Health insurance conditions

№	Name	Health insurance conditions
1	Parties to the contract	**Insurer:** JSC "Insurance Company Unison" (Registered No. 404393152); **Policyholder: a natural person who has entered into this Insurance Contract with the Insurer for his/her own benefit or for the benefit of third parties and who is obliged to pay the insurance premium**;
2	Subject of the contract	The subject of this Contract is the obligation of the Insurer, in consideration of the payment of the insurance premium by the Policyholder, to compensate for damage caused by an insured event in accordance with the procedure and amount specified in these Terms and Conditions and the insurance policy.
3	Definition of terms	**3.1. " Insured Person"** - a natural person from 1 year of age up to and including 65 years of age, in respect of whom insurance is provided; **3.2. "Family member"** - a spouse, child/stepchild. The family relationship must be confirmed by documents provided for by the legislation of Georgia. **3.3. "Family package"** - the minimum number of family members under the package (spouse up to and including 65 years of age and children up to and including 18 years of age) is 3 (three). One package is selected for all family members, the validity period of which begins on the same date, while the premium is determined according to the number of family members and the agreed discount, if any. **3.4. "Age restriction"** - natural persons under 65 years of age are eligible for insurance. Within the framework of family insurance: spouses under 65 years of age and children/stepchildren from 1 to 18 years of age; **3.5. Foreigner** - a person who is not a citizen of Georgia and a stateless person with status in Georgia; **3.6. Stateless person –** a person whom no state considers as its citizen in accordance with its legislation; **3.7. Electronic card/insurance policy –** a card placed on the official website of the insurer www.unison.ge 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; **3.8. "Medical institution" –** 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; **3.9. "Insured event"** - an event specified in this Agreement, upon the occurrence of which the Insurer is obliged to pay insurance compensation; **3.10. "Accident"** - 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;

		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 Policyholder in accordance with the insurance package selected by the Policyholder/Insured Person. **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 the conditions specified in Clauses 3.18, 3.19 and 3.21, and subject to strict compliance with and consideration of the conditions specified in other provisions of this Contract, the premium payable to the Insurer by the Policyholder/Insured Person, as well as the premium refundable by the Insurer to the Policyholder/Insured Person in the event of early termination of the insurance, shall be calculated, in the case of the Policyholder, according to the relevant total insurance period and, in the case of the Insured Person(s), according to the relevant individual insurance period, by dividing the total premium determined by the Insurer and agreed between the Parties by the number of months comprising the total and/or individual insurance period.

		3.24. Basis for determining the amount of the insurance premium: - The main grounds for determining the insurance premium provided for in these Terms and Conditions are: - Structure of the insurance package; - Number of declared (insured) persons; - Prices of medical services; - State regulations of Georgia; - Duration of the insurance period; - National currency exchange rate (according to the data of the National Bank of Georgia) - Consumer Price Index in the field of healthcare published by the National Bureau of Statistics of Georgia; - Loss ratio (the accumulated loss of the period compared to the premium earned for the corresponding period); **3.25. "Co-payment"** - the part of the cost of medical services paid by the insured, which is not reimbursed by the insurer; **3.26. "Reporting month"** - the month counted monthly during the validity of the contract, according to the date of signing this contract. **3.27. "Reporting day"** - the last calendar day of the reporting month. **3.28. "Double insurance"** - 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.
4	**Subject of insurance**	**Health insurance**
5	**Insurance coverages**	**5.1. Personal/family doctor services -** 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; **Note:** 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. **5.2 Disease prevention -** 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: - Consultation of one (any) narrow specialist; - Complete blood count; - Complete urine test; - Determination of glucose in the blood; - Determination of creatinine in the blood - Ultrasound examination of one (any) system; - Electrocardiogram; - Determination of prothrombin in the blood; - 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 persons insured for the first time, as well as for persons whose last continuous insurance period ended one (1) month or more ago, a waiting period shall apply to cardiology/cardiac surgery services as follows: 24 (twenty-four) months for the "Start" and "Classic" packages, and 12 (twelve) months for the "Advance," "Premium," and "UNIQUE" packages. **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 persons insured for the first time under any package, as well as for persons whose last continuous insurance period ended one (1) month or more ago, a waiting period of 12 (twelve) months shall apply to oncology 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 persons insured for the first time under any package, as well as for persons whose last continuous insurance period ended one (1) month or more ago, a waiting period of 12 (twelve) months shall apply to planned day hospitalization/one-bed-day hospitalization services, while a waiting period of 15 (fifteen) days shall apply to emergency day hospitalization/one-bed-day hospitalization 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; Hymorotomy; Septoplasty; - **Gastroenterology:** Excision/ligation of thrombosed hemorrhoids (hemorrhoids, hemorrhoidal nodes); Uncomplicated fissureectomy; Polypectomy from the small intestine; Endoscopic papillotomy/sphincterotomy; Endoscopic ligation of varicose veins (stomach, esophagus); Endoscopic gastrostomy; 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 epicystostomy (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 persons insured for the first time under any package, as well as for persons whose last continuous insurance period ended one (1) month or more ago, a waiting period of 15 (fifteen) days shall apply to outpatient services.

		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; **Note**: For persons insured for the first time under any package, as well as for persons whose last continuous insurance period ended one (1) month or more ago, a waiting period of 9 (nine) months shall apply to planned high-tech diagnostic examinations (computed tomography, magnetic resonance imaging, PET-CT). 5.12 **Medications prescribed by a doctor** - 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. 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; - Registered homeopathic remedies are reimbursed, unless they are prescribed by a homeopathic doctor. - 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. 5.14 **Emergency dental services** - include relief/treatment of acute toothache, diagnostic radiography, tooth and root extraction in case of emergency. According to the diagnosis. 5.15 **Planned dental services -** 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. 5.16 Up to 10-40% discount is applied to orthopedic and orthodontic dentistry/implantation in the specified provider clinics; 5.17 **Pregnancy** - 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). 5.17.1 **Childbirth** - 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). **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 24 (twenty-four) months applies to pregnancy and childbirth services.
6	**Additional coverages (if any under the insurance policy)**	Additional coverages (in the form of a travel insurance product), if any, must be specified in the insurance policy.

7	**Conclusion of an insurance contract**	7.1. The Insurance Contract shall be concluded between the Insurer and the Policyholder either in person or remotely, using one or more means of remote communication arranged by the Insurer; 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 (https://signifyapp.com/ka-GE/). Also, the contract can be concluded and the insurance policy issued remotely, using the insurer's website (https://unison.ge/). The contract concluded in this manner has the same legal force as a contract signed by the parties on paper. 7.3. The parties agree that the insurance conditions provided for by the contract are valid for the term of the policy. 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.
8	**Rules for receiving insurance services and issuing compensation**	**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.** **8.1. To receive family doctor services, as well as a referral for planned services/a letter of guarantee** **8.1.1.** 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. **8.1.2.** A referral for preventive examinations will be issued only after consultation with a family doctor. **8.2. Emergency outpatient clinic / emergency hospitalization / hospitalization due to an accident -** 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; 8.2.1. 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 8.2.2. 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 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. **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:** 8.3.1. When calling an ambulance - a note from the ambulance doctor about the state of health; a check and receipt confirming payment. 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; 8.3.3. In case of purchase of medications without a guarantee letter — a receipt containing a detailed list of the medications purchased, a payment receipt, and a prescription issued by a specialist physician. 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; 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. 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; **Note:** • The Insurer shall be entitled not to reimburse expenses related to inpatient treatment if the Insurer has not been informed of the Insured Person's hospitalization in accordance with the procedure established by these Terms and Conditions/the Insurance Contract. • Under a guarantee letter, a maximum one (1)-month supply of medication may be prescribed at one time. In the case of medications purchased without a guarantee letter, the cost of medications for a maximum of one (1) month of treatment shall be reimbursed at one time.

		• Referrals and guarantee letters issued by the Insurer shall be valid for 10 (ten) calendar days from the date of issuance. A referral issued by a family doctor shall also be valid for 10 (ten) calendar days from the date of issuance. • If, within the validity period of the guarantee letter, the Insured Person does not undergo the planned treatment for which the referral/guarantee letter was issued, the referral/guarantee letter shall be deemed invalid and the relevant expenses shall not be reimbursed by the Insurer. • The Insurer shall pay the insurance indemnity within 3 (three) business days from the date of submission of all requested documentation..
9	Exceptions	**The following are not covered under the insurance terms:** **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 depulpation for subsequent prosthetics); 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; 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; 9.3.4. Sending of examination material taken in Georgia abroad and examinations; 9.3.5. Vaccination/immunization (calendar and seasonal vaccinations); 9.3.6. Costs of anesthesia during physiological childbirth; 9.3.7. Costs of PET-examinations, ablation costs. 9.3.8. Examinations and costs related to obtaining any type of medical certificate; 9.3.9. Medical services related to weight correction, vision correction (including excimer laser treatment); **9.4. Costs related to the purchase, use and/or complications of the following means:** 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. 9.4.2. Assistive devices and corrective devices/devices (including glasses, lenses, hearing aids, endoprostheses, etc.), prostheses. 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); **Note:** The cost of any medical service for a foreigner/non-citizen will be reimbursed in accordance with the prices applicable to Georgian citizens.
10	**Rights, duties and responsibilities of the parties**	**10.1. The insurer is obliged to:** 10.1.1. To carry out insurance in accordance with the conditions specified in this Agreement and the annexes to this Agreement: 10.1.2. To strictly and properly fulfill the obligations assumed under this Agreement.

		10.1.3. In the event of an insured event, after the Policyholder/Insured Person submits all documents necessary for establishing the insured event and determining the amount of insurance indemnity, the Insurer shall duly and timely perform its obligations assumed under the insurance. **10.2. The insurer is entitled to:** 10.2.1. Require the Policyholder/Insured Person to duly and strictly perform the obligations assumed under this Contract and the relevant annexes; 10.2.2. Require the Policyholder to pay the insurance premium in accordance with the procedure and within the time limits established by this Contract; 10.2.3. Require the Policyholder/Insured Person to provide all information necessary for concluding the Insurance Contract in the form established by the Insurer; 10.2.4. Request from the Policyholder/Insured Person the documentation necessary for concluding the Insurance Contract and receiving subsequent services, including requiring the Policyholder to provide the following information necessary for concluding the Insurance Contract: the first name, surname, personal identification number, date of birth, place of employment and position of the Insured Persons and, in the case of family members, additionally, their status in relation to the Insured Person, date of birth and personal identification number, by completing the application form established by the Insurer; 10.2.5. Refuse to pay insurance indemnity in the event of failure or improper performance by the Policyholder/Insured Person of the obligations assumed under this Contract and the relevant annexes; 10.2.6. Refuse to pay insurance indemnity in the event of late and/or incomplete submission by the Policyholder/Insured Person of documentation related to the insured event; 10.2.7. Request from the Policyholder/Insured Person information and/or additional documentation related to the settlement of the insured event; 10.2.8. Obtain from other organizations the documentation necessary for the settlement of the insured event and identification of the Insured Person; 10.2.9. At its own discretion, through its representative, examine the Insured Person and review his/her medical history; verify the scope of medical services provided to the Insured Person at a medical institution and the expenses incurred and/or request and verify the medical prescription issued to the Insured Person; 10.2.10. At its sole discretion, at any time, remove from the list of providers a provider agreed upon with the Policyholder/Insured Person, including where such provider does not meet the service criteria and standards established by the Insurer, and replace it with another provider acceptable to the Insurer, of which the Policyholder/Insured Person shall be notified no later than 5 (five) business days thereafter; 10.2.11. In the event of detection of falsification or attempted falsification by the Policyholder/Insured Person of information and/or documentation specified in this Contract, require the Policyholder to pay GEL 5,000 (five thousand) for each such case. In addition, upon detection of such cases, the Insurer shall be entitled to unilaterally and immediately terminate this Contract without granting any additional period;

10.2.12. Refuse to pay insurance indemnity in the event of detection of falsification of the fact of occurrence of an insured event and/or documents necessary for receiving insurance indemnity, as well as in the event of submission of false information, and, if insurance indemnity has already been paid, demand repayment of the amount reimbursed;

10.2.13. On behalf of the Insured Person/Policyholder, apply to the Polypharmacy Study Group of the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs of Georgia for the purpose of identifying cases of polypharmacy and further response thereto. At the same time, by receiving insurance services, each Insured Person consents to his/her medical documentation and/or relevant information relating to the patient's health being made available to persons involved in the polypharmacy process;

10.2.14. After reimbursing the Insured Person for medical service expenses, claim compensation for the relevant expenses from the persons responsible for damage caused to the health of the Insured Person;

10.2.15. Unilaterally amend the terms of this Contract. If the Policyholder does not agree in writing to the proposed amendment within 2 (two) business days from receipt of the Insurer's notification regarding such amendment, the Insurer shall be entitled to terminate the Contract within 1 (one) month;

10.2.16. Increase the insurance premium and/or leave it unchanged, while adapting the Contract to changed circumstances arising from a change, during the insurance period, in any component forming the basis for determining the insurance premium. Such right of the Insurer shall arise only if the above-mentioned change adversely affects the basis for pricing, including the basis for determining the initial insurance premium. If the Policyholder does not agree to the proposed amendment within 2 (two) business days from receipt of the Insurer's notification regarding such amendment, the Insurer shall be entitled to terminate the Contract immediately, without granting any additional period;

10.2.17. During the validity period of the Contract, in the event of cancellation and/or amendment by the State of any state and/or referral healthcare programme, amend the terms and conditions specified in the Contract. The Policyholder/Insured Person shall be notified thereof in writing one month prior to the entry into force of such amendments;

10.2.18. Refuse to compensate for damage if the Insured Person or the Policyholder, by his/her actions, obstructs the exercise of a claim for compensation against a third party;

10.2.19. Request from the Policyholder/Insured Person the documentation necessary for concluding the Insurance Contract and receiving subsequent services;

10.2.20. In the event of double insurance, share the expenses related to the insured event with another insurer;

10.2.21. In the event of detection of dishonest conduct on the part of the Policyholder/Insured Person, demand repayment of the amount reimbursed.

10.3. The Policyholder/Insured Person shall be obliged to:

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

10.3.2. Ensure the provision to the Insurer of all necessary and accurate information required for concluding the Contract, in the form established by the Insurer;

		10.3.3. Notify the Insurer of the occurrence of an insured event in accordance with the procedure and within the time limits established by this Contract. At the same time, the Parties acknowledge that delayed notification by the Policyholder may materially affect the interests of the Insurer due to the following circumstances: • obtaining evidence may become impossible; • the Insurer may be deprived of the opportunity to assess the health condition of the Insured Person on site; • the Insurer's right of subrogation granted by law and/or the Contract may be restricted; • the Insurer may be deprived of the opportunity to take timely measures to reduce the amount of loss; • timely identification of the exclusions established by the Contract may be impeded; 10.3.4. Inform the Insured Persons of the insurance terms and conditions specified in this Contract and of the obligations imposed on them in accordance with the requirements of this Contract; 10.3.5. Duly and strictly perform the obligations assumed under this Contract; 10.3.6. If the Insured Person has simultaneously insured the same interest with several insurers, the Insured Person shall immediately notify the Insurer thereof and indicate the identity of all insurers and the amount of the sum insured; 10.3.7. Upon request, grant the Insurer the right and assist the Insurer, after reimbursement of the loss, in verifying the quality of the medical services provided and, if a deficiency in the medical services that resulted in an increase in the loss is identified, in applying to the medical institution and demanding reimbursement of the amount overpaid; 10.3.8. Grant the Insurer the right to apply, on behalf of the Insured Person, to the Polypharmacy Study Group of the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs of Georgia; 10.3.9. If the Insurer discovers that the services received by the Insured Person exceed the insurance limit applicable to the relevant coverage, the Insured Person shall, within 5 (five) business days from the date such excess is discovered by the Insurer and the Insured Person is requested to do so, reimburse the Insurer for the benefit received in excess of the insurance limit. **10.4. The Policyholder/Insured Person shall be entitled to:** 10.4.1. Require the Insurer to provide insurance in accordance with the terms and conditions specified in this Contract; 10.4.2. Upon the occurrence of an insured event, require the Insurer to pay insurance indemnity in accordance with the terms and conditions specified in this Contract; 10.4.3. Require the Insurer to duly perform its obligations; 10.4.4. Terminate this Contract in full compliance with the requirements of this Contract.;
11	**Subrogation rule**	If the Policyholder/Insured Person is entitled to make a claim against a third party for compensation of damage, such claim shall pass to the Insurer if the Insurer compensates the Policyholder for the damage. If the Policyholder waives his/her claim against a third party or the right securing such claim, the Insurer shall be released from the obligation to compensate the damage to the

		extent of the amount that the Insurer could have recovered in reimbursement of its expenses through exercise of such right or submission of such claim. If such insurance indemnity has already been paid, the Insurer shall be entitled to demand its repayment.
12	Term of the contract and conditions for termination (cancellation)	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. 12.2. The Contract may be terminated early either at the initiative of the Policyholder or at the initiative of the Insurer. 12.3. In the event of early termination of insurance at the initiative of the Policyholder, the Policyholder shall in all cases be obliged to notify the Insurer in writing. A wish expressed orally or by telephone notification shall not constitute grounds for cancellation of the insurance. 12.4. The insurance may be terminated at the initiative of the Insurer due to a violation of the obligation to pay the premium 12.5. The Insurer shall be entitled to unilaterally and immediately terminate the insurance if: • the Policyholder/Insured Person/Beneficiary provides the Insurer with incorrect information in any form, falsifies information, or misleads or attempts to mislead the Insurer; • the insurance shall be cancelled on the next business day following receipt by the Insurer of the relevant information. 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. 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.
13	Penalty/sanctions arising from termination of contract	13.1. This Agreement may be terminated early: 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; 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. 13.1.3. In the event of failure or improper fulfillment of the obligations assumed by the parties; 13.1.4. Other cases provided for by this Agreement and the legislation of Georgia. 13.2. In the event of early termination of the Agreement:

		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; 13.2.2. In the event of cancellation of the insurance at the request of the Policyholder/Insured Person: a. the earned premium shall not be refundable; b. the Insured Person shall be obliged to pay a penalty equal to the unearned insurance premium if he/she has received insurance indemnity at least once during the validity period of the Contract, except for family doctor services; c. if the Insured Person has not received any insurance indemnity, he/she shall be obliged to pay, as a penalty, 20% of the unearned premium, except where the Insured Person dies during the validity period of the policy; d. for the avoidance of doubt, the insurance premium earned prior to termination of the insurance shall in all cases be payable by the Policyholder/Insured Person. 13.3. Despite the early termination of this Agreement, each party shall fulfill the obligation that arose before the termination of this Agreement; 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; 13.5. The Insurer shall be entitled to unilaterally amend the terms of this Contract based on the percentage change in the Consumer Price Index in the healthcare sector published by the National Statistics Office of Georgia, in accordance with the percentage increase applicable to the relevant service and proportionally to the share of such service(s) in the Company's total loss ratio, which the Parties shall agree upon by entering into an additional agreement. If the Policyholder does not agree to the proposed amendment within 2 (two) business days from receipt of the Insurer's notification regarding such amendment, the Insurer shall be entitled to terminate the Contract immediately, without granting any additional period. Such notification may be made in accordance with Clause 13.4 of this Contract.
14	Insurance premium and payment terms	**14.1.** The full insurance premium payable by the Insured Person to the Insurer, according to the relevant insurance period and the insurance package selected by the Policyholder, shall be specified in the insurance policy. **14.2.** Upon the first breach by the Policyholder of the insurance premium payment procedure established by this Contract, including where the premium and/or any part thereof is not paid on time or in the prescribed amount, the Insurer shall be released from the performance of its obligations under the Contract.

		The Insurer shall be entitled to suspend the Contract and refuse to compensate insured events after 14 (fourteen) calendar days from the date of breach of the payment schedule, without prior notice, until the Policyholder fully performs his/her financial obligations. The Insurance Contract shall be reinstated only after payment of the insurance premium by the Policyholder. After repayment of the outstanding debt, the Insurer shall not regard events occurring during the period of indebtedness as insured events, and services provided during that period shall not be reimbursed by the Insurer. The Parties further agree that if the Policyholder/Insured Person fails to pay the premium due under the payment schedule within 30 (thirty) days, the Insurer shall, upon expiry of such period, be entitled to terminate this Contract and require the Insured Person to pay the outstanding insurance premium. **14.3.** The Insured Person shall pay the individual insurance premium in monthly instalments. The instalments for the first and last months shall be paid upon purchase of the policy. The insurance premium for the first and last months, constituting the first portion of the insurance premium, shall be paid within 4 (four) calendar days from the signing of this Contract and the material terms of the Contract, while the remaining amount of the premium shall be proportionally distributed over the following 10 (ten) months in equal instalments, based on the result obtained by dividing the remaining premium by 10 (ten) months. For the avoidance of doubt, until payment of the first insurance premium instalment or the one-time insurance premium, the Insurer shall be released from its obligations and the policy shall be cancelled. For a payment to be deemed made and for the payment to be identifiable, the insurance policy/card number must be indicated in the payment document.;
15	Dispute Resolution Procedure	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.
16	Communication between the parties	16.1. A notice from the Insurer to the Policyholder (Insured Person/Beneficiary) shall be sent by SMS, e-mail or postal communication to the contact details and address specified by the Policyholder in the application/insurance policy. The Insurer shall not be liable if the specified contact details are incorrect or have been changed without notifying the Insurer and, as a result, the notice could not be sent or was sent to an incorrect destination. The notice shall be deemed delivered upon dispatch. 16.2. If the Insurer sends a notice to the Policyholder at an e-mail address other than the one specified in the insurance application/policy, the notice shall be deemed delivered on the date of its receipt by the Policyholder/Insured Person, provided that receipt of such notice is confirmed by the Policyholder/Insured Person. 16.3. An insurance policy certified and issued by the Insurer by means of an electronic signature or electronic seal shall have the same legal force as the original. The Policyholder's consent to the insurance terms and conditions expressed through electronic communication with the Insurer shall be equivalent to the Policyholder's signature. The insurance policy and the relevant Contract may be concluded either in written hard-copy form or remotely through the Insurer's website. (https://unison.ge/).

		16.4. On any corporate email of the insurer ending with unison.ge - confirmation is equivalent to a signature.
17	Processing of personal data	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. 17.2. The Policyholder consents to the Insurer processing, in accordance with the legislation of Georgia, the personal data of the Policyholder/Insured Person, including special categories of personal data, within the framework and scope of this Contract, for the purposes of performance of the Contract and, where necessary, transferring such data to third parties. The Insurer shall also be entitled to process the personal data of the Policyholder/Insured Person for marketing purposes, including direct marketing purposes. 17.3. By concluding this contract/policy, the Insured Person 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. 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.
18	Final provisions	18.1. A complaint may be submitted to the Insurer at the following e-mail address: complaints@unison.ge, or by leaving a message with the Insurer's information service at 0 32 2 991 991; 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; 18.3. The relevant annexes to this Agreement are; Appendix #1 - Insurance Packages; Appendix #2 - List of Providers;