive purposes/without medical complaints, based on the referral of the family doctor, at the place of dislocation of the family doctor:</p> <ul style="list-style-type: none"> <li>- Consultation of one (any) narrow specialist;</li> <li>- Complete blood count;</li> <li>- Complete urine test;</li> <li>- Determination of glucose in the blood;</li> <li>- Determination of creatinine in the blood</li> <li>- Ultrasound examination of one (any) system;</li> <li>- Electrocardiogram;</li> <li>- Determination of prothrombin in the blood;</li> </ul>

- Thyrotropic hormone (TSH)

**Note:** Preventive services do not include those studies that are used to monitor and manage already diagnosed chronic diseases.

**5.3 Emergency medical service** - includes the provision of first aid on the spot by the emergency medical service, assessment of health status and, if necessary, transportation to a medical institution.

**5.4 Hospital service due to an accident** - includes those medical measures in the event of deterioration of health status as a result of external force (physical, mechanical, thermal, chemical), the postponement of which for more than 24 hours leads to disability or lethal outcome of the insured.

**5.5 Emergency hospital service**

**5.5.1 Emergency (critical) hospital service** - hospital service aimed at saving life with simultaneous resuscitation. Intervention begins within a few minutes of making the decision.

**5.5.2 Emergency-immediate hospital service** - hospital service provided in acutely started and/or clinically deteriorated, life-threatening conditions, when medical service begins no later than the first 24 hours after the occurrence of the insured event.

**Note:** For primary insured persons, as well as for those persons whose last continuous insurance period has been 1 (one) month or more, a waiting period of 15 (fifteen) days applies to emergency hospital service.

**5.6 Planned/urgent delayed hospital service**

**5.6.1 Urgent delayed hospital service** - is planned within a few days after the occurrence of the insured event.

**5.6.2 Planned hospital services** - are planned at a time convenient for the patient, the doctor and/or the medical institution.

**5.6.3** For primary insured persons, as well as for those whose last continuous insurance period has been 1 (one) month or more, a waiting period of 12 (twelve) months applies.

**5.7 Cardiology/cardiac surgery** - includes planned and emergency hospital services; which include interventional cardiology and cardiac surgery services.

**5.7.1.** For primary insured persons, as well as for those whose last continuous insurance period has been 1 (one) month or more, a waiting period of 24 (twenty-four) months applies.

**5.8 "Oncology"** - provides for reimbursement of the costs of diagnostics, therapeutic, chemo- and radiation treatment, pre-operative examinations and surgical treatment of both benign and malignant oncological problems; covers both outpatient and hospital services, and reimbursement of medicines will be made from the oncology limit and with the appropriate co-payment.

**Note:** For primary insured persons, as well as for those whose last continuous insurance period has been 1 (one) month or more, a waiting period of 12 (twelve) months applies to oncological services.

**5.9 Day hospital/one-bed day hospital service** - includes emergency and planned day hospital (day hospital service - service that is provided in a medical institution with an appropriate license, so that the insured person occupies a bed) and one-bed hospital (one-bed day hospital service - service that is provided in a medical institution with an appropriate license, so that the insured person's stay on the bed for medical reasons does not exceed 1 bed-day) medical services (therapeutic and surgical treatment; medical

manipulations; stay in a standard ward, diagnostic tests and medications necessary for treatment in the hospital). As well as their complications (meaning both complications that develop before the insured person's discharge from the medical institution and after discharge), except for emergency (critical) hospital service. Day hospital/one-bed day hospital The cases specified in the positive list of services (the cost of manipulations/interventions/surgical treatment of the specified diseases/conditions) will be reimbursed by the insurer if they comply with the exceptions of this agreement.

**Note:** For primary insured persons as well as for those persons whose last continuous insurance period has been 1 (one) month or more, a waiting period of 12 (twelve) months applies to day hospital/one-bed day hospital services.

**5.9.1. The positive list of day hospital/one-bed day hospital services in the case of day hospital/one-bed day service includes:**

- **Gynecology:** polypectomy; myomectomy/laparoscopic myomectomy; operations on the cervix; therapeutic hysteroscopy/hysteroresectoscopy; conization; ablation; excision and drainage of the Bartholin gland; Vaginal cyst excision; Laparoscopic salpingectomy; Laparoscopic cystectomy; Ovarian cyst excision/laparoscopic cystectomy; Any intervention/manipulation related to endometriosis; Ovariectomy;
- **Cardiovascular system:** Cardioversion; Ablation; Stenting; Operations/manipulations on veins;
- **Otorhinolaryngology:** Adenoidectomy; Tonsillectomy; Nasal polypectomy; Nasal septum resection; Concha disintegration; Conchotomy; Chronic sinusitis-endoscopic surgery; Myringotomy; Tympanotomy; Septoplasty;
- **Gastroenterology:** Excision/ligation of thrombosed hemorrhoids (hemorrhoids, hemorrhoidal nodes); Uncomplicated fissurectomy; Polypectomy from the small intestine; Endoscopic papillotomy/sphincterotomy; Endoscopic ligation of varicose veins (stomach, esophagus); Endoscopic gastrotomy; Endoscopic polypectomy; Paraproctitis excision and drainage; Laparocentesis; Laparoscopic cholecystectomy; Laparoscopic appendectomy; Laparoscopic hernioplasty; Pilonidal cyst excision; Endoscopic foreign body removal
- **Ophthalmology;**
- **Genitourinary tract:** lithotripsy; Hydrocele operations/manipulations; Orchiectomy; Orchiopexy; Epididymectomy; Endoscopic stone removal; Cystolithotomy; Percutaneous laparoscopy; Urethral and/or bladder catheterization, stenting; Laser and optical urethrotomy; Trocar epicycstostomy (except in emergency cases); Circumcision; Ligament incision
- **Mammology:** Breast resection; Fibroadenoma excision; Cyst excision;
- **Maxillofacial surgery:** Excision of a cyst in the maxillary sinus; Excision of a cyst in the mandibular canal; Excision of a benign tumor of the facial soft tissues; Subperiosteal abscess; Operative treatment of periostitis; Endoscopic surgery of a tumor of the vocal cord
- **Orthopedics, traumatology:** Dismantling of the fixator under regional or local anesthesia; Laparoscopic arthroplasty, meniscectomy;

- **Mixed surgery:** excision of scars, moles, tumor formations from the skin; finger amputation (except traumatic); drainage of soft tissue cysts and abscesses; excision of lymph nodes; cryotherapy, catheter ablation, thoracocentesis, drainage of the biliary tract with resuscitation monitoring, operations/manipulations related to skin abscesses, phlegmon, furuncle, carbuncle.

5.10 Emergency outpatient services provide for - reimbursement of necessary medical expenses related to the deterioration of the insured's health condition, the postponement of which for more than 24 hours will lead to the death, disability, or significant deterioration of the insured's health condition and which requires the beneficiary to stay in the clinic for less than 24 hours. Emergency outpatient cases are defined by the corresponding **positive list**:

5.10.1. The positive list of emergency outpatient services in the case of emergency outpatient services includes:

- **"Traumas"** - traumatologist consultation, X-ray examination, immobilization, repositioning, fixation, blockades;
- **"Wound"** - specialist consultation, surgical treatment and suturing of the wound. Medications, anti-rabies and anti-tetanus vaccination;
- **"Bleeding"** - doctor consultation, tamponade, coagulant; coagulation
- **"Heart rhythm disorders"** - consultation, electrocardiogram, rhythm stabilization;
- **"Hypertensive crisis"** - consultation, electrocardiogram, blood pressure stabilization;
- **Allergy**, anaphylactic conditions and with a tendency to develop laryngeal edema - consultation, anti-allergic treatment;
- **Acute bronchitis/acute obstructive laryngitis/epiglottitis**- consultation, bronchospasm relief;
- **Renal, abdominal and biliary colic**- consultation, complete blood count, complete urine analysis, single system ultrasound, intravenous infusion, pain relief;
- **"Urinary retention"**- consultation, catheterization, intravenous infusion, complete urine analysis;
- Unspecified pain and headache in the chest and abdomen - consultation, pain relief and blockade;
- Intoxication-consultation, gastric lavage, detoxification/infusion therapy, laboratory studies;
- Hyperthermia Pediatric Age - consultation, antipyretic treatment;
- Foreign body in the upper respiratory tract, ear, ear canal, digestive system - doctor's consultation, removal of foreign body.
- Anti-rabies, anti-tetanus, anti-botulism and anti-reptile bite vaccination immunization costs. In addition, only the first visit and vaccination are reimbursed by the emergency outpatient service, subsequent visits are reimbursed in accordance with the co-payment and limit of the planned outpatient service.

**Note:** For primary insured persons, as well as for those whose last continuous insurance period has been 1 (one) month or more, a waiting period of 15 (fifteen) days applies to emergency outpatient service.

5.11 **Planned outpatient services include** - receiving outpatient care that does not require emergency intervention and the insured person's stay in a medical institution for more than 24 hours;

		<p><b>Note:</b> For primary insured persons, as well as for those whose last continuous insurance period has been 1 (one) month or more, a waiting period of 9 (nine) months applies to planned high-tech examinations (computer tomography, magnetic resonance imaging PET-CT).</p> <p>5.12 <b>Medications prescribed by a doctor</b> - includes reimbursement of the costs of medications prescribed to the insured person by a family doctor or a narrow-profile specialist doctor for outpatient treatment.</p> <p>5.13 A medicinal product registered under the legislation of Georgia, which is used for the treatment or prevention of a disease and whose active substance or combination thereof is provided for the medical therapy of a specific disease, the prevention of a disease or its complications, according to treatment guidelines developed and approved by internationally recognized and/or local medical associations, and there is sufficient, reliable clinical evidence for the effectiveness of their use in accordance with them;</p> <ul style="list-style-type: none"> <li>- Registered homeopathic remedies are reimbursed, unless they are prescribed by a homeopathic doctor.</li> <li>- Biologically active/food supplements; immunomodulators; phytopreparations and para-medicinal products can be purchased by the insured only upon referral from a family doctor, in the specified provider pharmacy network with a 25% discount within the limits provided for in the package.</li> </ul> <p>5.14 <b>Emergency dental services</b> - include relief/treatment of acute toothache, diagnostic radiography, tooth and root extraction in case of emergency. According to the diagnosis.</p> <p>5.15 <b>Planned dental services</b> - include consultation with a dentist, diagnostic, surgical and therapeutic treatment, which includes tooth extraction, treatment of simple and complicated caries, cleaning from stones twice a year.</p> <p><b>Note:</b> For primary insured persons as well as for those whose last continuous insurance period has been 1 (one) month or more, a waiting period of 30 (thirty) days applies to emergency and planned dental services.</p> <p>5.16 Up to 10-40% discount is applied to orthopedic and orthodontic dentistry/implantation in the specified provider clinics;</p> <p>5.17 <b>Pregnancy</b> - includes financing of planned and emergency medical services necessary for the care of pregnant women (doctor's consultation, laboratory and instrumental examinations, abortion on medical grounds, diagnosis and treatment of pregnancy complications, manipulations, medications, both in outpatient and inpatient services).</p> <p>5.17.1 <b>Childbirth</b> - includes medical services related to physiological childbirth, medically indicated cesarean section, as well as their complications, complications of the postpartum period (medications, manipulations, anesthesia, ward (standard, intensive care, intensive care ward)).</p> <p><b>Note:</b> For primary insured persons, as well as for those whose last continuous insurance period has been 1 (one) month or more, a waiting period of 24 (twenty-four) months applies to pregnancy and childbirth services.</p>
6	<p><b>Additional coverages (if any under the insurance policy)</b></p>	<p>Additional coverages (in the form of a travel insurance product), if any, must be specified in the insurance policy.</p>

7	<p><b>Conclusion of an insurance contract</b></p>	<p>7.1. The conclusion of an insurance contract is carried out between the insurer and the insured physically or remotely using one or more remote communication means organized by the insurer;</p> <p>7.2. The parties agree that the contract can be concluded in electronic form, including by confirming the relevant link or through the Signify platform (<a href="https://signifyapp.com/ka-GE/">https://signifyapp.com/ka-GE/</a>). Also, the contract can be concluded and the insurance policy issued remotely, using the insurer's website (<a href="https://unison.ge/">https://unison.ge/</a>). The contract concluded in this manner has the same legal force as a contract signed by the parties on paper.</p> <p>7.3. The parties agree that the insurance conditions provided for by the contract are valid for the term of the policy.</p> <p>7.4. Upon automatic renewal of the contract, if the insurance continues with an insurance policy of the same or higher value, then the reimbursement conditions (reimbursement percentage, limit) for planned hospitalization, including day hospital, endoprosthesis and childbirth, correspond to the policy that the insured had purchased in the previous year, and if the insurance continues with an insurance policy of a lower value, then the reimbursement conditions for planned hospitalization correspond to the newly selected policy.</p>
8	<p><b>Rules for receiving insurance services and issuing compensation</b></p>	<p><b>8. To receive any service, it is advisable for the insured to contact the insurer's information service at 032 299 19 91, which will provide complete information about receiving the service, and if necessary, will schedule a visit to the family doctor.</b></p> <p><b>8.1. To receive family doctor services, as well as a referral for planned services/a letter of guarantee</b></p> <p><b>8.1.1.</b> The insured is obliged to notify the insurer's information service at 032 299 19 91, which organizes further medical services; family doctor services can also be received through the application, or through a personal manager if such a service is provided for in the insurance terms and conditions.</p> <p><b>8.1.2.</b> A referral for preventive examinations will be issued only after consultation with a family doctor.</p> <p><b>8.2. Emergency outpatient clinic / emergency hospitalization / hospitalization due to an accident</b> - the insured or a third party is obliged to notify the insurer's information service at 032 2 991 991 within 24 hours of hospitalization, and immediately after the accident, and to agree on further actions with it;</p> <p><b>8.2.1.</b> In the event of an accident - the beneficiary/third party is obliged to contact the insurer's information service at 032 2 991 991 no later than 48 hours after the accident and also to notify the insured event in writing no later than 14 fourteen days</p> <p><b>8.2.2.</b> The notification must include the following information - the insured's name and surname, personal number, name of the medical institution, time of hospitalization; If the notification is impossible to make a preliminary agreement on treatment due to objective reasons, these circumstances must be confirmed by appropriate documentary evidence; In the provider institution - after leaving the notification, the insured pays only the amount due to him, if any, and in the case of a non-provider - the insured pays the cost of the</p>

		<p>service himself, after submitting complete documentation to the insurer, the amount will be reimbursed through non-cash payment within the relevant limit and co-payment.</p> <p><b>8.3. In case the insured person pays the cost of medical services himself/herself, in order to receive reimbursement, he/she is obliged to submit to the insurer, together with the insured person's identity document, the following within 30 calendar days:</b></p> <p>8.3.1. When calling an ambulance - a note from the ambulance doctor about the state of health; a check and receipt confirming payment.</p> <p>8.3.2. In case of planned or emergency outpatient services - documentation of the medical service provided, a diagnosis and prescription certified by signature and seal on the title page or form 100/a, a conclusion of the conducted research, a receipt from the cash register of the relevant person receiving the money and a check from the cash register/terminal;</p> <p>8.3.3. In case of purchasing medicines without a prescription on a letter of guarantee - a receipt - a detailed list of purchased medicines, a check, a doctor's specialist's prescription.</p> <p>8.3.4. In case of emergency dental services - medical documentation of the service provided, a diagnosis certified by signature and seal on the title page or form №100/a; and purpose, the conclusion of the conducted research, X-ray images taken before and after the service (the specified image is not required in the case of treatment due to simple caries), the cashier's receipt of the relevant person receiving the money and the cash register/terminal receipt;</p> <p>8.3.5. Scheduled dental services: to receive the service, the insured person contacts the call center in advance, after notification, he applies to the specified provider dental institution, on the spot he pays only the co-payment share (if the relevant card provides for such), the remaining amount is settled directly with the provider by the insurer.</p> <p>8.3.6. In the event of scheduled or emergency hospital services and childbirth - a third party representing the insured person must submit, together with the insured person's identity document, form No. 100/a; Detailed calculation of the cost of medical services; Invoice, payment confirmation documents;</p> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>• The insurer is entitled not to reimburse the costs related to hospital treatment in the event that it is not informed about the hospitalization of the insured person in accordance with the procedure specified in these terms/contract.</li> <li>• A maximum of 1 month's supply of medication will be charged on the letter of guarantee at a time. In the case of medications purchased without a letter of guarantee, the cost of a maximum of 1 month's worth of medication will be reimbursed at a time.</li> <li>• If the insured person does not undergo the planned treatment for which the referral/letter of guarantee was issued within the validity period of the letter of guarantee, then the referral/letter of guarantee will be considered invalid and will not be reimbursed by the insurer.</li> </ul>
9	Exceptions	<p><b>The following are not covered under the insurance terms:</b></p>

- 9.1. The following cases and/or costs of services related to their complications are not subject to compensation:**
- 9.1.1 Costs of treatment of diseases caused by cases when the insured person intentionally puts himself in danger, except for cases when he acts with the aim of saving the life of another person; costs of self-treatment;
- 9.1.2 Deterioration of health status caused by a suicide attempt (if this does not concern saving the life of another person), participation in an (illegal) action; military service, an insured event occurring during imprisonment, medical services related to addiction to alcohol, drugs, toxic substances, as well as deterioration of health status caused by the influence of these substances, including deterioration of health status caused by a traffic accident while driving a vehicle while under the influence of these substances;
- 9.1.3 Participation in any type of professional and risky sports.
- 9.1.4 Medical services caused by an epidemic/pandemic;
- 9.1.5 That part of the costs of services financed by any state, municipal, social programs, the budget of a local self-government unit and/or a third party that is reimbursed by the relevant program/insurance (in those medical institutions where the programs do not operate, the Company will reimburse the costs to the extent provided for in these Terms and Conditions). In the event that the insured person exhausts the limit of a specific case established by the state program, the insurer undertakes to reimburse the costs remaining beyond the limit of the state program for this case. Also, in the event that the insured person, who is a beneficiary of a state program, voluntarily refuses to use the benefit of this program, one-time or permanently, the insurance company will not reimburse the additional costs caused by this change (except for the costs incurred during childbirth); In the event that the insured person exhausts the limit of a specific case established by the state program, the insurer undertakes to reimburse the remaining expenses for this case beyond the limit of the state program.
- 9.2. The following expenses for medical services related to diseases and/or their complications:**
- 9.2.1. Systemic diseases, congenital and/or genetic diseases and anomalies, chronic renal and/or hepatic failure, amyotrophic sclerosis, obesity, AIDS, hepatitis (of any form and stage), diabetes mellitus and non-diabetes, mental illnesses, epilepsy;
- 9.2.2. Reproductive system disorders, primarily sexually transmitted (except for vulvovaginal candidiasis, bacterial vaginosis and urethritis) diseases (except for primary screening diagnostics, which includes: doctor's consultation and smear bacterioscopy), as well as artificial insemination, infertility, treatment of sexual disorders and contraception costs, abortion performed for artificial and non-medical indications;
- 9.2.3. Costs of inpatient, day inpatient treatment of diseases existing before insurance, except for urgent (emergency) cases;
- 9.3 The following costs of services/procedures and/or services related to their complications:**
- 9.3.1. Experimental and non-traditional medicine (acupuncture, homeopathy, manual therapy), laser therapy, ultrasound therapy, cryotherapy, plasmapheresis costs, therapeutic massage and physiotherapy, cosmetic and reconstructive treatment costs (including dentistry: in particular veneering, tooth restoration, tooth depulption for subsequent prosthetics);

		<p>9.3.2. Any type of exoprosthetics, organ and tissue transplantation, dialysis session costs, amniotic fluid diagnostics and any type of genetic research; artificial insemination, sterilization, services of a psychotherapist, psychoanalyst and speech therapist;</p> <p>9.3.3. Implantation of defibrillators, pacemakers, drug depots and artificial larynx. Medical services that are not medically appropriate or performed without medical indication, additional and exclusive services, fees of a hired/invited doctor/non-standard ward expenses;</p> <p>9.3.4. Sending of examination material taken in Georgia abroad and examinations;</p> <p>9.3.5. Vaccination/immunization (calendar and seasonal vaccinations);</p> <p>9.3.6. Costs of anesthesia during physiological childbirth;</p> <p>9.3.7. Costs of PET-examinations, ablation costs.</p> <p>9.3.8. Examinations and costs related to obtaining any type of medical certificate;</p> <p>9.3.9. Medical services related to weight correction, vision correction (including excimer laser treatment);</p> <p><b>9.4. Costs related to the purchase, use and/or complications of the following means:</b></p> <p>9.4.1. Unregistered medicines, biologically active food supplements, homeopathic remedies, hygiene and care products, Bandages and sugar substitutes, immunomodulators, metabolic agents, vitamins, paratherapeutic agents, protectors, psychotropic drugs, systemic enzyme therapy, implants.</p> <p>9.4.2. Assistive devices and corrective devices/devices (including glasses, lenses, hearing aids, endoprostheses, etc.), prostheses.</p> <p>9.4.3. That part of the costs of services financed by any state, municipal, social programs, local government budget and/or third party that is reimbursed by the relevant program/insurance (in those medical institutions where programs do not operate, the Company will reimburse the costs to the extent provided for by these Terms);</p> <p><b>Note:</b> The cost of any medical service for a foreigner/non-citizen will be reimbursed in accordance with the prices applicable to Georgian citizens.</p>
10	<p><b>Rights, duties and responsibilities of the parties</b></p>	<p><b>10.1. The insurer is obliged to:</b></p> <p>10.1.1. To carry out insurance in accordance with the conditions specified in this Agreement and the annexes to this Agreement;</p> <p>10.1.2. To strictly and properly fulfill the obligations assumed under this Agreement.</p> <p>10.1.3. In the event of an insured event, after the insurer/insured has submitted all necessary documents for establishing the insured event and determining the amount of insurance compensation, to fulfill the obligation assumed under the insurance in a timely and proper manner.</p> <p><b>10.2. The insurer is entitled to:</b></p> <p>10.2.1. To require the insurer/insured to properly and strictly fulfill the obligations assumed under this Agreement and the relevant annexes;</p> <p>10.2.2. To require the insurer to pay the premium in accordance with the procedure and within the time limits established by this Agreement;</p> <p>10.2.3. To require the insurer/insured to submit all necessary information necessary for concluding an insurance contract in the form established by the insurer;</p>

- 10.2.4. To request from the insurer/insured the documentation necessary for concluding an insurance contract and receiving subsequent services, including, to require the insurer to submit the following information necessary for concluding an insurance contract - name, surname, personal number, date of birth, place of work and position of the insured persons, in the case of family members, additionally: status in relation to the insured, date of birth, personal number, in the application form established by the insurer;
- 10.2.5. Refuse to pay insurance compensation in case of non-fulfillment or improper fulfillment by the insurer (insured) of the obligations assumed under this Agreement and the relevant annexes;
- 10.2.6. Refuse to pay insurance compensation in case of untimely and/or incomplete submission of documentation related to the incident by the insurer (insured)
- 10.2.7. Request information/additional documentation related to the settlement of the incident from the insurer/insured;
- 10.2.8. Obtain the necessary documentation for the settlement of the insurance incident and identification of the insured from other organizations.
- 10.2.9. Conduct an examination of the insured through a representative at his/her own discretion and familiarize himself/herself with his/her medical history. To verify the volume of medical services provided to the insured in a medical facility, the costs incurred and/or to request and verify the prescription issued to the insured;
- 10.2.10. To remove a provider agreed with the insurer/insured from the list of providers at any time at its own discretion (including if it does not meet the service criteria and standards established by the insurer) and replace it with another provider acceptable to it, about which the insurer/insured must be notified immediately.
- 10.2.11. In case of detection of falsification or attempted falsification of information/documentation specified in this Agreement by the Insurer/Insured, the Insurer shall be required to pay 5,000 (five thousand) GEL for each such case, and upon detection of such cases, the Insurer shall be entitled to unilaterally terminate this Agreement immediately without setting an additional period;
- 10.2.12. Not to issue insurance compensation in case of detection of the fact of occurrence of an insured event and/or falsification of documents necessary for receiving compensation, as well as the fact of submission of false information, and in case of issuance of compensation, to demand the return of the compensated loss.
- 10.2.13. Instead of the insured/insurer, apply to the Polypharmacy Study Group of the Ministry of Labor, Health and Social Protection of Georgia for the identification of the fact of polypharmacy cases and further response. In addition, each insured person, by receiving insurance services, agrees to have his/her medical documentation and/or relevant information related to the patient's health made available to persons involved in the polypharmacy process;
- 10.2.14. After reimbursement of medical service expenses to the insured person, request compensation for the relevant expenses from those persons who are responsible for the damage caused to the insured person's health.
- 10.2.15. Unilaterally change the terms of this Agreement, and if the Insurer does not agree in writing with the proposed proposal within 2 (two) business days after receiving the notification from the Insurer about the implementation of such a change, the Insurer is entitled to terminate the Agreement within 1 (one) month;

10.2.16. Increase the insurance premium and/or leave it unchanged, but do not adapt the Agreement to the changed circumstances that have arisen in the event of a change in any component of the basis for determining the premium during the insurance period. In addition, such authority of the Insurer arises only after the aforementioned change worsens the basis for determining the price formation (initial insurance premium). If the Insurer, upon the implementation of such a change If the Insurer does not agree to the proposed proposal within 2 (two) business days from the date of receipt of the notification from the Insurer, the Insurer is entitled to terminate the Agreement immediately, without any additional period

10.2.17. During the validity period of the Agreement, in the event of the cancellation/change of any state/referral health care program(s) by the State, the Insurer/Insured shall be notified in writing one month before the changes come into force.

10.2.18. Not to compensate for damage if the Insured or the Insurer, by their actions, prevents the fulfillment of the claim for compensation for damage from a third party.

10.2.19. To request from the Insurer/Insured the documentation necessary for concluding the Insurance Agreement and receiving further services;

10.2.20. In case of double insurance, divide the costs of the insured event with another insurer;

10.2.21. In case of revealing dishonest actions on the part of the insurer/insured, demand the reimbursement of the amount paid;

**10.3. The insurer/insured is obliged to:**

10.3.1. Ensure payment of the premium in accordance with the procedure and within the time limits established by this Agreement;

10.3.2. Ensure submission of the necessary and accurate information to the insurer for concluding the agreement in the form established by the insurer;

10.3.3. Notify the insurer of the occurrence of the event in accordance with the procedure and within the time limits established by this Agreement,

**At the same time, the parties take into account that a delayed notification by the insurer will critically affect the interests of the insurer due to the following circumstances:**

- obtaining evidence becomes impossible;
- The insurer is not allowed to assess the health condition of the insured on site
- The right of subrogation granted to the insurer by law/contract is restricted
- The insurer is deprived of the opportunity to take timely measures to reduce the amount of loss;
- Timely identification of exceptions established by the contract is prevented;

10.3.4. To acquaint the insured persons with the terms of insurance specified in this contract and the obligations that they assume in accordance with the requirements of this contract;

10.3.5. To fulfill the obligations assumed under this contract in full and due manner.

10.3.6. In case the insured has insured the same interest with several insurers at the same time, the insured is obliged to immediately notify the insurer about this, indicating the identity of all insurers and the amount of the insurance sum.

10.3.7. request, grant the insurer the right and facilitate, after compensation for the loss, to verify the quality of the medical service provided and, if a deficiency in the

		<p>medical service is identified, which led to an increase in the loss, to apply to the medical institution and demand a refund of the overpaid amount.</p> <p>10.3.8. Grant the insurer the right to apply to the Polypharmacy Study Group of the Ministry of Labor, Health and Social Protection of Georgia instead of the insured;</p> <p>10.3.9. If the insurer discovers that the services received by the insured exceed the insurance limit of a specific coverage, the insured is obliged to return to the insurer the benefits received above the insurance limit within 5 (five) business days from the insurer's discovery and notification.</p> <p><b>10.4. The insurer/insured is entitled to:</b></p> <p>10.4.1 Require the insurer to provide insurance in accordance with the terms and conditions specified in this Agreement;</p> <p>10.4.2 In the event of an insured event, require the insurer to pay insurance compensation in accordance with the terms and conditions specified in this Agreement;</p> <p>10.4.3 Require the insurer to properly fulfill its obligations;</p> <p>10.4.4 Terminate this Agreement in full compliance with the requirements of this Agreement;</p>
11	<b>Subrogation rule</b>	<p>If the insurer/insured can claim compensation for damage from a third party, then this claim is transferred to the insurer if he compensates the insurer for the damage. If the insurer refuses its claim against the third party or the right to secure its claim, then the insurer is released from the obligation to compensate for the damage in the amount of the amount that it could have received as compensation for its expenses in connection with the exercise of the right or the presentation of the claim, and if such compensation has been given, the insurer is entitled to demand the return of</p>
12	<b>Term of the contract and conditions for termination (cancellation)</b>	<p>12.1. The insurance period begins at 24:00 on the day specified in the insurance policy and ends at 24:00 on the day specified in the policy. The policy enters into force at 24:00 on the day of payment of the premium in a lump sum or in the case of distribution of the insurance premium, the first installment, unless another term is established by the insurance policy.</p> <p>12.2. The contract may be terminated early both at the initiative of the insured and the insurer</p> <p>12.3. In the event of early termination of the insurance at the initiative of the insured, he is obliged to notify the insurer in writing in all cases; a desire expressed orally or by telephone is not a basis for cancellation of the insurance;</p> <p>12.4. The insurance may be terminated at the initiative of the insurer due to a violation of the obligation to pay the premium</p> <p>12.5. The insurer is entitled to unilaterally terminate the insurance immediately if:</p> <ul style="list-style-type: none"> <li>- the insurer/insured/beneficiary provides incorrect information to the insurer, falsifies it and misleads/attempts to do so in any way;</li> <li>- the insurance will be cancelled on the next business day after the insurer receives the relevant information.</li> </ul> <p>12.6. The withdrawal of a family member from the family package is considered as a termination of insurance for a specific insured and will be regulated by the terms of early termination of the contract.</p>

		<p>12.7. If the withdrawal of a family member from the family package results in a reduction of the number of family members to 2, then the family package will be cancelled by the insurer and the insurance package will be extended to each insured under the terms of the individual retail package and with the appropriate premium, while the spent limits will be transferred to a new individual package.</p>
13	<p><b>Penalty/sanctions arising from termination of contract</b></p>	<p>13.1. This Agreement may be terminated early:</p> <p>13.1.1. Based on a notification sent by the “Insurer” to the “Insured” (both in writing and via SMS), within 30 (thirty) days from the date of delivery/receipt of this notification;</p> <p>13.1.2. In the event of full fulfillment of the obligations assumed by the Insurer, or the full exhaustion of the relevant liability/compensation limit, the specific coverage limit is specified in the insurance policy.</p> <p>13.1.3. In the event of failure or improper fulfillment of the obligations assumed by the parties;</p> <p>13.1.4. Other cases provided for by this Agreement and the legislation of Georgia.</p> <p>13.2. In the event of early termination of the Agreement:</p> <p>13.2.1. The insurer is entitled to terminate the contract early without any warning in case of non-fulfillment or improper fulfillment of the obligations assumed by the insured, as well as in case of detection of dishonest actions on the part of the insured and to demand back from the insured the benefits received as a result of the above-mentioned actions;</p> <p>13.2.2. In case of cancellation of the insurance at the request of the insurer/insured:</p> <p>a. The earned premium is not refundable.</p> <p>b. The insured is obliged to pay a penalty in the amount of the unearned insurance premium, if he has received insurance compensation at least once during the validity period of the contract (except for the services of a family doctor).</p> <p>c. If the insured has not received compensation at all, he is obliged to pay 20% of the unearned premium as a penalty. Except for the case if the insured died during the validity period of the policy.</p> <p>d. In addition, for the avoidance of doubt, the insurance premium earned before the termination of the insurance shall be subject to payment by the insurer/insured in any case.</p> <p>13.3. Despite the early termination of this Agreement, each party shall fulfill the obligation that arose before the termination of this Agreement;</p> <p>13.4. Any amendment and/or addition to this Agreement shall enter into force upon written agreement, including by sending it by e-mail and receiving confirmation. In case of non-receipt of the confirmation by e-mail by the insured within 2 business days, the insurer shall be entitled to consider the confirmation as received after the expiration of 2 business days;</p>

		<p>13.5. The Insurer is authorized to unilaterally change the terms of this Agreement, based on the percentage change in the Consumer Price Index in the healthcare sector published by the National Bureau of Statistics of Georgia, in accordance with the increased “%” amount per service, in proportion to the share of the Company's total losses on these services(s), on which the Parties shall agree by concluding an additional agreement; and if the Insurer does not agree with the proposed proposal within 2 (two) business days after receiving a notification from the Insurer regarding the implementation of such a change, the Insurer is authorized to immediately terminate the Agreement without any additional period, while the notification may be made in accordance with paragraph 13.4</p>
14	<p><b>Insurance premium and payment terms</b></p>	<p><b>14.1.</b> The full insurance premium payable by the “Insured” to the “Insurer” according to the relevant insurance period and the insurance package selected by the “Insurer” is specified in the insurance policy;</p> <p><b>14.2.</b> In the event of the first violation by the Insurer of the premium payment procedure established by this Agreement (the premium and/or its part was not paid on time or in the established amount), the Insurer is released from the fulfillment of the obligations assumed under the Agreement. The Insurer is entitled to suspend the validity of the Agreement and not compensate for insured events 14 calendar days after the date of violation of the schedule, without any notification, until the Insurer fully fulfills its financial obligations. The Insurance Agreement shall be renewed only after the Insurer has paid the premium. After the debt is paid, the insurer will no longer consider the events that occurred during the debt period as insurance events and the services provided during this period will not be subject to compensation by the insurer. In addition, the parties agree that if the “Insurer”/“Insured” does not pay the premium payable according to the schedule within 30 (thirty) days, then, after the expiration of this period, the “Insurer” is entitled to terminate this Agreement and demand that the “Insured” pay the insurance premium arrears;</p> <p><b>14.3.</b> The “Insured” pays the individual insurance premium in installments on a monthly basis. The first and last monthly installments will be paid immediately upon purchasing the policy. The first and last month's insurance premium (the first part of the insurance premium) must be paid within 4 calendar days from the signing of this Agreement and the important terms of the Agreement, and the remaining premium amount will be distributed proportionally over the next 10 months, according to the result obtained by dividing the remaining premium by 10 months, in equal tranches; In addition, for the avoidance of doubt, until the first or one-time insurance premium is paid, the insurer is free from its obligations and the policy is canceled, and in order for the payment to be considered made and the payment to be identified, the insurance policy/card number must be indicated in the payment document as a mandatory rule;</p>
15	<p><b>Dispute Resolution Procedure</b></p>	<p>Any dispute arising out of the Agreement (including those relating to the existence, interpretation, performance and enforcement of the Agreement) shall be resolved through negotiation. In the event of failure to resolve the dispute, the parties shall refer the matter to court.</p>
16	<p><b>Communication between the parties</b></p>	<p>16.1. The Insurer shall send the Insured (Insured/Beneficiary) a notice by text message, e-mail, or postal mail to the address and details specified by the Insured in the</p>

		<p>application/insurance policy. In addition, the Insurer shall not be liable if the specified details are incorrect or have been changed and the Insured has not been notified, as a result of which the notice could not be sent or was sent to an incorrect address. The notice shall be deemed to have been delivered from the moment of sending;</p> <p>16.2. In the event that the Insurer has sent the Insured a notice to an e-mail address other than that specified in the insurance application/policy, the notice shall be deemed to have been delivered on the day of its receipt by the Insured/Insured, if the Insured/Insured has confirmed receipt of the notice;</p> <p>16.3. An insurance policy certified and issued by the insurer with an electronic signature or electronic seal is equivalent to the original, and the consent of the insurer to the insurance terms and conditions made by the insurer through electronic communication is equivalent to the signature of the insurer. The insurance policy and the relevant contract can be concluded in a material written form, as well as remotely, using the insurer's website (<a href="https://unison.ge/">https://unison.ge/</a>).</p> <p>16.4. On any corporate email of the insurer ending with unison.ge - confirmation is equivalent to a signature.</p>
17	<p><b>Processing of personal data</b></p>	<p>17.1. The Insurer is authorized to process personal data (including special categories of personal data) received within the framework of insurance in accordance with the requirements of the Law of Georgia on Personal Data Protection.</p> <p>17.2. The Insurer agrees that the Insurer is authorized to process the personal data of the Insurer/Insured, including special categories of data, in accordance with the legislation of Georgia, within the framework and scope of this Agreement, for the purposes of the Agreement and, if necessary, to transfer them to third parties. The Insurer is also authorized to process the personal data of the Insurer/Insured for marketing purposes, including direct marketing purposes.</p> <p>17.3. By concluding this contract/policy, the insured grants the insurer the authority to obtain the necessary information from third parties (doctors, any medical institution, transport service, etc.) and releases the latter from the obligation to keep the information confidential.</p> <p>17.4. The data subject has the right to request at any time from the insurer to cease using data about him for direct marketing purposes, in the same form as the said communication is carried out - by applying in writing or by telecommunication means.</p>
18	<p><b>Final provisions</b></p>	<p>18.1. A claim can be filed at the following e-mail address of the Insurer: complaints@unison.ge or by leaving a message at the Insurer's information service at 0 32 2 991 991;</p> <p>18.2. Any changes or additions to these Terms and Conditions are provided for (specified) in the insurance policy or in the relevant agreement concluded between the parties. The agreement of the parties is not required to make changes/additions to these Terms and Conditions, if this is required by the current legislation of Georgia;</p> <p>18.3. The relevant annexes to this Agreement are;  Appendix #1 - Insurance Packages;  Appendix #2 - List of Providers;</p>