Chapter One
GENERAL PROVISIONS

SECTION I. DEFINITIONS

Art. 1. The terms, used in these General Terms and Conditions, carry the meaning as defined below:

1. Insurance contract (Insurance policy), concisely referred to as the "contract" (the "policy"), consists of these General Terms and Conditions, Special Terms and Conditions and Addendums, if any. In respect with the written document, usually the contract is referred to as the "policy". The insurance contract contains specific information about the insured persons, the policy year, the insurance premium, the deductibles, and the commencement of the insurance.

2. Special Terms and Conditions (inventory of the Policy) form part of the contract, which contains specific names, addresses, terms, dates, amounts, coverages, and other terms and conditions, as well as the signatures of the parties to the contract.

3. Addendum is a supplementary part of the contract, which contains amendments or supplements thereof, as well as the signatures of the parties to the contract.

4. Parties to the contract are the insurer and the Policy holder.

5. Insurer is Insurance Sole-Shareholder Joint-stock Company BULSTRAD LIFE VIENNA INSURANCE GROUP EAD, with registered address and address of management at 6, Saint Sofia Street, Sofia city.

6. Policy Holder (negotiator) is the person, who contracts the insurance with the insurer and pays the premium determined by the contract. In case of the insurance applying to the health and/or bodily integrity of the policy holder, he is also the insured.

7. Insured (insured person) is the individual on whose health and/or bodily integrity the insurance is contracted, and to whom the medical expenses are reimbursed and/or the supply of health facilities or services is provided, in accordance with these General Terms and Conditions, the appendices thereto, and the insurance contract.

8. Group is a combination of 10 and more persons united by specific criterion, other than their wish to participate in an insurance.

9. Another beneficiary of coverage is the person to whom under certain stipulations of the contract, the insurance payment is made. Beneficiaries of this insurance might be relatives of first and second degree to the insured person. The beneficiaries shall be specified in the insurance contract.

10. Family member is the spouse, the person cohabitating permanently with the insured, parents, children under the age of 18 (or up to 25 years if they continue their education in high schools or universities), and grandchildren.

11. Health package is the aggregate of regulated in type and scope health facilities and services, provided to the insured person with the purpose of restoration, preservation and improvement of their health, and covered by the insurer under the conditions and the procedure, stipulated in the General Terms and Conditions, the appendices thereto and the insurance contract. To secure financially the usage of the health packages under the present insurance, the insurer implements two approaches, namely:

11.1. Subscription service - the insurer secures financially the health services and facilities purchased by the policy holder only through contracted medical care providers.

11.2. Reimbursement of expenses - the insurer reimburses the expenditures the insured persons have paid to performers of medical services of their own choice, in accordance with the health packages they have purchased, the limits of responsibility and reimbursement percentage, specified in the insurance contract.

12. Insurance event is an event that has occurred within the insurance term, which has its risk covered and at the occurrence of which the insurer pays off the insurance amount or assumes another liability, as specified in the insurance contract.

13. Covered risk is a possible consequence from the occurrence of an insurance event, defined in the conditions of the insurance contract, upon which the insurer has to pay the sum insured or a percentage thereof.

14. Sum insured is a sum that is agreed to be paid by the insurer to the insured under the defined conditions of the insurance contract. The insured sum within the present insurance policy is the maximum size of the insurer's responsibility in accordance with the concluded insurance contract to secure the provided insurance services and facilities and/ or reimbursement of the medical expenditures made within the term of the contract and committed to the medical service of the insured person.

15. Reimbursement percentage is the maximum amount of expenditure on certain type of health facilities or services within the framework of the respective health package subject to recovery by the insurer.

16. Insurance premium (concisely referred to as the „premium") is a sum, which the insurer requires in exchange of assuming the liabilities defined in the insurance contract.

17. Term of insurance (Insurance term) is the term during which the insurer covers the risks assumed. The beginning and the end of the insurance term shall be defined in the Special Terms and Conditions. The date of beginning of the insurance coverage is date of commencement.

18. Policy (insurance) year is a part of the insurance term between two annuities of the contract. The annuities are estimated in reference to the commencement of the insurance term.

19. Date of annual renewal is the date, falling twelve months from the commencement date of the contract.

20. Accident is an unpredicted, random and sudden event of origin extraneous to the insured, caused singularly by violent, incidental, external and visible factors, and not by disease, sickness or gradual mental or physical process, having occurred during the term of insurance and against the will of the insured, and which becomes the cause of physical damage to the insured (external or internal injury, fracture or crack of a bone, joint sprain, rupture or strain of tendon or muscle, burn or damage by frost of corporeal surface, poisoning, suffocation or drowning).

21. Sickness is the aggregate of complaints and clinical symptoms, diagnosed at a licensed medical facility for the first time during the insurance term and registered in an official medical document. The date of primary diagnose is assumed to be the date of occurrence of the sickness.

22. General Sickness is any malady after the criteria of the World Health Organisation, which does not qualify as occupational disease or traumatic injury.

23. Previously existing sickness or condition is a sickness, injury, medical condition or a symptom,

23.1. for which there were sought and procured, or provided for, treatment or medicines, or consultations, or diagnose, on the pa1rt of the person insured or the beneficiary before the commencement of the policy, or

23.2. whose origin goes back to, or about whose existence the insured person knew from before the commencement of the policy, notwithstanding whether treatment or medicines, consultation or diagnosed were sought or procured.

24. Acute sickness is sickness or malady of sudden occurrence, severe symptoms and short duration, including any kind of intense symptoms, like severe pain.

25. Medical necessity is a medical service or treatment, which in the opinion of a qualified medical practitioner is appropriate and consistent with the diagnosis and which in accordance with generally accepted medical standards could not have been omitted without adversely affecting the insured's condition or quality of medical care rendered. Medical necessity is any affection or acute chronic disease, which has caused discomfort to the individual and forced him to seek medical aid.

26. Emergency medical aid is a medical service or treatment of each patient suffering from newly occurred or existing affection that, if no urgent medical activities are taken immediately, could result in death or in irreversible morphological and functional alterations of major organs and systems.

27. Hospital is a medical institution for hospital treatment, established and licensed in accordance with the existing Bulgarian legislation, wherein are treated individuals with acute sicknesses, traumas, intensified chronic diseases, conditions requiring surgical treatment in hospital setting in accordance with the medical standards approved for use in the Republic of Bulgaria. Not qualifying as "hospital" are medical institutions for hospital treatment of individuals in need of prolonged recuperation and individuals with chronic diseases, requiring care and maintenance of satisfactory bodily or mental condition, as well as of individuals in need of physical therapy, motoric and mental rehabilitation, balneo-, climate- and thalassotherapy, as well as the rehabilitation centres and specialized hospitals, clinics and wards for treatment of mental patients, alcoholics and drug addicted.

28. Hospitalization /inpatient treatment, hospital medical treatment/ is uninterrupted, minimum 24-hour long, stay of the insured in hospital for urgent examination, observation or treatment, which has been advised by a doctor. The inpatient treatment cannot exceed more than 12 (twelve) months in total for any one insurance event.

29. Outpatient treatment - medical treatment of an insured person, who is not a hospital patient. Outpatient treatment medical facilities are registered in accordance with the Medical-treatment Facilities Act. Diagnostics, treatment, rehabilitation and monitoring of patients are carried out in these facilities, as also pregnancy monitoring and assistance. The activity of these medical-treatment facilities and of the medical and other specialist working in these facilities are carried out in compliance with the medical quality standards applicable to medical care and ensuring the patient's rights. The medical standards are approved by ordinances of the Minister of Health.

30. Physician is a legally licensed medical practitioner who is a doctor recognized by the laws of Bulgaria where treatment covered under this Policy is provided and who, in rendering such treatment, is practicing within the scope of his / her license and training.

31. Specialist physician is a person, duly qualified and licensed by law to practice medicine and who possesses a certificate of specialized education. The specialist should practice within the limit of the scope of their license and training.

32. Physical and rehabilitation medicine is a clinical medical specialty, mainly therapeutically oriented, which check-ups the biological impact of natural and preformatted physical factors on the human body and applies them through therapy by physical interventions or through medical rehabilitation. The activity is directed by a doctor specialized in „Physical and rehabilitation medicine" and is carried out practiced under his/ her direction. The expenditures on physiotherapy do not include those made on exercises during prenatal or maternity period, sportive massage and occupational therapy.

33. Rehabilitation centre is a medical facility under the health legislation (where hospitals are defined in a different item) for treatment of people who need long-term recovery conditions for the improvement of their health, or for people with chronic diseases, requiring care and support for their bodily and mental condition, as well as people, who need physical

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therapy, motor and mental rehabilitation, balneo-, climato-, and thallasso-treatment.
34. Dentist (Doctor of Dental Medicine) is a physician who is recognized as a dentist by the competent authority.
35. Nursing at Home are the services at the insured's home provided by a government licensed nurse and prescribed by a physician for medical (as distinct from domestic) reasons.
36. Medicaments/prescription drugs are any final product representing a chemical substance or combination of chemical substances, intended for treatment of diseases of humans and is administered for usage in finalized package, as well as any other substance or combination of substances, which can be applied on humans for prophylactic, diagnose, correction or modification of physiological functions of humans, but only those medicaments or pharmaceutical agents, prescribed by a doctor, which are in direct cause-effect relation to the set diagnose and are registered at the Bulgarian Drug Agency. Medicaments, in the sense of these General Terms and Conditions, are also generic medical products that are comparable to the original pharmaceutical product and contain the same active ingredients as the original formulation.
Not eligible for reimbursement are the following:
36.1. Restorative products and food supplements (nutrients);
36.2. Slimming products or products for weight control, for vegetative disturbances during travel, stimulants, anabolic hormones, and other substances with the character of doping;
36.3. Tonic products (roborants), medical wines, fish oil products;
36.4. Laxatives;
36.5. Cosmetic products, medical cosmetics;
36.6. Children food or baby products, other than those prescribed for medical condition covered by the insurance;
36.7. Contraceptives, except when they are used for medical treatment of sickness;
36.8. Colour lenses, computer eyeglasses, eyeglass rims.
37. Product level is the option or the cover level of the insurance coverage, opted for as active by the negotiator and specified in the insurance contract.
38. Package service is a service, which includes examinations and check-ups, ensuring adequate care for pregnant women in compliance with medical standards.
39. Limit of liability is the maximum amount, owed by the insurer according to the applicable product level. This amount should be deducted from the maximum insurance amount per person per one year of insurance. If, in the event of subscription services, the insured person exceeds the covered limit of liability, the insurer has the right to withhold the excess amount from a subsequent claim for reimbursement of expenses.
40. Medical expenses are all reasonable and warranted expenses, made in connection with medical or surgical treatment of medical condition, administered by specialist physician to whom the insured was referred to.
41. Reasonable and customary charges - this phrase should connote the average amount, calculated in relation to valid costs of services or treatment, determined on the basis of the insurer's experience and practice, where the method of their calculation is specified in Art. 16, paragraph 2 of these General Terms and Conditions.
42. Claim - the total amount of treatment costs of each individual accident, bodily injury or sickness.
43. Deductible is the portion of expenses, which remain the liability of the insured person under the conditions, specified in the insurance contract. The insured person should pay the deductible in relation to every individual event that leads to damage claim or its amount is deducted from the insurance payment due.
44. Period of postponement is the period stipulated in these General Terms and Conditions from the beginning of the term of the insurance coverage for insurance events occurred, during which the insurer does not owe any payments.
45. Period of temporisation is the period stipulated in these General Terms and Conditions from the beginning of the term of the insurance coverage, during which the insurer does not owe any payments for an occurred insurance event.

SECTION II. OBJECT

Art. 2. These General Conditions are an integral part of the insurance contract and form the basis, whereupon all claims for insurance payments are to be considered. Each insured person should read them carefully to make sure they understand all terms, exceptions, conditions and limitations.
Art. 3. (1) The insurance contract under this type of insurance is concluded against risks covered in compliance with the conditions of the contract, related to the health or physical integrity of the insured persons.
(2) The insurer undertakes in exchange of payments of insurance premium upon the occurrence of the insurance event within the risk covered to pay the insured sum specified in the terms and conditions of the insurance policy.
Art. 4. (1) Under the Health Care Insurance persons are insured at the insurance age between 18 (eighteen) and 70 (seventy) years.
(2) The minimum acceptance age to insure another beneficiary (a family member) under the coverage of the insurance contract is 0 (zero) years (after the acquisition of a personal identification number), and the maximum is 70 (seventy) years.
(3) The age of the insured is determined in full number of years as of the beginning of the insurance, and the insured person should not be older than 71 (seventy-one) years at the expiration of the policy term.
Art. 5. (1) Under this insurance the insurer insures individuals who are:
1. Citizens of an European Union Member State, who are insured persons under the Law of Health Insurance and possess valid and uninterrupted health-insurance rights as at the beginning of the month preceding the month of the conclusion of the insurance contract or the person's enrolment to it. The presence of valid and uninterrupted health insurance rights for the period of insurance of the person at the EU Member State should be established by presenting to the insurer the official documents and forms, required by the effective Bulgarian legislation.
2. Bulgarian citizens, working under labour contract in the Republic of Bulgaria, or are being insured on other grounds, and having valid and uninterrupted health-insurance rights in accordance with the effective Bulgarian legislation.
3. For all occasions, not mentioned in the above item 1 and item 2, the insurer concludes the insurance contract upon payment of the insurance premium, due by contract, and the fee for issuing an identification card of a foreign citizen in the amount of 85 (eighty five) per cent of the amount of the minimum social security income for self-employed persons in the Republic of Bulgaria at the moment of the person's enrolment to the insurance contract.
(2) An individual, who is not subject to compulsory health insurance in the Republic of Bulgaria, cannot be insured under „Inpatient Aid" package, unless he/she shall pay an additional insurance premium equal to 60 (sixty) minimum health insurance contributions for a self-insured person as at the date on which its individual insurance coverage begins.
Art. 6. If within one-month period following the conclusion of the insurance policy under this insurance, the insured person decides that he/she does not correspond to his/her needs, they have the right to terminate it with a written notice to the insurer and provided that no claims have been filed the insurance premium will be reimbursed, deducting the part corresponding to the time the insurer has been bearing a risk in full extent.
Art. 7. The territorial scope of Health Care Insurance is the territory of the Republic of Bulgaria.

Chapter Two
INSURANCE COVERAGE

Art. 8. (1) The insurer assumes risks, associated with the financial provision of certain health services and facilities in exchange of payment of the insurance premium.
(2) The insurer financially secures the performance and supply of health services and facilities purchased by the negotiator, by contracting health care providers – medical establishments or through a health institution freely chosen by the insured.
Art. 9. The health facilities and services included in the coverage of this insurance are described in Appendix No 1 "Risks covered under Health Care Insurance", which forms an integral part of these General Terms and Conditions.
Art. 10. (1) The health facilities and services enumerated under Appendix No 1 are grouped in six sections and two additional covers to two of the sections, namely:
1. Section I. "Prophylaxis";
2. Section II. "Outpatient Medical Aid" with additional coverage thereto "Pregnancy Monitoring" ;
3. Section III. "Inpatient Medical Aid" with additional coverage thereto "Childbirth"
4. Section IV. "Health Cares"
5. Section V. „Medicaments, bandage materials, auxiliary facilities and consumables";
6. Section VI. „Dental Aid".
(2) The method of use of each one of the services, and namely, in the form of subscription service or through reimbursement of expenses, is described in Appendix No 1.
(3) Depending on the type and scope of health care facilities and services, included in each section, the policy holder is entitled to a choice between three options - Standard, Optimum and Luxe.
(4) The options under paragraph 3, which have been selected upon the conclusion of the contract, cannot be changed during the validity term of the insurance contract.
(5) With respect to persons subject to health insurance in the Republic of Bulgaria, section „Inpatient Medical Aid" shall be used only as building on the main package of NHIF. The insured sum on section „Inpatient Aid" does not include the amount of the clinical pathways or the clinical / ambulatory procedure covered by the National Health Insurance Fund, whether the insured person has been hospitalised or not. Under this section, the insurer covers only expenses, which have been expressly agreed under the Special Terms and Conditions of the insurance contract.
(6) The insured sum under section „Inpatient Medical Aid" for persons, who are not obliged to pay compulsory health insurance in accordance with the Bulgarian law, is limited up to the price of the clinical pathways or the clinical / ambulatory procedure covered by the NHIF paid by NHIF for the respective treatment.
Art. 11. Upon the purchase of sections "Outpatient Medical Aid", "Inpatient Medical Aid" and/or "Health Cares", these all can be used in the form of subscription service, as also in the form of reimbursement of expenses, but after applying a deductible. The provisions of the previous sentence shall be valid, if no other way of use of the above packages has been agreed by the insurance contract.
Art. 12. (1) Additional coverage "Pregnancy Monitoring" to Section "Outpatient Medical Aid" includes additional services to be provided to the insured persons beyond the scope of the "Maternal Health Care" program of the National Health Insurance Find. The scope of

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examinations and check-ups, as also their limit, is described in Appendix No 1. If a package service is used by an insured person, the insurer shall make an insurance payment equal to the amount of the package service, paid by the person, but not more than the limit specified in Appendix 1. To be effected an insurance payment for a package service, the insured person shall be obliged to submit to the insurer detailed information in writing, provided by the medical facility, on the number of examinations and types of check-ups covered by the package price paid.
(2) The insurer owes an insurance payment on the additional coverage „Pregnancy Monitoring" after expiration of a period of temporisation of 3 (three) months following the entry into force of the insurance coverage of the insured person.
(3) Additional coverage "Childbirth" to Section "Inpatient Medical Aid" includes additional services to be provided to the insured persons beyond the scope of the clinical pathways for childbirth of the National Health Insurance Find. The scope of the services and their limit are described in Appendix No 1.
(4) The insurer owes an insurance payment on additional coverage „Childbirth" after expiration of a period of postponement of 6 (six) months following the entry into force of the insurance coverage of the insured person.
(5) The period of temporisation and respectively, the period of postponement in the case of the two types of additional coverage are not applied if an individual has been insured under more than one insurance contract concluded with the insurer and the policy (insurance) term with respect to that individual has not been interrupted.

Chapter Three
EXCEPTIONS FROM THE INSURANCE COVERAGE

Art. 13. Exceptions in this chapter are applicable to absolutely all insurance risks covered by this insurance.
Art. 14. (1) Insurance risks under this insurance and their consequences are not covered when the insurance event is caused by or is resulted of:
1. Medical treatment of a preliminary existing condition or a related condition, and medical expenses arising from such, except in case of sickness or condition with acute occurrence, which could result in a life-threatening situation or a serious decline in the physical functions of the insured person, to overcoming the critical situation, without any subsequent medical treatment for the improvements of their condition;
2. Medical treatment for alcoholism, abuse / drug addiction, drugs and other substances or any condition of addiction of any kind, and any injury or illness arising directly or indirectly from such abuse or condition;
3. Suicide or attempted suicide, self-harm and any unnecessary self-exposure to danger, except in the case of an attempt to save lives;
4. Intentional acts or fraud on the part of the insured, and the consequences of such; premeditated exposure to danger and commitment or attempted commitment of a criminal act; intentional damage inflicted or self-inflicted to their own health; non-compliance with prescribed regimen and / or treatment, simulating disease on the part of the insured person;
5. Damages incurred as a result of the participation of the insured person in high-risk activities such as (but not limited to) the following: automotive sports, air sports, diving deeper than 30 (thirty) meters, any sport involving animals, velocity races, off-piste skiing and racing in any form (except for walking). If any risk sport or activity is not specifically mentioned in this list, the insured person should contact the insurer to see if it is covered under this insurance policy;
6. Damages incurred as a result of the participation of the insured person in military or terrorist activities, riots and the like, as well as in case the injury occurred while the insured person is detained by authorities or in prison;
7. Care or medical treatment, which result directly or indirectly from the human immunodeficiency virus (HIV) or HIV-related diseases, including acquired immunodeficiency syndrome disease (AIDS) or AIDS-related complex (ARC) and any such infection, illness, injury or medical conditions resulting from these conditions, however they might be caused;
8. Cosmetic procedures or plastic surgery, as also any type of health services used to ensure cosmetic effects, removal of fat or other redundant bodily tissues, and any consequences of such medical treatment, examinations and check-ups relating to clarifying weight problems, whether weight gain or loss, eating disorders, whether or not they occur psychological reasons; diagnostics and hair loss treatment; diagnostics and acne vulgaris treatment; removal of lipoma, atheroma and naevus without medical indication;
9. Experimental medical treatment or such without issued permits and the consequences thereof; participation in activities or events for experimental and research purpose, and from experimental and unproven drug therapy;
10. Medicaments and other drugs purchased without prescription, as well as routine or preventive medications, vaccinations and examinations; examinations without diagnosis being made by a doctor;
11. Check-ups without diagnosis being made; examinations and therapies not corresponding to the diagnose;
12. Transplantation, haemodialysis and blood transfusion;
13. Contraception, infertility, fertilization, vasectomy, sexual dysfunctions, including gender reassignment;
14. Venereal diseases, sexually transmitted diseases, infertility and any associated state, or a form of or preparation for assisted reproduction, examinations and check-ups relating to reproductive problems;
15. Travel by plane undertaken by the insured person whose pregnancy is at a stage after the 28th (twenty-eight) gestational week;
16. Conditions resulting from injuries caused during birth, innate defects, diseases or abnormalities that lasted more than two months after birth;
17. Medical treatment of mental, psychic or neurological disorders, including transient depressive experience of life events, nostalgia, psychiatric treatment, as well as the costs of psychotherapist, psychologist, family therapist or counsellor in case of bereavement (with the exceptions of the coverage in the Lux option to the "Health Care" section in both packages);
18. Procedures to correct near-sightedness or far-sightedness with laser producers, the effects of which are of cosmetic and not of medical nature;
19. Laser treatment of prostatic gland;
20. PET scanner;
21. Any type of treatment not subject to approved medical standards or a treatment not compliant with the approved standards;
22. Diagnostics and sleep apnoea breathing therapy;
23. Medical treatment, associated with the collection, storage or implantation of stem cells, whether they belong to the insured person or to a donor;
24. Medical treatment of learning difficulties, hyperactivity, attention deficit disorder, speech therapy, behavioural problems or development problems of the child;
25. Abortion (except miscarriage, ectopic pregnancy or stillbirth);
26. Medical treatment, which is a direct or indirect result of nuclear energy, radioactive emission, nuclear explosions, natural disasters and other similar events with mass effect. Exception on the nuclear energy does not apply in cases where nuclear energy is used for medical treatment.
(2) Except as provided in paragraph 1 the insurer does not cover treatment and does not reimburse expenses in the following cases:
1. Emergency medical care;
2. If treatment is covered by the Ministry of Health and / or the National Health Insurance Fund; or a treatment, under a statutory insurance, state aid scheme, a grant agreement, other contract or a health program;
3. Costs of examinations and check-ups relating to the issuance of any type of medical certificates;
4. Costs of accommodation and treatment in hospices, nursing homes, hydro- or spa facilities, weight loss and / or balanced life clinics, health farm or other similar institutions, or in a medical establishment that has become virtually permanent home or residence of the insured person, and its accommodation there is organised entirely or partly for family reasons;
5. Costs of purchased drugs, auxiliary facilities and sanitary materials after expiration of a fifteen day term from their prescribing and respectively, six months for medicines prescribed on a multiple-use prescription book;
6. Costs of dioptric glasses / contact lenses after expiration of three months from their prescribing. When a dioptric correction of one eye only is prescribed to the insured person, the expenses on both glasses and contact lenses are covered;
7. Costs associated with finding a donor organ, as well as any costs incurred for the removal of the donor organ and / or a donor organ itself and / or travel costs of the provision of such, as well as any associated administrative costs;
8. Costs of implantation of artificial heart;
9. Any expenses arising after the expiry of the policy (insurance) term, unless in case of renewal of the insurance contract for another 12 (twelve) months, as well as any costs incurred after the end of the policy (insurance) term during which the insured person is aged more than 71 (seventy-one) years;
10. Any costs arising from emergency dental treatment, imposed by food or taking drinks (even if they contain a foreign body), normal wear and tear of teeth, brushing teeth or any other procedure for oral hygiene, or any means other than an external impact, any form of restorative or corrective work, the use of precious metals, orthodontic treatment of any kind or dental treatment, administered in a hospital, unless dental surgery constitutes the only possible treatment for pain relief.
11. Costs of coverage of Liquid based cytology (LBC) ThinPrep, with exception of cases of diagnosing precancerous alterations, after routine cytological investigation with cytological findings PAP III or IV;
12. Costs of genetic testing, as in the case the molecular-genetic and biochemical-genetic diagnosis is defined as analysis of DNA, RNA, genes, gene products (proteins and enzymes) and specific metabolites in order to detect changes associated with hereditary or acquired diseases. The method of analysis is carried out by specialized diagnostic genetic testing - cytogenetic and molecular-cytogenetic analysis, molecular-genetic analysis, biochemical genetic analysis;
13. Costs of diagnosis of food allergies, allergy inhaler test;
14. Sclerotherapy of spider and varicose veins, plasmapheresis, hyperbaric oxygen therapy;
15. Costs of medicaments prescribed for treatment of pregnancy-related conditions, if the pregnancy is a risk not covered by the insurance contract;
16. Costs of medicaments prescribed for dental treatment, if the dental aid is a risk not covered by the insurance contract;
17. PrenaTest costs.

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(3) The insurer does not cover inpatient treatment of insured persons not having uninterrupted health-insurance rights or whose health-insurance rights have been interrupted.
(4) Upon making insurance payments, the insurer observes the statutory provisions in the area of health care applicable to the medical insurance activity, including the statutory limits of payment.
(5) Through an explicit agreement in writing between the parties and upon payments of an additional premium, some of the exceptions of the insurance coverage may be covered.
Art. 15. (1) The insurer does not pay and does not refund amounts set by law as consumer fees, as well as any type of administrative charges and fees for issuing and / or obtaining documents, transcripts of documents and any other type of data carriers, as required by the medical establishments.
(2) The insurer does not owe insurance payment in the amount of the deductibles owed by the insured person under the insurance contract.
Art. 16. (1) The insured persons are liable for any expenses incurred by them, wherein the reasonable and usual costs for the same service are exceeded.
(2) The term „reasonable and usual expenses" within the meaning of paragraph 1 shall mean the average price of a particular health good or service, calculated as the simple arithmetic average of the price, which ZEAD BULSTRAD LIFE VIENNA INSURANCE GROUP EAD has paid by subscription for twelve consecutive months ending in the end of September of the previous year for all insurance claims relating to the same type of good or service at the prices of the medical facilities, optics and pharmacies, with which the insurer has contracts concluded.
(3) Every year, at the beginning of January, updated data of the average prices of the most frequently used health goods and services are published on the company's website.

Chapter Four
INSURANCE CONTRACT

SECTION I. PRECONTRACTUAL INFROMATION

Art. 17. (1) The insurance contract is issued on the basis of an insurance application filled by the policy holder, list of the insured persons, statement of their health condition, occupation and activities, as well as other information the insurer can request to assess the insurance risk.
(2) Provided that no insurance contract for any objective reason is signed within 3 (three) months after signing the statement of applicant's health condition, occupation and activities, a new statement is required.
(3) At the conclusion of the contract, the negotiator / the insured is obliged to declare the essential circumstances that are known to them and are relevant to the risk assessment. Essential are considered the circumstances, specifically addressed by the insurer with a question in writing. If a circumstance of essential has been incorrectly declared or suppressed by the negotiator / the insured, the contract is subject to alteration or termination in accordance with the procedure provided for in the Insurance Code.
(4) During the time of validity of the contract the negotiator/ the insured is obliged to declare in writing to the insurer, immediately upon learning about them, any new circumstances related to the occupation, occupational responsibilities, activities and country of residence of the insured. In case of failure, the procedure provided for in the Insurance Code is applied.

SECTION II. CONCLUSION, FORM, ACTION AND CHANGES OF THE INSURANCE CONTRACT

Art. 18. The insurance contract shall be issued by the insurer after the negotiator (the insured) has submitted the required documents.
Art. 19. (1) The insurance contract is concluded with healthy subjects with normal insurance risk.
(2) Persons with increased insurance risk, according to the criteria listed in the health declaration, shall be insured under the conditions laid down in the insurance contract or an annex to the contract and upon additional premium deposition.
Art. 20. (1) The insurance contract is concluded in writing based on a written application following a sample from the insurer to which the following documents are attached:
1. For individual insurance and group insurance of group consisting of less than 20 (twenty) persons - Health Declaration (after insurer's sample);
2. Group insurance for a group consisting of 20 (twenty) and more persons – a list and Health Declaration only at the request of the insurer.
3. For insurance of family members who want to be included in the insurance contract- Health Declaration.
(2) In the cases under paragraph 1, at the insurer's discretion, the contract may be concluded without requiring declarations of health.
(3) In the insurance application the negotiator indicates his choice of sections and options of health facilities and services, as also the format of their supply.
(4) An insurance contract may contain both selected sections, offered in the form of subscription service, and a product level in the form of "Reimbursement of expenses".
(5) If a group insurance contract is concluded without the individual limit of liability for an insured person in the group to be applied as specified in the respective option of the health package, an aggregated limit of liability for the entire group in the amount specified in the contract should apply.
Art. 21. (1) Upon conclusion of a group insurance contract, the negotiator is obliged, upon signing the contract, to provide the insurer with a list of the insured persons.
(2) The list referred to in paragraph 1 contains the following information: full name (Cyrillic), personal ID number (EGN) and selected plan/ product level for each person. When the insured person is a foreigner, the personal number of a foreigner (PNF), gender and date of birth must be shown. The list is after insurer's sample and represents Appendix No 2, which forms an integral part of these General Terms and Conditions.
(3) The negotiator is entitled to update the list of the insured persons during the validity term of the contract, by providing the insurer with the updated data in writing.
(4) The inclusion of a new insured occurs following the negotiator's notification in writing to the insurer and the person's addition to the list under paragraph 1.
(5) The inclusion of family members of insured persons to the group insurance contract shall occur, as follows:
1. Family members of persons included as at the enactment date of the insurance contract, may be added no later than two months after the enactment of the contract;
2. Family members of persons included after the enactment date of the insurance contract, can be added no later than one month after the beginning date of the insurance coverage of the persons concerned.
3. New-born child may be insured within one month after the date of birth.
(6) The negotiator is obliged to explain to the insured persons their rights and obligations under the contract, the medical care providers, the medical care conditions and order to obtain health care services and facilities, and to distribute to them identification cards by list in exchange of signatures on their part.
Art. 22. (1) Upon the payment of the insurance premium, the contract shall enter into force, unless otherwise agreed.
(2) The insurer shall provide to the negotiator/ the insured an identification card and a list of medical care providers that are in contractual relationship with the insurer.
(3) Changes in the list of medical care providers in contractual relationship with the insurer shall be published regularly on the website of the insurer.
Art. 23. (1) The insured person is entitled to the personal usage of the packages and options specified in the insurance contract.
(2) When an insured person has chosen subscription service as a kind of form of this insurance, they are entitled to free choice of a doctor and medical establishment on the entire territory of the country, with whom/which the insurer has a contract. In case that the insured persons have opted for reimbursement of expenses as a form of insurance, they are entitled to free choice of a doctor and medical establishment regardless of whether the insurer has a contract with them.
Art. 24. Costs of health services and facilities, not arranged in the insurance contract, as also those exceeding the liability limit under the contract, remain at the expense of the insured.
Art. 25. (1) The insured persons, upon any visit to the doctor or a medical establishment, identify themselves by means of a personal identity card and identification card with a valid duration.
(2) In case of a lost or destroyed identification card, the insured notifies the insurer, in order to have a copy reissued back to him/her. The insured receives the copy in exchange of a declaration of invalidity of the lost / destroyed document and payment of a fee of 5 (five) Bulgarian leva.
Art. 26. (1) The contract shall remain in force for a period of one year after the commencement date and can be renewed for further periods of one year.
(2) When there is an interruption of coverage, the insurer is entitled to apply article 20, paragraph 1, item 1.
Art. 27. (1) The insurer is entitled to change the size of the premium and/ or conditions of the contract. The negotiator should be informed about the change and be deemed to have consented to this change, unless a written objection against it is deposited within the period specified in the notification. In these circumstances, the insurance shall be terminated on the date specified in the notification by the insurer.
(2) In the event of legislative changes or other changes in circumstances beyond the insurer's control, whose consequences could not be foreseen in advance and that could result in significant changes in the conditions of provision of the insurance protection, the insurer can offer to the negotiator changes in the tariffs and terms and conditions of this insurance. The change takes effect following the consent of the negotiator. In the absence of consent on the negotiator's part, the insurance coverage drops out of the insurance contract and the negotiator is not obliged to pay the insurance premium on it, considered from the date of the change.
(3) The change in the insurance contract is effected by issuing an addendum, which shall take effect at 24 (twenty-four) hours on the date of issue, unless otherwise agreed.
(4) The insurer is entitled to withhold from the payments of the policy all expenses incurred on the part of the insurer in connection with misconduct on the negotiator/ the insured person.
Art. 28. (1) The contract shall be terminated by the end of the insurance period.
(2) The contract may be terminated before the expiration of the insurance period in the following cases:
1. If the insured person has intentionally provided incorrect facts and circumstances;
2. At the age of 71 years in the case of the insured person the insurance coverage shall terminate on the last day of the insurance year, in which the insured person has reached

Negotiator: .....
/Signature/

this age;
3. By a unilateral statement by the negotiator to the insurer in case of drop off of insurance interest during its term of effect - within three months before the expiration of the insurance year, with the insurer being exempt from liability to refund the insurance premium;
4. In individual insurance contracts - upon the death of the insured, in which case the insurer shall not refund the insurance premium;
5. In the event a postponed contribution of the insurance premium due (including the tax) at a particular maturity date, according to the contractual terms and conditions, has been delayed more than 15 (fifteen) days – in accordance with the procedure stipulated by the Insurance Code.
6. In other cases expressly stipulated in the insurance contract or referred to in the Bulgarian legislation.
(3) An early termination of an individual insurance coverage of an insured person under a group insurance contract enters into force as of the date of return of his/her identification card to the insurer. Until the date of return of the card, the negotiator owes payment of the insurance premium with respect to the individual.
(4) In the event the insurance contract has been concluded by an employer and the insured persons are his employees and/or workers and/or individuals hired under civil contracts or management contracts, the negotiator is obliged to take the identification card of the insured person on the date of termination of the employment relationship between them, and to return it to the insurer. Otherwise, the negotiator will bear all expenses incurred after the date of termination of the individual insurance coverage for the particular individual.
(5) In case of early termination of the contract through the fault of the negotiator, the insurer is not liable to refund any unused premium for the rest of the insurance period, unless otherwise agreed.
(6) In the event of net loss ratio exceeds 150 per cent during the term of the insurance contract, the insurer is entitled to propose increase of the insurance premium. In case the negotiator does not accept the proposal, the insurer is entitled to an early termination of the insurance contract. In case the negotiator has paid insurance premium for a period after the termination date, the insurer is liable to refund it.
(7) Upon an early termination of the contract, the insured persons are required to return as soon as possible the identification cards to the insurer. Any expenses incurred by the insured person in the form of reimbursement of expenses after the end of his/her individual insurance coverage are not liable to payment by the insurer.
Art. 29. The insurer is entitled to refuse the renewal of the insurance contract, as well as to terminate or alter the conditions of the contract, if:
1. There has been on the part of the negotiator / insured person the perpetration of fraud, misrepresentation of facts, as well as if false statements have been made. In this case, the insured persons should return any amounts already paid to them under the insurance contract.
2. The negotiator / insured person has violated conditions of the insurance contract.
Art. 30. The insurance contract may not be terminated by the negotiator in case of:
1. Change of the insurance premium and / or other conditions resulting from the legal provisions;
2. Change leading to reduction of the amount of insurance premium and/ or expanding of insurance coverage.
Art. 31. (1) The insurance premium is specified in the insurance contract.
(2) The insurance premium is paid of once or annually. Through a written agreement between the parties to the contract, the premium payment may be rescheduled.
(3) The insurance premium is paid at the conclusion of the Insurance contract, for all insured persons covered by the contract, unless otherwise agreed.
(4) The negotiator is obliged to pay the insurance premium, or instalments thereof in the case of deferred payment and time limits specified in the contract. In case that the negotiator has delayed payment of a premium or any instalment thereof, or has paid an amount smaller than the amount due, the insurer can reduce the insured sum, alter the contract or terminate it in accordance with the procedure provided for in the Insurance Code.
Art. 32. (1) In case that the age of the insured person was listed incorrectly and as a result the insurance premium paid is insufficient the negotiator is liable to immediate payment of the balance of the premium.
(2) In case that the age of the insured person was incorrectly listed and as a result, a higher amount of insurance premium was paid, the insurer is liable to refund the premium excess without interest.
(3) In case that the age of the insured person was incorrectly listed, but because of their precise age the insured person is entitled to no coverage under this insurance, the insurer does not owe insurance payments, and its liability is limited only to the refunding without interest of the total insurance premium paid.
Art. 33. (1) The insurer shall prepare a health record of the insured person and keep a record of the insured persons, which contains the necessary information about their health status, premiums and instalments paid, health services and facilities used, and expenses reimbursed.
(2) Upon request of the insured, the insurer shall provide, at the end of each policy (insurance) year, information about the health care services and facilities used.
Art. 34. The insurer is entitled to be informed about the health of the insured persons and may, during the term of the insurance contract, carry out checks through its internal or independent experts, and to request additional information about the health condition of the insured person from the health care providers.

Chapter Five
RELATIONSHIPS UPON OCCURRENCE OF AN INSURANCE EVENT

Art. 35. (1) The insured person is required to submit all documents related to the establishment of the event.
(2) If the presented documents reveal that the data for risk assessment have been wrongly presented in the insurance application, or a change has occurred without the insurer receiving information for that, the sum insured or part of it shall be changed according to the correct data and the insurance premium paid.
(3) The insurer has the right to decline payment of sum insured or percentage of it, if the policy holder / the insured has presented wrong or forged proof or documents.
Art. 36. (1) To perform insurance payment upon reimbursement of expenses paid, i.e. in cases when the expenses have been made by the insured, he/she should present the following documents (in original or a certified copy):
1. Application after insurer's sample;
2. Medical application, filled in by the doctor, who performed and / or assigned the treatment;
3. Prescriptions for medications and auxiliary facilities prescribed, if they have not been recorded correctly in a medical document (ambulatory list or other document containing identical requisites);
4. Invoices for the incurred expenses with recorded separate positions for each service provided (or a breakdown of separate expenses enclosed to the invoice), along the fiscal receipts thereto, originals are required;
5. Epicrisis from the hospital facility;
6. Description of the medical services provided;
7. Paramedic transport - documents proving the necessity of such issued by health care providers;
8. For dental aid - radiography for treatment of pulpitis, periodontitis and surgical services; an ambulatory list containing the procedures performed. For children up to 18 years of age and pregnant women, X-ray radiography is not required. A document evidencing the full dental status of the insured person shall be enclosed to the first dental-related claim recorded;
9. Stickers for purchased dioptric glasses / contact lenses and for the medical products used;
10. Stickers for medical devices used or other evidence certifying the use of the medical device, issued / provided by the medical facility which has conducted the operational intervention;
11. Any other documents verifying the date, the cause and the circumstances of the insurance event, or evidencing the medical expenses made;
(2) All forms of claims should contain precisely listed invoices and enclosed invoices and receipts, containing the following requisites:
1. Patient's name;
2. Printed invoice number;
3. Name and practice of the practicing medical specialist or medical facility;
4. Description of the services or products provided;
(3) In the event the documents submitted in accordance with paragraph 1, item 4 do not contain separate positions for each service provided and respectively, there is no data of the prices of each service provided, in the case of an inpatient treatment the insurer will pay the price claimed, but not more than 30% (thirty percent) of the price of the respective clinical pathway or the clinical / ambulatory procedure; respectively, in the event of an outpatient treatment, the insurer will pay the price claimed, but not more than the average price of the service calculated in accordance with Article 16, paragraph 2 of these General Terms and Conditions.
(4) Each invoice for purchase of medical supplies should be supplemented with a medical document containing the medicine prescribed and/or prescription and a cash receipt. The invoice should contain a description of the purchased medicines.
(5) All required documents, which are necessary to determine the basis and amount of the insurance payment shall be provided at the expense of the insured person.
Art. 37. In case of death of the insured person, following the procurement of health services, the insurer shall refund the medical expenses to the legal inheritors of the insured, after corroborative documents or documents issued by the medical establishment rendering the service have been submitted.
Art. 38. (1) The insurance payment is made within 15 (fifteen) days from the date of submitting to the insurer of all requested documents.
(2) Should additional evidence be required for the elucidation of the causes and circumstances of the occurrence of the insured event, which have not been expressly specified in the insurance contract upon its conclusion and which are necessary to establish the grounds and amount of the claim, the insurer shall notify the insured / beneficiaries under the insurance contract that additional evidence is required, at the latest within 45 (forty-five) days of the submission of evidence established by the insurance contract.
(3) In case of a partial or full refusal to make an insurance payment, the insurer shall inform the insured person about its arguments; the notification may be made through either one of the following methods: by a letter, an e-mail message, depending on the method chosen by the insured person in his/her application for payments of amounts.
Art. 39. The insurer makes insurance payments up to the limit of liability specified in the insurance contract for each level of coverage of the respective insured for insurance

Negotiator: .....
/Signature/

events occurring during the insurance term, for which are made reasonable and necessary expenses.

Art. 40. The liability of the insurer in respect of all claims filed shall terminate immediately upon termination of the insurance contract and/ or removal of the insured person from the policy.

Art. 41. (1) The insured person is liable to refund expenses incurred by the insurer in the following cases:

1. if the insured person has failed to return his/her identification card after the termination of his/her individual insurance coverage and has incurred expenses at medical establishments with which the insurer has a contract - he/she owes to the insurer all amounts paid by the latter to the medical establishment for medical services, which have been provided after the termination of his/her individual insurance coverage;
2. if the insured person has exceeded the limit set for the subscription service – he/she owes to the insurer all amounts paid by the latter to the medical establishment in excess of the limit of liability;
3. if the insured person has received a treatment or a health service in the form of subscription service that represent a risk excluded from the insurance;
4. in any other case of insurance payments not stipulated as due by the insurer, which fall outside the scope of the payments agreed upon under the insurance contract and specified in these General Terms and Conditions.

(2) The insurer notifies in writing the insured person about the amount, and terms and conditions of reimbursement of the amounts.

Art. 42. (1) When to the subject of the insurance contract an option "Prophylaxis" is included, the negotiator should prepare in advance an application for prophylactic screening to be conducted, indicating therein the desired period of performance, which covers extends to no more than 90 (ninety) days and shall commence no earlier than 30 (thirty) calendar days from the date of submitting of the preliminary application to the insurer.

(2) The preliminary application to shall be submitted to the insurer within a period not later than 120 (one hundred and twenty) days before the end of coverage under the insurance contract, and the application to may be sent by a letter, e-mail or fax.

(3) The Insurer shall provide the negotiator with information about the minimum number of persons that can be listed for prophylactic screening at the same day, depending on the insurance coverage, not later than 30 (thirty) days prior to the period, requested as per paragraph 1.

(4) The negotiator shall submit a final schedule with the desired dates for the prophylactic screening of the insured persons within a period not later than 30 (thirty) days prior to the first opted date for prophylaxis. The schedule should include specific dates and explanations as to the number and spatial location of the individuals in the cases when those insured under the contract reside in more than one locality.

(5) The negotiator shall send to the insurer the name registers of persons subject to prophylactic screening, as well as the dates on which they shall pass screening within a period not later than 7 (seven) days before the medical check-ups, as specified in the final schedule described in paragraph 4.

(6) The insurer organises additional (spare) dates for the prophylactic screening of persons who, for objective reasons, have been unable to pass on the main timeline. The number of additional (spare) dates is determined by the insurer and depends on the number of the insured persons and the insurance coverage.

(7) The negotiator is obliged to inform and organise the insured persons to conduct the prophylactic screening, according to the final schedule submitted to the insurer.

(8) In case the insured persons fail to appear for the prophylactic screening on the scheduled main date and the arranged spare dates, the obligation of the insurer for organising and conducting the screening shall be considered discharged.

Chapter Six
ADDITIONAL PROVISIONS

Art. 43. In case of sickness or accident the insured shall be obliged to cooperate for the speediest possible recovery and in any medical examinations desired by the insurer, or any supervision in a hospital requested by the insurer, all this at the expense of the insurer.

Art. 44. As soon as an insurance event occurs, the insured must make every effort to limit its consequences.

Art. 45. The insurer shall have the right, through its medical representatives, to examine any insured whenever and as often as the insurer may reasonably require within the term of issuance of a decision on the claim for insurance payment filed by the insured person.

Art. 46. (1) All notifications, for which the law requires an official written record, and which shall be sent to the negotiator or the insured person shall be sent to the last address of which the negotiator has notified the insurer in writing. The insurer's obligations are considered to be observed if the notification is sent to the last known address of the negotiator/insured person.

(2) All notifications, for which the law requires an official written record, and which shall be sent to the insurer have to be sent / deposited in writing to the correspondence address of the insurer.

(3) All notifications, for which the law does not require an official written record, may be exchanged by e-mail as well, if the insured person has expressed his/her wish and specified a current e-mail address.

(4) The date of notification reception is considered to be the notification date, unless the insured has failed to inform the insurer about his/her current address, and respectively, the insured person – of his/her current address or a change in his/her e-mail address. In the latter case, the date when the notification has been sent off is considered to be notification date.

Art. 47. In case of loss or destruction of the policy, the negotiator should immediately notify the insurer so that a certified copy should be reissued back to the negotiator. The negotiator receives the copy in exchange of declaration of invalidity of the lost / destroyed copy.

Art. 48. (1) All personal data obtained in connection with the insurance contract are used for the policy preparation and maintenance. The insurer shall not disclose the personal data without the consent of the person concerned, except for the cases specified by the legislation or in prevention of insurance fraud.

(2)The insured persons agree that the insurer has the right to obtain personal information by medical and other parties with regard to their health condition.

Art. 49. On the grounds of article 19, paragraph 1 of the Personal Data Protection Act, the insurer informs the negotiator and the insured that:

1. The insurer is registered with the Personal Data Protection Commission as an administrator of personal data.
2. The personal data presented shall be used by the Insurer for the purposes of: conclusion and administration of contracts, accomplishment of the legal rights and interests of the insurer with regard to the insurance contracts concluded.
3. Following explicit content, the personal data can be disclosed to the following categories of recipients: bodies with "personal data administrator" clearance under §1, item 3 of the Personal Data Protection Act; third parties for the purposes of direct marketing; third parties, institutions or organisations when revealing the data follows explicit law regulation; third parties for statistical purposes; third parties following explicit agreement between the parties.
4. Presenting the personal data is entirely of a free will. Refusal of their presentation is grounds for the insurer to refuse to conclude a contract or take other action, should the lack of this data prevents the insurer from performing an objective risk assessment or threaten the accomplishment of its legal interests.
5. Any person, who has presented their personal data, has the right of access to it, as well as the right to ask for data amendment following the procedure and terms, defined in the Personal Data Protection Act.

Art. 50. If the coverage under insurance contract with this insurance has been covered by other insurance contract(s), concluded with an earlier date, the insurance contract shall cover only the excess of the coverage, provided by the other insurance contract(s).

Art. 51. The rights under this insurance contract become void by prescription following a term, defined by the effective Bulgarian legislation.

Art. 52. (1) These General Terms and Conditions form an integral part of the insurance contract and should be considered together to avoid any misunderstanding.

(2) Promotional materials or informative brochures are not part of the insurance contract.

Art. 53. Any disputes between the parties shall be settled by mutual consent and in the absence of accord - by the competent Bulgarian court. Bulgarian law is applicable.

Art. 54. Any taxes, fees and others of the like which are actual or are to be fixed on the received insurance payment, are charged to the beneficiaries, the insured or their heirs.

Art. 55. Any subsequent amendments and supplementations to the present General Terms and Conditions shall enter into force only for insurance contracts concluded following the date of alteration and do not affect the extant, unless it should be required by a recent amendment of legislation or should the parties arrange otherwise.

FINAL PROVISIONS

§1. These General Terms and Conditions have been adopted at a meeting of the Managing Board of ZEAD Bulstrad Life Vienna Insurance Group EAD by decision under Minutes No. 104 dated 27th February, 2013, as amended and supplemented by decision under Minutes No. 147 dated 10th December, 2014, as amended and supplemented by decision under Minutes No. 210 dated 30th May 2017, effective 01st July 2017.

§2. An integral part of these General Terms and Conditions are Appendix No 1 "Risks covered under Health Care Insurance" and Appendix No 2 "Sample of a List of the Insured persons".

The negotiator attests that he is aware of these General Terms and Conditions, accepts them and will communicate them to all interested parties.

Negotiator: .....

(Name of the company, UIC)

Insured person : ..... Signature: ..... Date: .....

(name, father's name, surname)