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TERMS & CONDITIONS

Individual Health Insurance

#MED-001/26

TBC INSURANCE

Definitions

For the purposes of this insurance, the terms used in these Insurance Terms and Conditions shall have the meanings set out below:

Insurer
JSC "TBC Insurance"

Policyholder
A natural person who enters the Insurance Contract with the Insurer for his/her own benefit and/or for the benefit of one or more third parties and is responsible for the payment of the Insurance Premium. For the avoidance of doubt, where the Insured is a minor, the Policyholder may only be the Insured's legal representative (parent or legal guardian).

Insured
A natural person specified in the Insurance Policy and in whose favour insurance is effected under the Insurance Contract.

Beneficiary
A person entitled to receive Insurance Indemnity and/or services provided under the Insurance Policy. For the purposes of this insurance, the Beneficiary shall be the Insured.

Insurance Policy
A document issued by the Insurer evidencing the existence of insurance coverage. In case of any inconsistency between the Insurance Policy and the Insurance Terms and Conditions, the provisions of the Insurance Policy shall prevail.

Insurance Premium
The consideration payable by the Policyholder to the Insurer in the amount and in the manner specified in the Insurance Policy.

Earned Premium
The portion of the Insurance Premium attributable to the period elapsed from the commencement of the Insurance Period up to a specific date. The amount of Earned Premium shall be calculated on a pro rata basis for the relevant period. The Insurance Premium shall be earned on a daily basis.

Unearned Premium
The portion of the Insurance Premium attributable to the period remaining from a specific date until the expiry of the Insurance Period. The amount of Unearned Premium shall be calculated on a pro rata basis for the relevant period. The Insurance Premium shall be earned on a daily basis.

Insured Event
An event defined by the Insurance Contract and the Applicable Insurance Coverage, which occurs during the Insurance Period (following the expiry of the Waiting Period, where applicable) and gives rise to the Insurer's obligation to provide Insurance Indemnity and/or finance covered medical services in accordance with the terms and conditions of the Insurance Contract.

Insurance Indemnity
The amount payable by the Insurer to the Beneficiary / Medical Provider upon the occurrence of an Insured Event, in accordance with the terms and conditions of the Insurance Contract.

Insurance Period/Contract Term
A one-year period during which the Insurance Coverage remains in force under the Insurance Contract.

Continuous Policy Renewal
The issuance of a new Individual Health Insurance Policy upon the expiry or early termination of the Insurance Period under an Insurance Policy issued pursuant to these Insurance Terms and Conditions, provided that the Insurance Period of the new policy commences on the calendar day immediately following the expiry or termination of the Insurance Period of the current policy.

Continuous Individual Insurance Period
The aggregate of the Insurance Periods of continuously renewed Individual Health Insurance Policies.

For the avoidance of doubt, a Continuous Individual Insurance Period shall not include a situation where a person was insured by another insurer and, upon the expiry of the previous policy, purchased an Individual Health Insurance Policy from JSC "TBC Insurance", and/or a situation where a person was covered under a corporate health insurance policy issued by JSC "TBC Insurance" and, upon the expiry of such policy, purchased an Individual Health Insurance Policy.

Waiting Period
A period during which the Insurer shall not reimburse the cost of medical services incurred by the Insured. The duration of the Waiting Period shall be calculated based on the Continuous Individual Insurance Period.
In the event of any interruption between the cancellation and/or expiry of the current policy and the issuance of a new Insurance Policy, the Waiting Period shall recommence from the beginning as of the start date of the new Insurance Period. In the case of Continuous Policy Renewal, the period already elapsed within the Continuous Individual Insurance Period shall be credited against the applicable Waiting Period.

Insurance Card
An Insurance Card purchased by the Policyholder and specified in the Insurance Policy, setting out the Insurance Coverages provided under the Insurance Terms and Conditions together with the applicable Insurance Limits and Coverage Percentages. A digital version of the Insurance Card shall be available through the Insurer's Mobile Application.

Insurance Coverage
The scope of medical services available under the Insurance Card, within which the Insurer reimburses the Insured's medical expenses, as further described in detail in Annex No. 1.

For the avoidance of doubt, the Insurer shall assign a specific medical service to the relevant Insurance Coverage in accordance with the definitions set out in Annex No. 1 and shall reimburse the cost of such medical service within the applicable reimbursement percentage and Insurance Limit of the relevant Insurance Coverage, irrespective of the meaning or interpretation of the term or terms used in the title of such coverage in any other source.

Coverage Percentage
The percentage of the cost of a medical service covered under the applicable Insurance Coverage, within which the Insurer undertakes to reimburse the Insured for medical expenses in

accordance with the terms and conditions of the Insurance Contract.

Sum Insured/ Insurance Limit/ Sub-limit
The maximum amount payable by the Insurer during the Insurance Period in respect of medical services covered under a specific Insurance Coverage. The applicable Insurance Limits are specified in the Insurance Card. Upon exhaustion of a limit or sub-limit, no other limit and/or sub-limit available under other Insurance Coverage may be used for reimbursement of such services.

Co-payment
The portion of the cost of a medical service payable by the Insured, taking into account the applicable Coverage Percentage;

Policy Territory
Georgia, excluding the occupied territories.

Medical Provider
A natural person or legal entity from whom the Insured may receive medical services on the basis of a Referral and/or Guarantee Letter. The list of Medical Providers is available through the Insurer's mobile application. The Insurer shall be entitled, at any time and without prior notice to the Policyholder and/or the Insured, amend the list of Medical Providers.

Medical Institution
A medical and/or pharmaceutical facility/pharmacy operating in the territory of Georgia and duly authorized to perform the relevant activities in accordance with the laws of Georgia.

Hired/Invited Doctor
An independent medical practitioner/physician whose fee for medical services provided or to be provided to the Insured at the relevant Medical Provider exceeds the minimum tariff or price established by the same Medical Institution for an analogous or identical medical service.

Referral/Guarantee Letter
A document issued by the Insurer and/or its duly authorized representative in physical or electronic form, entitling the Insured to receive the specific service indicated therein and covered under the Insurance Contract, until the expiry of the Insurance Period.

Medical Necessity
A health condition which, based on generally accepted medical practice in Georgia and/or internationally, applicable clinical guidelines and treatment protocols, requires medical intervention (including treatment or diagnostic examination) as prescribed by a physician duly authorized to practice within the relevant medical specialty or subspecialty. Such Medical Necessity must be supported by the submitted medical documentation (such as an outpatient medical record, inpatient medical record and/or Form No. IV-100/a etc.), and all such medical documentation must be consistent with one another and with the relevant diagnosis(es).

Personal Accident
An unforeseen and unexpected event caused by the direct impact of identifiable external forces (physical, mechanical, thermal or chemical), resulting in bodily injury to the Insured.

Urgent Medical Condition
A sudden deterioration of health where a delay in medical treatment exceeding twenty-four (24) hours results in death, significant deterioratin or loss of working capacity.

Urgent Medical Intervention
A medical intervention which must be performed without delay, the postponement or failure of which would inevitably result in the patient's death, permanent total disability or permanent partial disability.

Professional Sports
Sporting activities conducted on a professional basis, including the training of professional athletes and sports clubs, as well as participation in local and international sporting events and competitions.

1. SUBJECT OF INSURANCE

1.1. The subject of Insurance is the Insured's financial interest related to his/her health, which includes reimbursement and/or financing of the costs of medical services incurred as a result of the occurrence of an Insured Event defined under the Insurance Contract.

1.2. The insurance shall apply only to those services and expenses that are expressly covered under the relevant Insurance Coverage, subject to the applicable Exclusions and Insurance Limits. For the avoidance of doubt, the insurance shall not apply to any service that is not expressly included within the respective Insurance Coverage.

1.3. The insurance provided under these Insurance Terms and Conditions is based on the information supplied to the Insurer by the Policyholder and/or the Insured. If such information is not provided to the Insurer and/or contains incorrect or inaccurate data, the Insurer shall be released from the obligation to perform its obligations under the Insurance Contract.

1.4. The Insurer shall remain released from the obligation to perform its obligations under the Insurance Contract even after the occurrence of an Insured Event, if the circumstance in respect of which the obligation to provide information was breached had an impact on the occurrence of the Insured Event and on the Insurer's performance of its obligations.

2. INSURANCE PROCEDURE

2.1. Only one Insurance Policy may be purchased in respect of a single natural person (Insured). Accordingly, double insurance under the Individual Health Insurance Terms and Conditions with the Insurer shall not be permitted. In the event that two or more active Insurance Policies exist in respect of the same Insured, only the Insurance Policy purchased first shall remain valid and applicable.

2.2. The following persons shall not be eligible for insurance coverage:

2.2.1. Persons insured under the Insurer's Corporate Health Insurance.

2.2.2. Persons who, at the time of issuance of the Insurance Policy and/or commencement of the Insurance Period, are receiving inpatient treatment, are bedridden and unable to move independently, and/or require assistance in performing activities of daily living.

2.3. If the Policyholder purchases insurance for a person who is not eligible for insurance coverage (including the Policyholder himself/herself), such person shall not be considered an Insured, even if the applicable Insurance Premium has been paid in respect of such person. Any Insured Event related to such person shall not be subject to reimbursement by the Insurer. If Insurance Indemnity has already been paid, the Policyholder and/or the Insured shall be obliged to return such amount to the Insurer unconditionally. In such case, the Insurer shall be entitled to terminate the Insurance Contract.

2.4. If a person is insured under an Individual Health Insurance Policy and subsequently wishes to enroll in the Insurer's Corporate Health Insurance program, the authorized manager shall communicate with such person and provide him/her with the option either to remain insured under the Individual Health Insurance Policy, in which case such person shall not be eligible for enrollment in the Corporate Health Insurance program, or to enroll in the Corporate Health Insurance program, in which case the Individual Health Insurance Policy shall be terminated.

3. MAJOR RIGHTS AND OBLIGATIONS OF THE PARTIES

3.1. **The Insured shall be entitled to:**

3.1.1. Request and receive financing of covered medical services and/or Insurance Indemnity upon the occurrence of an Insured Event, in accordance with the terms and conditions of the Insurance Contract;

3.1.2. Request an oral and/or written explanation of the reasons on the basis of which Insurance Indemnity was denied;

3.2. **The Insured shall be obliged to:**

3.2.1. Receive medical services only from duly licensed and/or authorized Medical Institutions and/or from physicians certified in the relevant specialty;

3.2.2. Submit to the Insurer all documents relating to an Insured Event as required under the Insurance Contract in the Georgian language. Documents in any language other than Georgian may be submitted to the Insurer only if accompanied by a notarized Georgian translation;

3.2.3. Provide the Insurer with all information, documentation and materials necessary to enable the Insurer to pursue subrogation and/or recourse claims against persons responsible for the damage caused to the Insured;

3.2.4. Familiarize himself/herself with the Insurance Terms and Conditions in detail and act in accordance therewith;

3.2.5. Provide the Insurer with all information, documentation and consents necessary for the conclusion of the Insurance Contract, the performance of contractual obligations and/or the settlement of claims.

3.3. **The Policyholder shall be obliged to:**

3.3.1. Disclose to the Insurer, upon entering into the insurance relationship, all circumstances that may have a material impact on the Insurer's decision to decline the Insurance Contract or to conclude it on modified terms and conditions;

3.3.2. Cooperate with and assist the Insurer in obtaining and investigating information and documentation relating to the occurrence of an Insured Event and its consequences.

3.4. **The Insurer shall be obliged to:**

3.4.1. Issue the Insurance Policy and provide the Policyholder with the Insurance Contract and the related documentation;

3.4.2. Subject to the due performance by the Policyholder and/or the Insured of their obligations under the Insurance Contract, provide Insurance Indemnity and/or finance covered medical services in favour of the Insured, the Policyholder and/or the Medical

Institution upon the occurrence of an Insured Event, in accordance with the terms and conditions of the Insurance Contract;

3.4.3. Ensure high-quality insurance services and continuously monitor the quality thereof.

3.5. **The Insurer shall be entitled to:**

3.5.1. Refuse to pay Insurance Indemnity in the event of a breach by the Policyholder and/or the Insured of the terms, conditions and procedures set out in the Insurance Contract;

3.5.2. Refuse to pay Insurance Indemnity in the event of the detection of falsification by the Insured, the Beneficiary and/or the Policyholder (or with their participation) of the occurrence of an Insured Event and/or any document or information required for obtaining Insurance Indemnity, as well as the submission of false, incorrect or inaccurate information and/or documentation. If Insurance Indemnity has already been paid, the Beneficiary shall be obliged to return such amount to the Insurer unconditionally. Furthermore, the Insurer shall be entitled to cancel and/or terminate the insurance coverage immediately;

3.5.3. Demand repayment of any Insurance Indemnity already paid if it is subsequently determined that the loss was not caused by an Insured Event.

3.5.4. Disclose information relating to the Insured (including Personal Data) to Medical Providers for the purpose of ensuring the timely and efficient provision of insurance services and/or fulfilling obligations imposed by applicable law. The Insurer shall also be entitled to obtain from Medical Institutions all information necessary for the performance of its obligations under the Insurance Contract, including Personal Data and health-related information concerning the Insured;

3.5.5. Require the Policyholder and/or the Insured to provide, in the form prescribed by the Insurer, all information necessary for the conclusion of the Insurance Contract;

3.5.6. Refuse to finance medical services and/or an Insured Event (including payment of Insurance Indemnity) where the respective medical service is provided prior to the commencement of the Insurance Period, prior to the expiry of the applicable Waiting Period, and/or after the expiry of the Insurance Period. If an Insured Event and/or the receipt of medical services commenced during the Insurance Period and continues after its expiry, the Insurer shall reimburse only those costs relating to medical services actually provided during the Insurance Period.

3.5.7. Not issue a Referral / Guarantee Letter where its validity period exceeds the Insurance Period;

3.5.8. Following the occurrence of an Insured Event, require the Insured and/or the Policyholder to provide any certificate(s), document(s) or information necessary to determine the circumstances of the Insured Event and/or the extent of the loss. In addition, where necessary, require the Insured to undergo a medical examination by a physician designated by the Insurer and, where appropriate, obtain and review the Insured's medical records and medical history;

3.5.9. The Insurer's representative shall be entitled to verify the scope and nature of medical services provided to the Insured by a Medical Institution, as well as the related expenses;

3.5.10. Claim compensation for the relevant expenses from persons responsible for the damage caused to the Insured's health. The Insurer shall also be entitled to demand repayment of any Insurance Indemnity already paid where, due to the fault of the Policyholder and/or the Insured, the Insurer is unable to exercise its right of subrogation and/or recourse;

3.5.11. Verify whether the Insured is insured under a health insurance policy issued by another insurer and, if such coverage exists, obtain information from such insurer regarding the terms and conditions of the Insured's health insurance, share with such insurer the documentation submitted by the Insured, and apportion the costs of the Insured Event between the insurers. Furthermore, where the Insurer requires the Insured's consent in order to obtain information from another insurer, the Insured shall be obliged to provide such consent unconditionally and in the appropriate form.

3.5.12. Where the cost of a single Insured Event and/or the amount payable in respect thereof exceeds GEL 1,500 (one thousand five hundred), the Insurer shall be entitled to deduct in full the Unearned Premium remaining under the Insurance Policy from the amount otherwise payable and to pay Insurance Indemnity and/or finance the relevant medical services only in the amount of the remaining balance. For example, if the amount payable in respect of a medical service is GEL 1,600 and the Unearned Premium remaining under the Insurance Policy is GEL 500, the Insurer shall be entitled to finance such medical service in the amount of GEL 1,100 (GEL 1,600 less GEL 500).

4. LIABILITY

4.1 In the event of the first occurrence of fraud, falsification or attempted falsification of the terms and conditions set out in the Insurance Contract by the Policyholder and/or the Insured, or in the event of falsification of an Insured Event, submission of forged documents, or provision of false, incorrect or inaccurate information and/or documentation to the Insurer, the Insurer reserves the right to cancel the Insurance Policy and refuse to pay Insurance Indemnity. If Insurance Indemnity has already been paid, the Insured and/or the Beneficiary shall be obliged to return such amount to the Insurer unconditionally. In addition, the Insurer shall be entitled to impose a one-time penalty of GEL 2,000 (two thousand) on the Insured and/or the Beneficiary.

5. ENTRY INTO FORCE OF THE INSURANCE CONTRACT AND RENEWAL OF ITS TERM

5.1. The Insurance Contract shall enter into force at 00:00 on the commencement date of the Insurance Period specified in the Insurance Policy and shall remain in force until 24:00 on the expiry date of the Insurance Period.

5.2. The Policyholder shall be obliged to pay in full and on time the one-time Insurance Premium or the first installment of the Insurance Premium in accordance with the payment schedule specified in the Insurance Policy.

5.3. The Policyholder shall be granted a period of twelve (12) days from the date of issuance of the Insurance Policy to pay the one-time Insurance Premium or the first installment thereof. If the applicable Insurance Premium is paid in full within such period, the Insurance Policy shall enter into force at 00:00 on the fourteenth (14th) day following its issuance. If the twelve (12)-day period expires without payment being made in full, the issued Insurance Policy shall be cancelled automatically.

6. AUTOMATIC RENEWAL OF THE INSURANCE PERIOD

6.1. The Insurance Period shall be automatically renewed for each subsequent twelve (12)-month period.

6.2. Upon renewal of the Insurance Period, the Insurer shall be entitled to unilaterally amend the terms and conditions of the Insurance Contract, including, without limitation, the Insurance Terms and Conditions, Insurance Coverages and Insurance Premium. The Insurer shall notify the Policyholder of such amendments no later than fourteen (14) calendar days prior to the automatic renewal of the Insurance Period.

6.3. The Policyholder shall be entitled to refuse renewal of the Insurance Period by providing written notice to the Insurer at any time within fourteen (14) calendar days prior to the automatic renewal of the Insurance Period. If the Policyholder does not provide such written notice within the specified period, the Insurance Period shall be deemed automatically renewed, and any amendments (if any) shall be deemed accepted and confirmed by the Policyholder and shall enter into force upon commencement of the renewed Insurance Period.

6.4. Upon renewal of the Insurance Policy, the Insured shall be entitled to opt a different from the previous Insurance Card. If, upon renewal, the Insured upgrades the Insurance Card, for example, from the **“Sasheno”** Card to the **“Sasheno+”** Card, the applicable Insurance Limits for those Insurance Coverages that are subject to a Waiting Period under the relevant product shall not be increased and shall remain the same as those applicable under the **“Sasheno”** Card during the previous Insurance Period. The increase of Insurance Limits applicable to coverages subject to a Waiting Period shall take effect only during the subsequent Insurance Period, following an additional twelve (12) months, provided that the Insurance Policy has been renewed through Continuous Policy Renewal under the **“Sasheno+”** Card.

7. AMENDMENT OF THE INSURANCE CONTRACT

7.1. The Insurer shall be entitled, at any time, to unilaterally amend the terms and conditions of the Insurance Contract, including, without limitation, the Insurance Terms and Conditions, Insurance Coverages and Insurance Premium. The Insurer shall notify the Policyholder of such amendments no later than thirty (30) calendar days prior to the effective date of the amendment.

7.2. The Policyholder shall be entitled, at any time within the above-mentioned thirty (30) calendar day period, to reject such amendment to the Insurance Contract by providing written notice to the Insurer and to terminate the Insurance Contract. In such case, the Policyholder shall be obliged to pay in full the outstanding portion of the total Insurance Premium applicable to the current Insurance Period prior to termination of the Insurance Contract.

7.3. If the Policyholder does not reject the amended terms and conditions and/or terminate the Insurance Contract within the thirty (30) calendar day period, such amendments shall be deemed accepted and confirmed by the Policyholder and shall enter into force on the date specified in the written notice.

8. INSURANCE PREMIUM AND PAYMENT TERMS

8.1. The Insurance Premium shall be payable in GEL.

8.2. The amount of the Insurance Premium and the applicable payment schedule shall be specified in the Insurance Policy

8.3. Where the Insurance Premium is payable in installments, in the event of a breach of or delay in the payment schedule specified in the Insurance Policy (meaning any payment due under the payment schedule other than the first payment), the Policyholder shall be granted an additional grace period of fourteen (14) days for payment. If the Insurance Premium is not paid within such fourteen (14)-day period, the Insurance Contract (including insurance services) shall be automatically suspended upon expiry of the additional fourteen (14)-day grace period, without any further notice (Insurance Suspension). Furthermore, if the Insurance Premium remains unpaid as of 17:00 on the thirtieth (30th) calendar day following the payment due date specified in the Insurance Policy, the Insurance Contract and the Insurance Policy shall be terminated.

8.3.1. No Insurance Indemnity shall be payable in respect of Insured Events occurring during the period of Insurance Suspension.

8.3.2. During the period of Insurance Suspension, no Insurance Indemnity shall be payable in respect of Insured Events that occurred prior to the commencement of Insurance Suspension. Reimbursement of such Insured Events shall be considered only after reactivation of the Insurance Contract and in accordance with the terms and conditions of the Insurance Contract.

8.4. In the event of termination of the Insurance Contract due to a delay of thirty (30) days in the payment of the Insurance Premium where the Insurance Premium is payable in installments, or in the event of early termination of the Insurance Contract by the Policyholder, the Policyholder shall be obliged to pay in full the Earned Premium accrued and outstanding as of the date of termination of the Insurance Contract and, in addition, shall pay, as a penalty, seventy-five percent (75%) of the Unearned Premium.

8.5. If the Insurance Contract with a Policyholder who is not a citizen of Georgia is terminated on any of the grounds specified in Clause 8.4, the Policyholder shall be obliged to pay in full the Earned Premium accrued and outstanding as of the date of termination of the Insurance Contract and, in addition, shall pay the full amount of the Unearned Premium as a penalty. Where the total Insurance Premium has been paid in full in advance (as a one-time payment), such Insurance Premium shall not be refundable to the Policyholder.

8.6. The Parties agree that, upon payment of any amount by the Policyholder to the Insurer towards the Insurance Premium, irrespective of any payment reference, description or purpose indicated in the payment instructions, such payment shall be applied first towards the earliest outstanding financial obligation owed by the Policyholder to the Insurer (being the oldest due and payable debt), regardless of whether such obligation arises under this Insurance Contract or under any other health insurance contract concluded with the Insurer. For the avoidance of doubt, this order of application shall apply exclusively to financial obligations arising under health insurance contracts with the Insurer and shall not apply to any indebtedness arising in connection with any other insurance product or service.

9. TERMINATION OF THE INSURANCE CONTRACT / INSURANCE COVERAGE

9.1. The Insurance Contract may be terminated:

9.1.1. At the initiative of the Policyholder, at any time, within five (5) calendar days following delivery to the Insurer of a written request for termination of the Insurance Contract. In such case, the Policyholder shall be obliged to pay in full the total Earned Premium applicable to the current Insurance Period and, in addition, shall pay, as a penalty, seventy-five percent (75%) of the Unearned Premium (for Policyholders who are not citizens of Georgia, the provisions of Clause 8.5 shall apply). Notwithstanding the foregoing, within fourteen (14) calendar days following the effective date of the Insurance Policy, the Policyholder may terminate the Insurance Contract without any charge or penalty (withdrawal from the Insurance Contract) by submitting a special written notice to the Insurer (the relevant notice form is attached to the Insurance Policy), provided that no request for medical services has been made by the Insured during such period in accordance with the terms and conditions of the Insurance Contract. In such case, the Insurance Premium paid by the Policyholder shall be refunded in full and the Insurance Contract shall terminate on the second (2nd) Business Day following receipt of the relevant request by the Insurer.

9.1.2. At the initiative of the Insurer, at any time, by providing the Policyholder with written notice of termination of the Insurance Contract at least fourteen (14) calendar days in advance.

9.2. The Insurance Contract shall also terminate upon the occurrence of any of the following events:

9.2.1. Expiry of the Insurance Period specified in the relevant Insurance Policy, unless the Insurance Period is renewed automatically;

9.2.2. Death of the Insured;

9.2.3. Mutual written agreement between the Policyholder and the Insurer;

9.2.4. Termination of the Insurer's operations in accordance with applicable law;

9.2.5. Failure by the Policyholder to settle the outstanding indebtedness by 17:00 on the thirtieth (30th) day following the due date of such indebtedness;

9.2.6. Any other circumstance provided for under the legislation of Georgia.

9.2.7. The Insurer shall be entitled to terminate the Insurance Contract unilaterally, at its own initiative, where cooperation with the Insured becomes impossible (including, without limitation, communication problems with the Insurer, Provider Clinics, physicians and/or other service providers, offensive or abusive conduct by the Insured, and similar circumstances). In such case, the Insurance Contract may be terminated with immediate effect.

10. NOTICES AND COMMUNICATIONS

10.1. The Parties agree that, for the purposes of these Insurance Terms and Conditions, communications may be made using the address, e-mail address and/or mobile telephone number specified in the Insurance Policy. Accordingly, any letter sent by the Insurer to the recorded address or e-mail address, or any notification sent to the recorded mobile telephone number (including a text message), shall constitute an official written notice from the Insurer. Where a notification is sent to a mobile telephone number, the date on which such notification is sent by the Insurer shall be deemed to be the date of delivery to the recipient.

10.2. The Insurer shall send notices to the Policyholder at the residential address specified in the Insurance Policy or, where the Policyholder has notified the Insurer of a change of address in accordance with these Insurance Terms and Conditions, to the most recently recorded address. Any notice and/or correspondence sent to such address shall be deemed duly received by the Policyholder, irrespective of whether the recipient is no longer located at such address or the address has been indicated incorrectly or inaccurately.

11. DISPUTE RESOLUTION

11.1. Any dispute or disagreement arising out of or in connection with these Insurance Terms and Conditions shall be resolved through negotiation between the Parties. If the Parties fail to resolve the dispute through negotiation, such dispute shall be submitted to and resolved in accordance with the legislation of Georgia by applying to the Tbilisi City Court.

12. CONFIDENTIALITY

12.1. All information provided by either Party to the other Party in any form, whether oral or written, shall be deemed confidential and shall not be disclosed to any third party without the prior consent of the other Party, except as required by applicable legislation of Georgia or as otherwise provided for in these Insurance Terms and Conditions.

13. PROCESSING OF PERSONAL DATA

13.1. The Policyholder and/or the Insured acknowledge that they have been informed that the Insurer shall process their Personal Data, including Special Category Personal Data, in accordance with the requirements of the legislation of Georgia, including for the purposes of concluding the Insurance Contract and settling claims. The Insured further confirms and agrees that the Insurer shall be entitled to request and obtain from any institution any information and documentation relating to an Insured Event. The Insurer shall also be

entitled to obtain from any private or public institution, including affiliated, related or commonly controlled entities of JSC "TBC Insurance", the Service Agency of the Ministry of Internal Affairs of Georgia, the Public Service Development Agency and Medical Institutions, the Policyholder's and/or the Insured's Personal Data and/or any other documentation necessary for the fulfilment of the Insurer's statutory obligations.

13.2. The Policyholder and/or the Insured acknowledge that they have been informed that their Personal Data shall be processed in accordance with JSC "TBC Insurance"'s Personal Data Processing Policy, available at www.tbcinsurance.ge. The Policyholder and/or the Insured further acknowledge that they have been informed of their rights as data subjects, including the right to request access to their Personal Data and the right to request that JSC "TBC Insurance" rectify, update, supplement, block, erase or destroy such data, except where otherwise provided by applicable law.

13.3. The Policyholder and/or the Insured authorize the Insurer to process their Personal Data and, where necessary, make such data available to partner organizations for the purposes of offering insurance services, improving service quality and/or conducting insurance-related research.

13.4. The Policyholder and/or the Insured authorize the Insurer to process information relating to the insurance relationship with the Policyholder, including the term, status, Insurance Premium and other relevant information, and to make such information available to the Insurer's agents and/or partner organizations that require access thereto for the performance of their rights and obligations and for the fulfilment of the Insurer's contractual and/or statutory obligations.

ANNEX N1

1. COVERED SERVICES AND HOW TO USE YOUR INSURANCE

Under your health insurance and based on Medical Necessity, you will be eligible for coverage of the services listed below when prescribed by a duly licensed physician, subject to the applicable limits, co-payments and Exclusions specified in your Insurance Card.

1.1 **24/7 Call Center - *2000 OR (032) 2-42-11-11** - To check the terms of insurance and/or to arrange medical services, please call one of the numbers above.

1.2 **(Ambulance (Urgent Medical Assistance) -** Urgent medical services provided on site by a private Ambulance team and, where necessary, urgent transportation to a medical institution. You may call any licensed private Ambulance center in the nearest city or regional center.

- If you call a Provider's Ambulance team through the mobile application TBC Insurance or our Call Center, you will receive the service free of charge upon presenting your ID Card.

- If you call a private Ambulance independently, pay the full cost of the service and then upload the required documentation for reimbursement consideration to the mobile application TBC Insurance or place it in the designated box at our Service Center.

1.3 **Family Doctor/Pediatrician Consultation at Clinic -** The Family Doctor will provide a consultation at a Basic Clinic, continuously monitor your health condition and, where necessary, issue a sick leave certificate. Based on Medical Necessity, the Family Doctor will also provide Referrals for outpatient services at Provider Clinics and for medicines at Provider Pharmacy Networks.

- To schedule an appointment with a Family Doctor/Pediatrician at a clinic, use the mobile application TBC Insurance or call our Call Center. You will receive the service at a Basic Clinic.
- To schedule a remote audio consultation with a Family Doctor/Pediatrician, use the mobile application TBC Insurance or call our Call Center. The consultation will be provided by your personal Family Doctor.
- To schedule a remote video consultation with a Family Doctor/Pediatrician, use the REDMED mobile application. The service will be provided by REDMED (REDMED LLC, identification number 405341465).

➢ Please note that reimbursement of costs for services received without following the procedure described above will not be considered by the Insurer.

1.4 **Preventive Checkup** - To arrange a Preventive Checkup, contact your Family Doctor. You can undergo the tests listed below only at a Basic Clinic, without Medical Necessity, upon presenting a Referral issued by your Family Doctor and your ID Card:

- Electrocardiography
- Complete blood count
- Urinalysis
- Blood glucose test
- Prothrombin test

➢ **Hospital Treatment -** Hospital treatment where, based on Medical Necessity, the stay at the medical institution is 24 hours or longer (including a standard ward, intensive care unit and critical care unit).

1.5 **Hospital Treatment due to Personal Accident** - Urgent medical care at a hospital related to a sudden deterioration of health caused by a Personal Accident, including medicines, diagnostic tests, therapeutic and surgical treatment, and the costs of a standard ward and/or intensive care unit.

1.6 **Urgent Hospital Treatment** - Urgent medical care at a hospital related to a sudden deterioration of health, including medicines, diagnostic tests, therapeutic and surgical treatment, and the costs of a standard ward and/or intensive care unit, according to the limit and Coverage Percentage specified in your Insurance Card, except for cases covered under Delivery or Oncology.

1.6.1 **Receiving Services in case of Hospital Treatment due to Personal Accident and/or Urgent Hospital Treatment** - You must notify us via Call Center no later than 24 hours after the occurrence of the event, stating the name and surname of the Insured, personal identification number, name of the medical institution and time of admission to the medical institution.

At the Company's Provider Clinic, after notifying us, you will receive the service upon submission of your ID Card. Upon admission to a Non-Provider Clinic, pay the full cost of the service and then upload the required documentation for reimbursement consideration to the mobile application TBC Insurance or place it in the box at our Service Center.

- Please note that reimbursement for services received without notification will not be considered.

1.7 **Planned Hospital Treatment** - You will be reimbursed for planned surgical and/or therapeutic hospital treatment and the preoperative tests required for the relevant service (except for services covered under either Day-Care Treatment or Oncology), according to the limit and Coverage Percentage specified in your Insurance Card.

1.7.1 To receive services covered under Planned Hospital Treatment, you may apply to a Provider Clinic. If the relevant or alternative service/treatment is not available at a Provider Clinic, you may apply to a Non-Provider Clinic.

To obtain a Guarantee Letter for services at the Company's Provider Clinic, upload the required documentation (your ID Card, a detailed cost estimate/calculation for the service and Form #100-IVa) to the mobile application TBC Insurance or place it in the box at our Service Center. You will receive notification of the decision within no more than 3 business days. If the case is eligible for reimbursement under the terms of the Insurance Contract, we will send a Guarantee Letter to the Provider Clinic, and you will receive a confirmation notification.

- Reimbursement of any amount paid by the Insured at a Provider Clinic will not be considered by the Insurer.

At a Non-Provider Clinic, you must provide us with the medical and financial documentation for the planned treatment/service (your ID Card, a detailed cost estimate/calculation for the service and Form #100-IVa) no later than 3 (three) business days before receiving the service. If the case is eligible for reimbursement, you will receive a prior approval notification. After receiving the service, pay the full cost of the service/treatment and then upload the required documentation for reimbursement consideration to the mobile application TBC Insurance or place it in the box at our Service Center. If the treatment/services received or their cost do not correspond to the service/treatment approved in advance by the Insurer, the prior approval will be deemed invalid, and the Insurer will assess the case in light of the new circumstances.

- If the Insurer has not issued prior approval for the service received, or if the relevant or alternative service/treatment is available at a Provider Clinic, reimbursement of the costs of such service/treatment will not be considered by the Insurer.

1.8 **Day-Care Treatment -** You will be reimbursed for urgent and planned therapeutic and/or surgical services included in the list below, regardless of the duration of your stay at the clinic; planned outpatient manipulations; any other medical services (except for services covered under the Oncology and High-Technology Diagnostic Tests coverage) where your stay at the clinic does not exceed one overnight stay; and the preoperative tests required for the relevant service, subject to the Exclusions, co-payment and limit specified in your Insurance Card.

- Interventions covered under Day-Care Treatment will be financed from the same limit even if the service is received in combination with other services (Hospital Treatment, Outpatient Treatment).
- The costs of medical services required for complications following interventions/manipulations/surgical treatment covered under Day-Care Treatment will also be covered within the co-payment and limit applicable to Day-Care Treatment (including complications arising either before or after the Insured is discharged from the medical institution).
- You can receive the services according to the procedures described under Planned Hospital Treatment and Urgent Hospital Treatment

1.9 **List of Day-Care Treatments:**

1.9.1 Endoscopic (including laparoscopic and thoracoscopic) operations and/or manipulations

1.9.2 Ophthalmology:

- Any kind Any kind of ophthalmological surgery/manipulation

1.9.3 Otorhinolaryngology:

- Adenoidectomy, tonsillectomy, adenotonsillectomy
- Maxillary sinusotomy
- Myringotomy

1.9.4 Maxillofacial Surgery:

- Excision of benign soft tissue tumors of the face
- Surgery due to periostitis
- Cystectomy
- Draining of inflammatory infiltration, abscess
- Alveolitis treatment through curettage

1.9.5 Cardiovascular System:

- Coronary angiography, CT coronary angiography
- Stenting
- Cardioversion
- Operations/manipulations on veins

1.9.6 Gastroenterology:

- Fissurectomy
- Laparocentesis
- Drainage of biliary ducts

1.9.7 Orthopedics, Traumatology:

- Removal of external fixators, implanted plates and screws, only if they were implanted during the Continuous Individual Insurance Period
- Arthroscopic operations/manipulations

1.9.8 Miscellaneous Surgery:

- Excision of benign lesions from the skin and subcutaneous tissue
- Drainage/removal of soft tissues, cysts and abscesses
- Thoracocentesis
- Operations/manipulations related to abscesses, phlegmon, furuncles and carbuncles
- Dermoid/pilonidal cyst drainage/resection
- Manipulations/operations on hemorrhoidal nodes, hemorrhoids and/or the anal sphincter
- Cryodestruction and electrocoagulation/laser coagulation of benign lesions

1.9.9 Mammalogy:

- Removal of fibroadenoma and/or cysts

1.9.10 Gynecology

- Manipulations/operations on the cervix
- Therapeutic and diagnostic hysteroscopy/hysteroresectoscopy
- Excision and drainage of the Bartholin gland
- Excision of a vaginal cyst
- Manipulations related to endometriosis

1.9.11 Urology:

- Catheterization/stenting/stent removal of the ureter and/or urinary bladder
- Trocar epicystostomy
- Lithotripsy, percutaneous litholapaxy
- Operations and/or manipulations related to hydrocele/varicocele/spermatocele
- Orchidectomy, orchiopexy, epididymectomy
- Laser and optical surgery

1.10 **Nurse's Care at Home -** You will be reimbursed for the cost of manipulations performed at home by a nurse, as prescribed by the treating physician, within 2 weeks

after discharge from a medical institution, subject to the applicable limit and co-payment, provided that the related Hospital Treatment was eligible for reimbursement under this Insurance Contract.

Pay the full cost of the service and then upload the required documentation for reimbursement consideration to the mobile application TBC Insurance or place it in the box at our Service Center.

1.11 **Oncology** - Costs of planned and urgent medical services related to the diagnostics and treatment (including registered monoclonal antibodies) of malignant neoplastic diseases diagnosed after the start of your Continuous Individual Insurance Period, as well as complications arising from such diagnosis and treatment (except for services included in the Day-Care Treatment List)

1.11.1 **Oncology – Hospital** - Costs of hospital treatment related to malignant neoplastic diseases and complications arising from their diagnostics and treatment (including a standard ward, intensive care unit, critical care unit and Gamma Knife), where, based on Medical Necessity, the stay at the clinic is 24 hours or longer, and the preoperative tests required for the relevant service; as well as chemotherapy, hormone therapy, radiotherapy and radiation therapy (manipulations and medicines), regardless of the duration of the stay at the clinic.

- You can receive the services according to the procedures described under Planned Hospital Treatment and Urgent Hospital

1.11.2 **Oncology- Outpatient** - Costs of planned outpatient diagnostics and treatment related to malignant neoplastic diseases and complications arising from their diagnostics and treatment (including specialist consultations, laboratory tests, instrumental examinations, PET CT and manipulations), where, based on Medical Necessity, the stay at the clinic is less than 24 hours (except for services covered under Oncology – Hospital).

You can receive the services according to the procedures described under Planned Outpatient Treatment, subject to the limit and Coverage Percentage specified in your Insurance Card.

1.11.3 **Oncology - Medicines** - Costs of registered medicines (meaning medicines with an active/valid registration under the national regime of state registration of pharmaceutical products) prescribed for the outpatient treatment of malignant neoplastic diseases and complications arising from their diagnosis and treatment (except for medicines covered under Oncology – Hospital).

You can receive the services according to the procedures described under Medicines, subject to the limit and Coverage Percentage specified in your Insurance Card.

1.12 **Pregnancy** - You will receive coverage for the costs of outpatient services related to a pregnancy that begins after the start of your Individual Insurance Period and/or complications caused by such pregnancy (doctor's consultations, laboratory tests, instrumental examinations, outpatient manipulations and registered medicines (meaning medicines with an active/valid registration under the national regime of state registration of pharmaceutical products)) at Basic Provider Clinics and Provider Pharmacy Networks, only based on a Referral issued by a Family Doctor or a Digital Referral SMS code (according to the procedures described under Outpatient Treatment and Medicines).

- ➢ The costs of medical services required in the event of termination of pregnancy due to a Personal Accident or an ectopic pregnancy, as well as the treatment of critical pregnancy-related complications (life-threatening complications requiring treatment in an intensive care unit and/or critical care unit) that require immediate Urgent Hospital Treatment, will be reimbursed under the applicable Coverage Percentage and limit of Hospital Treatment due to Personal Accident or Urgent Hospital Treatment, regardless of the Waiting Period (if established/specified in your Insurance Card).
- ➢ The Insurer will not reimburse the costs of hospital services related to pregnancy and/or complications caused by pregnancy.

1.13 **Delivery** - You will be reimbursed for the costs of medical services related to physiological delivery and/or caesarean section, as well as the treatment of complications arising within a maximum of 30 calendar days after delivery (including registered medicines (meaning medicines with an active/valid registration under the national regime of state registration of pharmaceutical products), manipulations, anesthesia, board, a hired physician, and a standard ward, upgraded ward, critical care unit or intensive care unit), subject to the limit and Coverage Percentage specified in your Insurance Card.

To receive the services, you may apply to any licensed clinic:

- If you apply to a Provider Clinic of the Company, the Provider Clinic will provide us with the documentation required to obtain a Guarantee Letter (your ID Card, a detailed cost estimate/calculation for the service and Form #100-IVa), and you will receive a notification of the decision.
- If you give birth at a Non-Provider Clinic or at a Provider Clinic without a Guarantee Letter, pay the full cost of the service and then upload the required documentation for reimbursement consideration to the mobile application TBC Insurance or place it in the box at our Service Center.

- ➢ Urgent medical care required in the event of postpartum sepsis or a critical condition (a life-threatening condition requiring treatment in an intensive care unit and/or critical care unit, or urgent surgical intervention) will be reimbursed within the limit and Coverage Percentage applicable to Urgent Hospital Treatment, according to the procedure described under Urgent Hospital Treatment and subject to the Waiting Period applicable to Delivery coverage.

1.14 **Urgent Outpatient Treatment -** Medical services provided in an Emergency (ER) Department in connection to a sudden deterioration of health (specialist consultations, instrumental examinations and laboratory tests, outpatient manipulations and medicines), except for services covered under High-Technology Diagnostic Tests, which must be provided within the first 24 hours after the occurrence of the event; as well as urgent vaccination: anti-tetanus, anti-viper and one full course of anti-rabies vaccination.

You must notify us of the event through the Call Center no later than 6 hours after its occurrence (but before discharge from the clinic), stating the Insured's full name, personal identification number, name of the medical institution and time of admission.
When visiting a Provider Clinic, after notifying us, you will receive the service subject to the limit and Coverage Percentage specified in your Insurance Card, upon presenting your ID Card.
When visiting a Non-Provider Clinic, after receiving the service, pay the full cost and then upload the required documentation for reimbursement consideration to the mobile application TBC Insurance or place it in the box at our Service Center.

➢ Please note that reimbursement for services received without notification will not be considered.

1.15 **Planned Outpatient Treatment -** You will be reimbursed for planned medical services where, based on Medical Necessity, the stay at a medical institution is less than 24 hours, including specialist consultations, laboratory tests and instrumental examinations (except for services covered under Pregnancy and Oncology).

1.15.1 Under the Planned Outpatient Treatment coverages: Planned Outpatient Treatment at Basic Clinics, Planned Outpatient Treatment with Referral, High-Technology Diagnostic Tests and Planned Outpatient Treatment with Referral at TOP Provider Clinics (if such coverage is specified in your Insurance Card), you can receive services only at the Insurer's Provider Clinics, upon presenting your ID Card and a Referral / Guarantee Letter issued by your Family Doctor or an authorized representative of the insurance company.

➢ Reimbursement of costs for services received without a Referral / Guarantee Letter will not be considered by the Insurer

1.15.2 To obtain a Referral / Guarantee Letter for planned outpatient treatment, contact your Family Doctor at a Basic Clinic.

- You can also use a Digital Referral to receive outpatient services prescribed by a specialist. Upload Form #100-IVa issued by the specialist to the mobile application TBC Insurance. If your request is approved, we will send the Digital Referral to your selected Provider Clinic within 1 business day after receiving the request, and you will receive the Referral SMS code. At the Provider Clinic, upon presenting your ID Card, you will receive the service subject to the limit and Coverage Percentage specified in your Insurance Card. If the service is not eligible for coverage under the terms of the Insurance Contract, you will receive the relevant notification.

1.15.3 **High-Technology Diagnostic Tests -** Diagnostic tests prescribed by a specialist during services covered under Planned and Urgent Outpatient Treatment (and covered under this Insurance Contract): computed tomography (CT) and magnetic resonance imaging (MRI), including contrast-enhanced examinations; angiography; scintigraphy; densitometry; esophagogastroduodenoscopy, bronchoscopy, laryngoscopy and colonoscopy performed with biopsy and/or sedation; allergy panel; and prolonged EEG (lasting 3 hours or longer).

- To undergo the test(s) as part of a case covered under Planned Outpatient Treatment, contact your Family Doctor at a Basic Clinic to obtain a Referral / Guarantee Letter or use a Digital Referral. Reimbursement for services received without a Referral / Guarantee Letter under Planned Outpatient Treatment will not be considered by the Insurer.
- For a case covered under Urgent Outpatient Treatment, the test will be financed according to the limit and Coverage Percentage specified for High-Technology Diagnostic Tests in your Insurance Card and in accordance with the procedure described under Urgent Outpatient Treatment.

1.15.4 **Planned Outpatient Treatment – "REDMED" -** After activating your Insurance Card in the REDMED application, you can use the "Doctor's Video/Audio Consultation" service with designated Family Doctors and/or specialists without a Family Doctor's Referral, subject to the limit and Coverage Percentage specified in your Insurance Card.

- Reimbursement for services received without following the procedure described above will not be considered by the Insurer.

1.15.5 **Psychotherapy -** You can receive a consultation with a designated psychotherapist/psychologist (the list of eligible specialists is determined by the Insurer) at

the specified Provider Clinic, subject to the limit and Coverage Percentage specified in your Insurance Card.

To receive the service, you must present your ID Card and a Digital Referral (if such coverage is specified in your Insurance Card).

You can request a Digital Referral for a consultation with a psychotherapist/psychologist through the mobile application TBC Insurance.

- Reimbursement for services received without a Referral will not be considered by the Insurer

1.16 **Medicines -** You will receive coverage for registered medicines (meaning medicines with an active registration under the national regime of state registration of pharmaceutical products) prescribed by a duly licensed physician for outpatient treatment, only at a Provider Pharmacy Network and based on a Referral/SMS code issued by a Family Doctor or an authorized representative of the Company (except for medicines covered under Pregnancy, Oncology and Other Pharmacological Products with Referral).

1.16.1 To obtain a Referral/SMS code, contact your Family Doctor at a Basic Clinic or upload the prescription issued by a specialist (Form #100-IVa) to the mobile application TBC Insurance and request a Digital Referral to the Insurer's Provider Pharmacy Network. You will receive the Referral SMS code within 1 business day after submitting the request. If the medicine/pharmacological product is not eligible for coverage under the terms of the Insurance Contract, you will receive the relevant notification.

At a Provider Pharmacy Network, upon presenting a Referral/SMS code issued by a Family Doctor or an authorized representative of the Company, you will pay only your co-payment share of the cost of the medicines.

- If the required quantity of the medicines prescribed under the Referral (prescription) is unavailable at a Provider Pharmacy, purchase the available quantity based on the issued Referral. Once the Pharmacy Network confirms the quantity purchased, you will receive an updated Referral code by SMS for the remaining quantity of the medicine.

1.16.2 Under a single Referral/SMS code, coverage is limited to the quantity of medicines required for no more than one month of treatment

- If less than 1 month remains before your insurance expires, the costs of medicines will be reimbursed according to the number of remaining days.
- Reimbursement for medicines purchased without a Referral/SMS code will not be considered.

1.16.3 **Other Pharmacological Products with Referral -** The following registered products (meaning products with an active/valid registration under the national regime of state registration of pharmaceutical products) prescribed for outpatient treatment (except for products covered under Pregnancy and Oncology) may be purchased only at a Provider Pharmacy Network based on a Referral/SMS code issued by a Family Doctor or an authorized representative of the Company, according to the procedures described under Medicines: vitamins, multivitamins, monoclonal antibodies, immunomodulators, immunostimulants, psychotropic medicines, herbal medicinal products (plant-based preparations), systemic enzymes, antifungal agents, medicines for the treatment of diabetes, antiseptics, biologically active food supplements and homeopathic remedies.

- Reimbursement for products purchased without a Referral will not be considered by the Insurer.

1.16.4 **Spectacle Lenses and Contact Lenses with referral –** (Valid only if your card provides this coverage)

coverage includes financing of the costs of glasses (1 pair) or contact lenses (5 pairs) at the provider network. Offer does not apply to ALCON Air Optix 8.6 NIGHT AND DAY and Ephemeral One-Day By Alcon lenses.

- To receive service, apply to Ophthalmologist at the provider „Afflelou Paris", who, after assessing the vision condition, will issue and upload the appropriate prescription for you; based on which, you will receive an SMS code of digital referral for the prescribed lenses. In „Afflelou Paris" and GPC pharmacy network, you will pay only your co-payment to purchase Spectacle Lenses or Contact Lenses based on digital referral.
- In case you already have „Afflelou Paris" Ophthalmologist's prescription for lens, you can request a digital referral for a new pair of lenses by uploading corresponding prescription to Mobile app TBC Insurance

1.17 **Urgent Dental Treatment -** Primary dental care provided in an emergency, specifically and exclusively emergency tooth extraction (based on radiographic indications) and the related local anesthesia, allergy testing and diagnostic procedures (dentogram and visiogram).

You may apply to any licensed clinic:

- When visiting a Provider Clinic of the Company, you will receive the service upon presenting your ID Card, subject to the limit and co-payment specified in your Insurance Card.
- When visiting the Non-Provider Clinic of the Company, pay the full cost of the service and then upload the required documentation for reimbursement consideration to the mobile application TBC Insurance or place it in the box at our Service Center.

1.18 **Planned Dental Care (Therapeutic and Surgical Dental Services) at a Provider Clinic**
You will be reimbursed only for the following services received at your Provider Dental Clinic: dental consultation; diagnostic procedures — dentogram/visiogram and orthopantomogram based on Medical Necessity; local anesthesia; dental fillings for caries, pulpitis and periodontitis; dental cleaning using scaling and/or AirFlow once every 6 months; tooth extraction (including the extraction of highly complex and impacted teeth based on Medical Necessity); apicoectomy; odontogenic cystectomy; and allergy tests related to the procedures listed in this paragraph.

- ➢ To receive the service, visit your Provider Dental Clinic, where you will receive the service upon presenting your ID Card, subject to the limit and Coverage Percentage specified in your Insurance Card.
- ➢ To obtain a Referral for an allergy test at a Provider Clinic, upload the physician's prescription to the mobile application TBC Insurance and use a Digital Referral.
- ➢ Reimbursement will not be considered for the costs of any dental services/treatment other than those listed above (including medicines and services performed using a microscope), or for the costs of services received without following the procedures described above.

1.19 **Benefits / Additional Services -** In addition to the services covered by your insurance, you can use various benefits/exclusive discounts offered by specific Providers and partner organizations. Detailed information is available in the mobile application TBC Insurance.

- ➢ To use an offered discount, present your ID Card at the Company's Provider Clinic or partner organization.

- Services for which the Provider Clinic/institution does not offer a discount, as well as services received at the Company's Non-Provider Clinic/institution, are not eligible for reimbursement by the Insurer.

- The offered discounts are subject to amendment

2. EXCLUSIONS (THE FOLLOWING COSTS ARE NOT COVERED):

2.1. **Costs related to the following diseases, their diagnostics and complications caused by them:**

2.1.1 Alcoholism, toxicomania, drug addiction

2.1.2 Congenital and/or genetic diseases/defects/pathologies (only the doctor's initial consultation is covered)

2.1.3 Disorders of reproductive function and sexual health disorders; infections predominantly transmitted through sexual contact (bacterial and fungal infections, as well as the doctor's initial consultation and initial smear bacterioscopy, are covered)

2.1.4 HIV infection, AIDS; hepatitis of any form or stage (hepatitis A is covered; rapid diagnostic tests for HIV infection and hepatitis B and C performed as part of preoperative tests are also covered)

2.1.5 Chronic renal failure, mental illnesses, cataract

2.1.6 Benign and/or malignant neoplastic diseases diagnosed and/or for which diagnostic procedures had commenced before the start of the Continuous Individual Insurance Period.

2.2. **The following treatment and related services, and complications caused by them:**

2.2.1 Services provided without Medical Necessity; experimental or alternative medicine

2.2.2 Additional or exclusive services, non-medical services, and hired/invited physician's fees (the costs of a hired/invited physician and an upgraded ward during Delivery are covered within the applicable limit); services received abroad (including diagnostic testing of samples sent from Georgia)

2.2.3 Planned vaccination and immunization

2.2.4 Any type of certificate/services required to obtain any type of certificate (a certificate issued by a Family Doctor based on medical records is covered)

2.2.5 Contraception/contraceptives, assisted reproduction procedures, sterilization, family planning; induced abortion without Medical Necessity

2.2.6 Weight correction, bariatric surgery, intragastric inflatable balloon placement, botulinum toxin injections, cosmetic and plastic services, MonaLisa Touch

2.2.7 Sanatorium treatment, spa and balneological treatment, rehabilitation services and palliative care/treatment

2.2.8 Medical exercise, massage, physical therapy procedures, PRP and intra-articular injections

2.2.9 Vision correction; operations and/or manipulations on the nose and/or nasal cavity (except for services received in an ER department)

2.2.10 External prosthetic fitting procedures, ablation, organ and tissue transplantation (except for aortocoronary bypass surgery and skin autograft due to a burn sustained during the Insurance Period)

2.2.11 Speech therapist, psychiatrist, psychotherapist and psychoanalyst — except for services covered under the Insurance Card

2.2.12 Genetic tests; robot-assisted surgery and/or treatment; dialysis

2.3. **Costs of the following appliances and associated services:**

2.3.1 Cosmetic, hygienic and care products, including but not limited to any shampoo, cleanser or mouthwash

2.3.2 Unregistered medicines/medicinal products (meaning products without an active/valid registration under the national regime of state registration of pharmaceutical products); GLP-1 and/or GIP receptor agonists, regardless of their registration status

2.3.3 Auxiliary and corrective devices (including glasses and lenses — except for those covered under the Insurance Card, hearing aids, plaster casts, arch supports, fixation devices, corsets, compression stockings, etc.); any type of external and internal prostheses, implants, pacemakers, defibrillators and artificial lenses

2.4. **Medical costs associated with the following circumstances and complications caused by them:**

2.4.1. Self-treatment, self-injury, attempted suicide, any unlawful act under the Criminal Code; medical services/treatment received during deprivation of liberty

2.4.2. Motor vehicle accidents occurring while driving under the influence of alcohol, narcotic and/or toxic substances; alcohol or drug intoxication and/or the influence of toxic substances

2.4.3. Participation in any kind of professional and/or hazardous sport, such as alpinism, rock climbing, hang gliding, paragliding, parachuting, scuba diving, combat sports, hunting, rafting, auto and motorcycle racing, horse racing, snowmobiling, freestyle skiing, Heli-Skiing, and caving or speleology in areas where the use of special equipment is mandatory

2.4.4. Epidemics, natural disasters, radiation exposure

2.4.5. Where the financing of medical services/treatment is provided under any state medical/healthcare program, reimbursement will be considered only for the amount/share payable by the patient under the relevant program, regardless of whether the medical institution participates in the program or whether the Insured has used the program

2.4.6. Services subject to a Waiting Period under your insurance

2.4.7. Services received in breach of the notification obligation established under the Insurance Contract

3. INSURANCE INDEMNIFICATION PROCEDURE

3.1 To receive Insurance Indemnity, apply to us within 60 (sixty) calendar days after receiving the service. Upload the medical and financial documentation required under the Insurance Contract (see the list below) to the mobile application TBC Insurance or place it in the box at our Service Center. The Company reserves the right to request the original documents.

3.2 Services costing up to GEL 500 will be reimbursed within 1 (one) business day. Services costing more than GEL 500 will be reimbursed within a maximum of 3 (three) business days.

3.3 Services costing more than GEL 500 will be reimbursed within a maximum of 3 (three) business days.

3.4 For dental services, any amount will be reimbursed within 3 (three) business days.

3.5 Documents required for reimbursement:

- ID Card;
- Bank account details of the Insured (or of the insured parent/guardian if the Insured is a minor) bank account number;
- A specialist's prescription or Form #100-IVa, duly completed, signed and stamped, containing a detailed description of the services received;
- A detailed cost breakdown/calculation for the medical services received and/or medicines purchased (order or statement), certified with a stamp;
- Financial documentation confirming payment, certified with a stamp — a cash register receipt/check or a document treated as equivalent to a receipt in the form established by the Ministry of Finance;
- In the case of dental services: dentograms/visiograms taken before and after the service. When uploading documents through the online portal, you may submit only the electronic version of the visiogram. Children receiving services related to primary teeth and pregnant persons are not required to submit dentograms/visiograms.

3.5.1 Please note that documents submitted after 60 calendar days will not be considered, and no reimbursement will be issued.

3.6 Please note that, to assess reimbursement of an Insured Event, we may request any document, certificate or other information necessary to establish the Insured Event, its circumstances and the extent of the loss. In such a case, you must provide the requested documents and information within 30 (thirty) calendar days after our request. If the requested information/documents are not provided within this period, the Insurer is entitled to refuse reimbursement of the claim.

3.7 Medical services provided to persons who are not Georgian citizens will be financed/reimbursed based on the prices applicable to Georgian citizens.

4. INSURANCE CARDS

4.1 Individual Health Insurance includes the following 2 Insurance Cards: **“Sasheno”** and **“Sasheno+”**.

4.2 The Insurance Card selected by the Policyholder when entering into the Insurance Contract is specified in your Insurance Policy.

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Coverage		Sasheno %	Sasheno		Sasheno+ %	Sasheno+	
24/7 Call Center		100%	Unlimited		100%	Unlimited	
Ambulance		100%	10 cases		100%	10 cases	
Family Doctor / Pediatrician at the Clinic		100%	Unlimited		100%	Unlimited	
Preventive Checkup		100%	Once		100%	Once	
Hospital Treatment							
Hospital Treatment due to Personal Accident		100%	15000		100%	20000	
Urgent Hospital Treatment		100%	8000		100%	10000	
Planned Hospital Treatment	Waiting period 12 months	90%	5000		90%	7000	
Urgent Day-care Treatment		60%			70%		
Planned Day-care Treatment	Waiting period 12 months	60%			70%		
Nurse's Care at Home		90%			90%		
Oncology							
Oncology - Hospital	Waiting period 12 months	80%	3000		90%	5000	
Oncology - Outpatient	Waiting period 6 months	50%			60%		
Oncology - Medicines	Waiting period 6 months	40%			50%		
Pregnancy and Delivery							
Pregnancy (with Referral at Basic Clinics)		50%	500		60%	700	
Pregnancy - Medicines		60%			80%		
Delivery	Waiting period 12 months	100%	500		100%	700	
Outpatient treatment							
Urgent Outpatient Treatment		100%	Unlimited		100%	Unlimited	
Planned Outpatient Treatment at Basic Clinics		80%	2000	2000	90%	3000	3000
Planned Outpatient Treatment – „REDMED"		60%			80%		
Planned Outpatient Treatment with Referral		50%			60%		
High-Technology Diagnostic Test		50%			50%		
Psychotherapy		40%	5 visits		40%	5 visits	
Planned Outpatient Treatment with Referral at TOP Clinics					30%	3000	
Medicine							
Medicines with Referral		60%	2000	2000	80%	3000	3000
Other Pharmacological Products with Referral		30%			35%		
Spectacle Lenses and Contact Lenses with referral		50%	10		50%	10	
Dental Treatment							
Urgent Dental Treatment		100%	Unlimited		100%	Unlimited	
Planned Dental Treatment at Provider Clinics		60%	1500		75%	2000	
Discount on Travel Insurance		40%	Unlimited		40%	Unlimited	