Information Document

Type of the insurance agreement: Retail Health Insurance

- ✓ This document includes an incomplete information about the terms of insurance. The Information Document does not have the same legal force as the insurance agreement. The introduction of this document and the explanations provided do not give rise to legal consequences and claims between the parties.

1. **Information about the insurance company and the type of agreement:**
   - ✓ JSC "International Insurance Company IRAO" (I/N 205023856)
     Address: Georgia, Tbilisi, V. Bochorishvili str. #88/15

   - ✓ The good insured by the health insurance agreement is the health of the client/insured, which, in the event of an insured event, gives rise to the obligation to issue/reimburse the insurance amount in accordance with the terms of the agreement.

2. **Information about the insurance premium, conditions of termination of the agreement, form and terms of submitting a complaint and deadlines:**

   - ✓ **Health insurance agreement my be terminated:**
     - In case of fulfillment of obligations assumed by the insurer;
     - In case of non-fulfilment of the obligations assumed by the party to the contract;
     - By written agreement of the parties.
     - In other cases stipulated by legislation and/or insurance contract;

   - ✓ **Complaints about insurance services can be submitted:**
     - By contacting the call center at: +995 32 2949 949;
     - By written application to the following addresses:
       #88/15 V. Bochorishvili Str., Tbilisi, Georgia
       #35/31 Dzmebi Zubalashvilebi Str., Batumi, Georgia
       #1/38 Tsminda Nino Str. Kutaisi, Georgia
       #22 Al. Vardoshvili Str., Telavi, Georgia
       #15 Tabukashvili Str., Akhaltsikhe, Georgia
       #64 M. Kostava Str., Zugdidi, Georgia
       #1 Giorgadze Str., Marneuli, Georgia

     - Via e-mail: quality@irao.ge

- The complaint will be reviewed by the the Quality Management Service within 10 business days after submission.
- The response to the complaints to the customers is given identically to the source of the submission or according to the request of the customer (by phone, in writing, by e-mail).
- Customers have the opportunity to request an official written response, regardless of the source of the submission of the complaint.
- The form of submitting a complaint is attached to the health insurance contract

✓ **Supervisory Authority of the insurer**

LEPL Insurance State Supervision Service of Georgia
Address: #3 L. Mikeladze Str., Tbilisi, Georgia
Tel.: +995 32 223 44 10
Website: www.insurance.gov.ge

✓ **Information on the financial cost and amount taken into account by the health insurance contract: specified in the insurance policy**

3. Information on the deductible and the reimbursement of the insured event provided in the health insurance contract: determined by the insurance conditions

4. Conditions for insurance coverage, receiving services, issuing compensation and exclusions:

1. Irao - Assistance

Provides for 24-hour phone consultation, delivering information related to the insurance to the Insured and organizing of medical services, planning visit to the personal doctor and calling for the emergency medical brigade.

1.1. **Terms of Receiving Insurance Service**

1.1.1. Please, call on the following number to contact Irao - Assistance - (032) 2 949 949.

2. Personal Doctor Services

Provides for reimbursement of the cost of the Personal Doctor Services, which includes consultation of the Insured and monitoring of health conditions, in the presence of medical evidence issuing the prescription for the additional consultations and/or examinations to be carried out, prescribing medical treatment, issuance of a Guarantee Letter to provider pharmaceutical companies, coordination of tactics of treatment with specialists of specific field, issuance of medical bulletin;

2.1. **Terms of Receiving Insurance Service**

2.1.1. In order to receive personal doctors' services, the Insured contacts Irao - Assistance and agrees date of the visit.

3. Urgent Medical care provided by ambulance crew

Provides for compensation of the cost of the service rendered by licensed provider ambulance crew, emergency medical treatment and in the presence of medical evidence transportation within the territory of Georgia.

3.1. Terms of Receiving Insurance Service

3.1.1. The Insured (or his/her representative) contacts Irao - Assistance. If the ambulance is needed Irao - Assistance ensures calling for the emergency ambulance crew for the Insured. In such case, the Insured shall submit his/her Insurance Card and ID to emergency ambulance crew and he/she shall not have to pay the cost of the service;

3.1.2. Insured (or his/her representative) calls the provider ambulance crew himself/herself; he/she shall pay full cost of the service and contacts the Insurer for compensation. In order to receive compensation following documents should be presented to the insurance company during 30 (thirty) calendar days since receiving medical services or they should be uploaded in private space- https://online.irao.ge/login:

3.1.2.1. Insurance card;

3.1.2.2. Identification Documentation;

3.1.2.3. Medical documentation sealed and signed by institution/doctor confirming conducted services;

3.1.2.4. Financial documentation confirming payment, in the form approved by Ministry of Finance and printed at a printing house, which is equivalent to receipt or document including detailed calculation of the services.

The Insurer shall make the payment via non-cash within 1 (one) working day after receiving all the necessary documents stipulated in the contract if the estimated amount to be paid does not exceed 200 (two hundred) GEL. Payment in excess of the above amount is made via non-cash payment within 5 (five) working days after receiving all the necessary documents stipulated in the contract. Documents can be placed in boxes placed in the company's offices and/or by uploading them in the private space - https://online.irao.ge/login. Insurance reimbursement is not paid by cash.

In case if documents are sent electronically, the insured is obliged to keep the original documents for 6 (months) months.

4. Preventive Care

Provides for compensation of the cost of services performed without any medical evidence. Preventive care includes consultations of Personal Doctor, blood test, urine test, ECG, glucose level in blood, prothrombin index and ultrasound of any single system.

4.1. **Terms of Receiving Insurance Service**

In order to receive service, the Insured should contact Irao - Assistance for organizing visit with the personal doctor, which provides the Insured with medical referral(s) for necessary tests define by the terms and conditions. These services can be received in Tbilisi and regions at the personal doctor's dislocations, where the Insured has opened medical card;

5. In-Patient Care

Provides compensation of the cost of surgical and conservative In-Patient Care (instrumental and laboratory examinations for diagnostics, therapeutic and surgical treatment, medicines, parenteral and enteral nutrition, standard and intensive care ward) occurred during the insurance period in the presence of medical evidence and appointed by the doctor.

5.1. In-Patient Care includes:

5.1.1. **In-Patient services due to the accident –** in the presence of corresponding medical evidence provides compensation of the cost for the unity of measures related to the health condition deterioration caused by external forces (physical, mechanical, thermal, chemical) during the insurance period and in the event of the delay of this measures death of the patient or abrupt deterioration of condition could occur. Delay of the Insured in the medical institution should exceed one bed day considering corresponding medical evidence.

5.1.2. **Urgent In-Patient services -** in the presence of corresponding medical evidence provides compensation of the cost for the unity of measures related to the health condition deterioration during the insurance period and in the event of the delay of this measures death of the patient or abrupt deterioration of condition could occur. Delay of the Insured in the medical institution should exceed one bed day considering corresponding medical evidence. Herewith, this service does not cover services that are reimbursable under the terms/exclusions of this insurance agreement and are included in the coverage of cardiology, oncology and day in-patient services.

5.1.3. **Planned In-Patient services (waiting period for primary insured 12 months) -** provides compensation of the cost of planned in-patient treatment during the Insurance Period, that is subject to compensation with the conditions/exceptions of this Insurance Agreement and is not in the coverage of cardiology, oncology and day In-Patient services and delay of the Insured in the medical institution should exceed one bed day considering corresponding medical evidence.

5.1.4. **Cardiology (waiting period for primary insured for planned services 12 months) -** provides compensation of the cost of planned and emergency cardio surgery, planned and emergency interventional cardiological treatment, planned and emergency interventions/manipulation during the Insurance Period. Mentioned

services cover above-mentioned events, when the delay of the Insured in the medical institution considering corresponding medical evidence is or exceeds one bed day. From the limit and co-payment defined in the policy for this service, expenses of the further complications will be covered also (including complications after and before the patient was released from the medical institution, despite the conditions caused by these complications will be part of Urgent In-Patient or outpatient services). Moreover, coronarography not followed with stenting will be reimbursed within the limits defined for outpatient services, considering relevant copayment.

5.1.5. **Day In-Patient services (waiting period for primary insured for planned services 12 months)** - provides compensation of the cost of planned and emergency interventions/manipulation/surgical operations indicated in positive list (despite the delay in the medical institution) and moreover cases which are not included in positive list, but delay of the Insured in the medical institution does not exceed one bed day considering corresponding medical evidence.

5.1.5.1. Gynecology

5.1.5.1.1. Polypectomy
5.1.5.1.2. operations/manipulations on cervix
5.1.5.1.3. hysteroscopy performed for treatment purposes/hystero resectoscopy
5.1.5.1.4. Ablation
5.1.5.1.5. Excision and Drainage of Bartholine Gland
5.1.5.1.6. Vaginal cyst removal
5.1.5.1.7. Laparoscopic cystectomy, ovariectomy, salpingectomy, adnexectomy
5.1.5.1.8. Manipulations/interventions/surgical treatment related to the endometriosis and adenomiosis;

5.1.5.2. Otorhinolaryngology

5.1.5.2.1. Adenoidectomy
5.1.5.2.2. Tonsillectomy
5.1.5.2.3. Adenotonsillectomy
5.1.5.2.4. Nasal Polypectomy
5.1.5.2.5. Septum Resection
5.1.5.2.6. Pinna Disintegration
5.1.5.2.7. Canthotomy
5.1.5.2.8. Chronical Sinusitis - Endoscopic Operation
5.1.5.2.9. Miringotomy
5.1.5.2.10. Haimorotomia
5.1.5.2.11. Septoplasty

5.1.5.3. Ophthalmology

5.1.5.3.1. Cataract Operation
5.1.5.3.2. Lacrimal Gland Drainage
5.1.5.3.3. Entropion/Ectropion Operation

5.1.5.3.4. Keratoplasty
5.1.5.3.5. Laser/Photocoagulation
5.1.5.3.6. Enucleation/Evisceration
5.1.5.3.7. Pterygium Removal
5.1.5.3.8. Pupilloplasty
5.1.5.3.9. Dacryocystorhinostomy
5.1.5.3.10. Dacryocystectomy
5.1.5.3.11. Vitrectomy
5.1.5.3.12. Sealing Sclera
5.1.5.3.13. Intrastromal Corneal Ring Implantation
5.1.5.3.14. Penetrating Keratoplasty
5.1.5.3.15. YAG Laser Surgery
5.1.5.3.16. Operations on Lacrimal Sac
5.1.5.3.17. Operations on Cornea

5.1.5.4. Gastroenterology

5.1.5.4.1. fissurectomy
5.1.5.4.2. Polypectomy from Rectum
5.1.5.4.3. Papillotomy/Sphincterotomy
5.1.5.4.4. Varicose Vein (Stomach, Esophagus) Ligation
5.1.5.4.5. Gastrostomy
5.1.5.4.6. Polypectomy
5.1.5.4.7. Electrocoagulation
5.1.5.4.8. Papillosphincterotomy
5.1.5.4.9. Laparocentesis
5.1.5.4.10. Laparoscopical Cholecystectomy
5.1.5.4.11. Drainage and/or Removal of Dermoid/Pilonidal Cyst

5.1.5.5. Genitourinary Tract

5.1.5.5.1. Trocar Episistostomy
5.1.5.5.2. Lithotripsy
5.1.5.5.3. Operations/Manipulations Related To Hydrocele/Varicocele
5.1.5.5.4. Surgery Related To Phimosis
5.1.5.5.5. Orchiectomy
5.1.5.5.6. Orchiopexy
5.1.5.5.7. Epididymectomy
5.1.5.5.8. Endoscopic Removal of Stone
5.1.5.5.9. Cystolithotomy
5.1.5.5.10. Percutaneous Lapaxy
5.1.5.5.11. Catheterization/ Stenting of Urethra and/or Bladder
5.1.5.5.12. Laser and Optical surgery

5.1.5.6. Mamology

5.1.5.6.1. Cyst Removal

5.1.5.7. Face and Jaw surgery

5.1.5.7.1. Removal of a cyst in the Highmore cavity
5.1.5.7.2. Removal of cyst grown into lower jaw canal
5.1.5.7.3. Removal Of Subperiosteal Abscess
5.1.5.7.4. Operational Treatment of Periostitis
5.1.5.7.5. Cystectomy
5.1.5.7.6. Opening of Inflamed Infiltrate Abscess
5.1.5.7.7. Alveolitis Treatment with Scraping

5.1.5.8. Mixed Surgery

5.1.5.8.1. Removal and/or drainage of tender tissue cysts and abscess
5.1.5.8.2. Striping or ligation, phlebectomy of varicose veins of lower limb
5.1.5.8.3. Removal of lymphomas for treatment purposes
5.1.5.8.4. Catheter ablation
5.1.5.8.5. Thoracentesis
5.1.5.8.6. Drainage of bile duct with reanimation monitoring
5.1.5.8.7. Operations/manipulations related to skin abscess, phlegmon, furuncle, Carbuncle

5.1.5.9. Orthopedy, Traumatology

5.1.5.9.1. Removal of metal construction
5.1.5.9.2. Laparoscopically arthroscopy/meniscectomy

Herewith, from the limit and co-payment defined in the policy for this service, expenses of the further complications will be covered also (including complications after and before the patient was released from the medical institution, despite the conditions caused by these complications will be part of Urgent In-Patient or outpatient services).

Note: None of the interferences/manipulations/surgeries will be covered from the above-mentioned service that according to international classification revision 10 (ICD 10) is defined as benign or malignant tumor.

5.2. Terms of Receiving Insurance Service

5.2.1. In the case of urgent In-Patient services due to accident, urgent In-Patient services, urgent Day In-Patient services and urgent cardiology services - the Insured (or his/her representative), contact Irao Assistance during 48 hours (in the events of addressing both - provider and non provider medical institutions), unless notification is delayed due to objective circumstances, when the medical institution is not able to identify the Insured or Insured is in such condition when notification is impossible due to the health condition. Notification should include the following information: **first and last name of the Insured, Insurance Card**

number, name of medical institution, time of addressing to the medical institution, preliminary diagnosis.

5.2.1.1. In the event of addressing provider medical institution of the Insurer based on notification, the Insured will be able to receive treatment within the limits/copayment indicated in the Insurance Policy.

5.2.1.2. In the event of addressing non-provider medical institution, moreover, in the event of receiving services without notification in provider or non-provider medical institutions, the Insured pays for the services fully and then addresses the Insurer for reimbursement. And the Insurer, in compliance with the conditions of the Insurance Agreement, shall reimburse the cost of the medical service. Expenses of the medical services received without notification in provider medical institution will be reimbursed according cost purchased by the Insurers, while in non-provider medical institution in the limit of limits and copayments defined in the insurance policy. In order to receive compensation following documents should be presented to the insurance company during 30 (thirty) calendar days since receiving medical services or they should be uploaded in private space- https://online.irao.ge/login:

5.2.1.2.1. Insurance card;

5.2.1.2.2. Identification Documentation;

5.2.1.2.3. Form IV-100a filled in according to the rules of the Ministry of labor, health and social defense, confirmed with seal of the institution and signature of the doctor.

5.2.1.2.4. Detailed calculation of the services;

5.2.1.2.5. The original payment order and the original of the cash register receipt or printout of the POS-terminal confirming payment.

The Insurer shall make the payment via non-cash within 1 (one) working day after receiving all the necessary documents stipulated in the contract if the estimated amount to be paid does not exceed 200 (two hundred) GEL. Payment in excess of the above amount is made via non-cash payment within 5 (five) working days after receiving all the necessary documents stipulated in the contract. Documents can be placed in boxes placed in the company's offices and/or by uploading them in the private space - https://online.irao.ge/login. Insurance reimbursement is not paid by cash.

In case if documents are sent electronically, the insured is obliged to keep the original documents for 6 (months) months.

5.2.2. In the case of planned In-Patient services, planned day In-Patient services and planned cardiological services:

5.2.2.1. While addressing Insurer's provider medical institution, the Insured will be ensured with services in the medical Institution in the limits and copayment indicated in the Insurance Policy. 5 (five) days prior to receiving the services the Insured shall present full list of documentation, based on which the Insurer issues guarantee letter in 1 (one) working day for the amounts less than 1000 (one thousand) Gel and in 5 (five) working days if cost of the service exceeds 1000 (one thousand) Gel.

5.2.2.2. In order to receive guarantee letter the Insured or his/her representative should present to the Insurer:

5.2.2.2.1. Insurance Card;

5.2.2.2.2. Document confirming identification;

5.2.2.2.3. Form IV-100a filled in according to the rules of the Ministry of labor, health and social defense, confirmed with seal of the institution and signature of the doctor.

5.2.2.2.4. Detailed calculation of medical services;

5.2.2.3. While addressing non-provider medical institution, or receiving medical services in provider medical institution without presenting documentations for guarantee letter, the Insured pays for the services fully and then addresses the Insurer for reimbursement. And the Insurer, in compliance with the conditions of the Insurance Agreement, shall reimburse the cost of the medical service.

In order to receive compensation following documents should be presented to the insurance company during 30 (thirty) calendar days since receiving medical services or they should be uploaded in private space- https://online.irao.ge/login:

5.2.2.3.1. Insurance card;

5.2.2.3.2. Identification Documentation;

5.2.2.3.3. Form IV-100a filled in according to the rules of the Ministry of labor, health and social defense, confirmed with seal of the institution and signature of the doctor.

5.2.2.3.4. Detailed calculation of the services;

5.2.2.3.5. The original payment order and the original of the cash register receipt or printout of the POS-terminal confirming payment.

The Insurer shall make the payment via non-cash within 1 (one) working day after receiving all the necessary documents stipulated in the contract if the estimated amount to be paid does not exceed 200 (two hundred) GEL. Payment in excess of the above amount is made via non-cash payment within 5 (five) working days after receiving all the necessary documents stipulated in the contract. Documents can be placed in boxes placed in the company's offices and/or by uploading

them in the private space - https://online.irao.ge/login. Insurance reimbursement is not paid by cash.

In case if documents are sent electronically, the insured is obliged to keep the original documents for 6 (months) months.

6. Oncology (waiting period for primary insured 12 months)

In the presence of corresponding medical evidence provides compensation of the cost of urgent and planned surgical treatment (instrumental and laboratory examinations for diagnostics, therapeutic and surgical treatment, medicines, parenteral and enteral nutrition, standard and intensive care ward), diagnostics, chemotherapy, radio and radiation therapy, also laboratory and instrumental inspections and medicines for benign and malignant oncological diagnoses (diagnoses should be in accordance with International Classification of Diseases, Tenth Revision (ICD - 10)). Herewith, from the limit and co-payment defined in the policy for this service, expenses of the further complications will be covered also (including complications after and before the patient was released from the medical institution, despite the conditions caused by these complications will be part of Urgent In-Patient or outpatient services).

6.1.Terms of Receiving Insurance Service

6.1.1. In the case of oncosurgery, radio and radiation therapy and chemotherapy

6.1.1.1. While addressing Insurer's provider medical institution, the Insured will be ensured with services in the medical Institution in the limits and copayment indicated in the Insurance Policy. 5 (five) days prior to receiving the services the Insured shall present full list of documentation, based on which the Insurer issues guarantee letter in 1 (one) working day for the amounts less than 1000 (one thousand) Gel and in 5 (five) working days if cost of the service exceeds 1000 (one thousand) Gel. In order to receive guarantee letter the Insured or his/her representative should present to the Insurer:

6.1.1.1.1. Insurance Card;

6.1.1.1.2. Document confirming identification;

6.1.1.1.3. Form IV-100a filled in according to the rules of the Ministry of labor, health and social defense, confirmed with seal of the institution and signature of the doctor.

6.1.1.1.4. Detailed calculation of medical services;

6.1.1.2. While addressing non-provider medical institution, or receiving medical services in provider medical institution without presenting documentations for guarantee letter, the Insured pays for the services fully and then addresses the Insurer for reimbursement. And the Insurer, in compliance with the conditions of the Insurance Agreement, shall reimburse the cost of the medical service. In order to receive compensation following documents should be presented to the insurance company during 30 (thirty) calendar days since receiving medical

services or they should be uploaded in private space- https://online.irao.ge/login:

6.1.1.2.1. Insurance card;

6.1.1.2.2. Identification Documentation;

6.1.1.2.3. Form IV-100a filled in according to the rules of the Ministry of labor, health and social defense, confirmed with seal of the institution and signature of the doctor.

6.1.1.2.4. Detailed calculation of the services;

6.1.1.2.5. The original payment order and the original of the cash register receipt or printout of the POS-terminal confirming payment.

The Insurer shall make the payment via non-cash within 1 (one) working day after receiving all the necessary documents stipulated in the contract if the estimated amount to be paid does not exceed 200 (two hundred) GEL. Payment in excess of the above amount is made via non-cash payment within 5 (five) working days after receiving all the necessary documents stipulated in the contract. Documents can be placed in boxes placed in the company's offices and/or by uploading them in the private space - https://online.irao.ge/login. Insurance reimbursement is not paid by cash.

In case if documents are sent electronically, the insured is obliged to keep the original documents for 6 (months) months.

6.1.2. **In the event of oncological diagnosis, for reimbursement of expenses of laboratory and instrumental inspections and medicines** please see terms of receiving service for planned outpatient care and for medicines.

7. Pregnancy (waiting period for primary insured 12 months)

Provides for reimbursement of the costs for planned and urgent medical care related to the pregnancy and its complications (doctor's consultation, laboratory and instrumental tests, termination of pregnancy based on a **Medical Evidence,** diagnosing and treatment of pregnancy complications, manipulations, pregnancy related medications, both in outpatient and In-Patient services). **Mentioned coverage will be compensated fully within the limits and copayment indicated in the Insurance Policy and exclusions stipulated in the agreement are not spread on it, unless state/referral program(s).**

7.1.Terms of Receiving Insurance Service

7.1.1. In order to receive services with participation of personal doctor, The Insured addresses personal doctor, who identifies the problem and provides the Health Insured with medical referral(s) for necessary tests in provider medical institutions. In provider medical institution after presenting Medical Referral, ID and Insurance policy, the Health Insured shall not have to pay full cost of medical service, the insured pays only his/her part of amount envisaged by Insurance package (if such exists).

Using electronic referral is available for the Insured, who has opened medical history with the personal doctor of the Insurer. In case the insured has Form IV-100a filled in according to the rules of the Ministry of labor, health and social defense, confirmed with seal of the institution and signature of the doctor or/and the diagnosis and prescription, results of the conducted examinations confirmed with an authorized person's signature and seal one working day prior receiving the service the insured shall send request on e-mail: mimartva@irao.ge. After confirmation of medical services, the Insurer ensures sending electronic referral to specific provider medical institution. In provider medical institution after presenting ID and Insurance policy, the Health Insured shall not have to pay full cost of medical service, the insured pays only his/her part of amount envisaged by Insurance package (if such exists).

7.1.2. Free choice - addressing to the provider or non-provider medical institution without referral of personal doctor and/or electronic referral the Insured pays for the services fully and then addresses the Insurer for reimbursement. In addition, the Insurer, in compliance with the conditions of the Insurance Agreement, shall reimburse the cost of the medical service. Expenses of the medical services received without referral in provider medical institution will be reimbursed according copayment defined free choice. In order to receive compensation following documents should be presented to the insurance company during 30 (thirty) calendar days since receiving medical services or they should be uploaded in private space- https://online.irao.ge/login:

7.1.2.1. Insurance card;

7.1.2.2. Identification Documentation;

7.1.2.3. medical documentation of the obtained service prescribed by licensed doctor (Form IV-100a filled in according to the rules of the Ministry of labor, health and social defense, confirmed with seal of the institution and signature of the doctor or the diagnosis and prescription, results of the conducted examinations confirmed with an authorized person's signature and seal);

7.1.2.4. The original payment order and the original of the cash register receipt or printout of the POS-terminal confirming payment.

The Insurer shall make the payment via non-cash within 1 (one) working day after receiving all the necessary documents stipulated in the contract if the estimated amount to be paid does not exceed 200 (two hundred) GEL. Payment in excess of the above amount is made via non-cash payment within 5 (five) working days after receiving all the necessary documents stipulated in the contract. Documents can be placed in boxes placed in the company's offices and/or by uploading them in the private space - https://online.irao.ge/login. Insurance reimbursement is not paid by cash.

In case if documents are sent electronically, the insured is obliged to keep the original documents for 6 (months) months.

8. Delivery (waiting period for primary insured 12 months)

Provides for reimbursement of the costs of physiological delivery, Caesarean section with or without medical evidence, likewise, its complications, medical services related to bed period complication ((medicines, manipulations, anesthesia, ward (standard/nonstandard, reanimation, intensive care unit), nutrition, doctor's honorarium)). Moreover from the limit and co-payment defined in the card for this service, expenses of the further complications will be covered also (including complications after and before the patient was released from the medical institution, despite the conditions caused by these complications will be part of Urgent In-Patient or outpatient services). Except sepsis after delivery, atonic bleeding after delivery and extra uterine pregnancy, that will be financed with relevant limits defined for In-Patient treatment. **Mentioned coverage will be compensated fully within the limits and copayment indicated in the Insurance Policy and exclusions stipulated in the agreement are not spread on it, unless state/referral program(s).**

8.1. **Terms of Receiving Insurance Service**

8.1.1. In the event of addressing provider medical institution of the Insurer based on insurance card and document confirming identification, the Insured will be able to receive treatment within the limits of the limits/copayment indicated in the Insurance Policy. In the event of Caesar section, in order to receive guarantee letter the Insured or his/her representative should present to the Insurer:

8.1.1.1. Insurance card;

8.1.1.2. Identification Documentation;

8.1.1.3. Form IV-100a filled in according to the rules of the Ministry of labor, health and social defense, confirmed with seal of the institution and signature of the doctor.

8.1.1.4. Detailed calculation of the services;

During planned Caesarean section In the event of receiving guarantee letter 5 (five) days prior to receiving the services the Insured shall present full list of documentation, based on which the Insurer issues guarantee letter in 1 (one) working day for the amounts less than 1000 (one thousand) Gel and in 5 (five) working days if cost of the service exceeds 1000 (one thousand) Gel.

8.1.2. While addressing non-provider medical institution, or receiving medical services in provider medical institution without presenting documentations for guarantee letter, the Insured pays for the services fully and then addresses the Insurer for reimbursement. In addition, the Insurer, in compliance with the conditions of the Insurance Agreement, shall reimburse the cost of the medical service. In order to receive compensation following documents should be presented to the insurance company during 30 (thirty) calendar days since receiving medical services or they should be uploaded in private space- https://online.irao.ge/login:

8.1.2.1. Insurance card;

8.1.2.2. Identification Documentation;

8.1.2.3. Form IV-100a filled in according to the rules of the Ministry of labor, health and social defense, confirmed with seal of the institution and signature of the doctor.

8.1.2.4. Detailed calculation of the services;

8.1.2.5. The original payment order and the original of the cash register receipt or printout of the POS-terminal confirming payment.

The Insurer shall make the payment via non-cash within 1 (one) working day after receiving all the necessary documents stipulated in the contract if the estimated amount to be paid does not exceed 200 (two hundred) GEL. Payment in excess of the above amount is made via non-cash payment within 5 (five) working days after receiving all the necessary documents stipulated in the contract. Documents can be placed in boxes placed in the company's offices and/or by uploading them in the private space - https://online.irao.ge/login. Insurance reimbursement is not paid by cash.

In case if documents are sent electronically, the insured is obliged to keep the original documents for 6 (months) months.

9. Outpatient services

Provides for reimbursement of the costs of expenses of treatment/diagnostical measures related to the Insured's health condition deterioration during relevant medical evidence (specialist consultation, instrumental and laboratory tests, medicines only for urgent outpatient services), conducted to the Insured in any licensed medical institution and the delay of the Insured in the medical institution does not exceed one bed day or does not occupy bed considering corresponding medical evidence.

9.1. Outpatient services include:

9.1.1. **Urgent outpatient services** - provides only the reimbursement of the cost of medical services required for the cases specified in the positive list within the limit / co-payment specified in the insurance policy.

9.1.1.1. Trauma - injury to the body as a result of external force (physical, mechanical, thermal, chemical) - doctor's consultation, surgical treatment / bandaging / suturing of the wound; X-ray examination, correction of the fracture and immobilization; X-ray examination, consultation and fixation of the dislocation.

9.1.1.2. Intoxication - doctor's consultation, detoxification / infusion therapy, laboratory tests.

9.1.1.3. Hypertensive crisis - doctor's consultation, electrocardiography, stabilization of blood pressure.

9.1.1.4. Bleeding - doctor's consultation, tamponade, coagulants.

9.1.1.5. Renal, abdominal, biliary colic - doctor's consultation, general blood and urine tests, ultrasound, IV infusion, analgesic and spasmolytic agents

9.1.1.6. Bronchial and cardiac asthma status - doctor's consultation, drug therapy, seizure suppression.

9.1.1.7. Acute / life-threatening allergic reaction - consult a doctor, anti-allergic treatment.

9.1.1.8. Acute obstructive laryngitis - consultation, cessation of the attack.

9.1.1.9. urgent Vaccination - Provides physician consultation, outpatient manipulation, antirabies, anti-tetanus, botulism and antigiurzin vaccine. However, in the event of an insured event, the first vaccination will be reimbursed within the co-payment and limit of the urgent vaccination service. Each subsequent, will be reimbursed within the co-payment and limit of the planned outpatient services.

Cases/services, which are not indicated in the positive list and are subject to reimbursement in accordance with the terms / exceptions of the agreement, will be covered by the limit and co-payment defined for the planned outpatient clinic.

9.1.2. **Planned outpatient services** - Provides for reimbursement of medical services received at any licensed medical institution within the limits and copayment defined in the Insurance policy;

9.1.3. **Outpatient services without exclusions** - receiving the services is possible only with the referee of personal doctor in the medical institution defined in the Insurance Policy. This service covers only: consultations of doctor/specialists, instrumental and laboratory tests that could be conducted in the base of medical institutions indicated in the Policy.

9.1.4. **Physiotherapy, and Therapeutic Massage at D. Tatishvili medical center** - Provides for 30% discount, there is no need for referral; it is enough to present an insurance card at the medical institution to receive the service.

9.1.5. **In house nurse service** - Provides for reimbursement of costs for manipulations conducted by nurse, which were prescribed by doctor after In-Patient treatment. Service is covered for 2 weeks from planned outpatient service copayment and limits defined in the insurance policy.

9.2. Terms of Receiving Insurance Service

9.2.1. In case of urgent outpatient services

9.2.1.1. The Insured (or his/her representative), contact Irao Assistance during 24 hours (in the events of addressing both - provider and non-provider medical institutions), unless notification is delayed due to objective circumstances, when the medical institution is not able to identify the Insured or Insured is in such condition when notification is impossible due to the health condition. Notification should include the following information: **first and last name of the Insured, Insurance Card number, name of medical institution, time of addressing to the medical institution,**

preliminary diagnosis. In the event of addressing provider medical institution Insured pays only co-payment share indicated in insurance policy (if any).

9.2.1.2. In the event of addressing non-provider medical institution, moreover, in the event of receiving services without notification in provider or non-provider medical institutions, the Insured pays for the services fully and then addresses the Insurer for reimbursement. In addition, the Insurer, in compliance with the conditions of the Insurance Agreement, shall reimburse the cost of the medical service. In order to receive compensation following documents should be presented to the insurance company during 30 (thirty) calendar days since receiving medical services or they should be uploaded in private space- https://online.irao.ge/login:

9.2.1.2.1. Insurance card;

9.2.1.2.2. Identification Documentation;

9.2.1.2.3. Form IV-100a filled in according to the rules of the Ministry of labor, health and social defense, confirmed with seal of the institution and signature of the doctor.

9.2.1.2.4. Detailed calculation of the services;

9.2.1.2.5. The original payment order and the original of the cash register receipt or printout of the POS-terminal confirming payment.

The Insurer shall make the payment via non-cash within 1 (one) working day after receiving all the necessary documents stipulated in the contract if the estimated amount to be paid does not exceed 200 (two hundred) GEL. Payment in excess of the above amount is made via non-cash payment within 5 (five) working days after receiving all the necessary documents stipulated in the contract. Documents can be placed in boxes placed in the company's offices and/or by uploading them in the private space - https://online.irao.ge/login. Insurance reimbursement is not paid by cash.

In case if documents are sent electronically, the insured is obliged to keep the original documents for 6 (months) months.

9.2.2. In case of planned outpatient services

9.2.2.1. In order to receive services with participation of personal doctor, The Insured addresses personal doctor, who identifies the problem and provides the Health Insured with medical referral(s) for necessary tests in provider medical institutions. In provider medical institution after presenting Medical Referral, ID and Insurance policy, the Health Insured shall not have to pay full cost of medical service, the insured pays only his/her part of amount envisaged by Insurance package (if such exists).

Using electronic referral is available for the Insured, who has opened medical history with the personal doctor of the Insurer. In case the insured

has Form IV-100a filled in according to the rules of the Ministry of labor, health and social defense, confirmed with seal of the institution and signature of the doctor or/and the diagnosis and prescription, results of the conducted examinations confirmed with an authorized person's signature and seal one working day prior receiving the service the insured shall send request on e-mail: mimartva@irao.ge. After confirmation of medical services, the Insurer ensures sending electronic referral to specific provider medical institution. In provider medical institution after presenting ID and Insurance policy, the Health Insured shall not have to pay full cost of medical service, the insured pays only his/her part of amount envisaged by Insurance package (if such exists).

9.2.2.2.Free choice - addressing to the provider or non-provider medical institution without referral of personal doctor and/or electronic referral the Insured pays for the services fully and then addresses the Insurer for reimbursement. In addition, the Insurer, in compliance with the conditions of the Insurance Agreement, shall reimburse the cost of the medical service. Expenses of the medical services received without referral in provider medical institution will be reimbursed according copayment defined for free choice. In order to receive compensation following documents should be presented to the insurance company during 30 (thirty) calendar days since receiving medical services or they should be uploaded in private space- https://online.irao.ge/login:

9.2.2.2.1. Insurance card;

9.2.2.2.2. Identification Documentation;

9.2.2.2.3. medical documentation of the obtained service prescribed by licensed doctor (Form IV-100a filled in according to the rules of the Ministry of labor, health and social defense, confirmed with seal of the institution and signature of the doctor or the diagnosis and prescription, results of the conducted examinations confirmed with an authorized person's signature and seal, in case of need medical card);

9.2.2.2.4. The original payment order and the original of the cash register receipt or printout of the POS-terminal confirming payment.

The Insurer shall make the payment via non-cash within 1 (one) working day after receiving all the necessary documents stipulated in the contract if the estimated amount to be paid does not exceed 200 (two hundred) GEL. Payment in excess of the above amount is made via non-cash payment within 5 (five) working days after receiving all the necessary documents stipulated in the contract. Documents can be placed in boxes placed in the company's offices and/or by

uploading them in the private space - https://online.irao.ge/login. Insurance reimbursement is not paid by cash.

In case if documents are sent electronically, the insured is obliged to keep the original documents for 6 (months) months.

9.2.3. In case of in house Nurse service

9.2.3.1. The Insured pays for the services fully and then addresses the Insurer for reimbursement. In addition, the Insurer, in compliance with the conditions of the Insurance Agreement, shall reimburse the cost of the medical service. In order to receive compensation following documents should be presented to the insurance company during 30 (thirty) calendar days since receiving medical services or they should be uploaded in private space- https://online.irao.ge/login:

9.2.3.2. Insurance card;

9.2.3.3. Identification Documentation;

9.2.3.4. Form IV-100a filled in according to the rules of the Ministry of labor, health and social defense, confirmed with seal of the institution and signature of the doctor or the diagnosis and prescription given for in-patient treatment , results of the conducted examinations confirmed with an authorized person's signature and seal, in case of need medical card);

9.2.3.5. Detailed calculation of the services;

9.2.3.6. Financial documentation confirming payment, in the form approved by Ministry of Finance and printed at a printing house, which is equivalent to receipt or document including detailed calculation of the services.

The Insurer shall make the payment in cash only in case when the estimated sum to be reimbursed does not exceed GEL 200 (two hundred). The payment of sums exceeding the aforementioned amount or in case documents were uploaded in private space- https://online.irao.ge/login shall be made via non-cash payment by the Insurer within 5 (five) days since receiving all the necessary documents under the Insurance Agreement.

In case if documents are sent electronically, the insured is obliged to keep the original documents for 6 (months) months.

10. Medicines

Reimbursement of the cost of the Medications prescribed by any licensed doctor and/or personal doctor according to corresponding Medical Evidence in the course of outpatient and dental care and prescribed under the scheme set forth by Georgian legislation. At one time only, the Insurer shall reimburse the amount of medications needed for one-month course of treatment.

10.2. Terms of Receiving Insurance Service

10.2.1. Based on the referral of the personal doctor, the Insured shall present Insurance Policy and documents confirming identification in pharmacy network based on

which he/she will pay only his/her share defined under the Insurance Policy (if any).

10.2.2. While purchasing medicines without referral of personal doctor, Insured pays for the services fully and then addresses the Insurer for reimbursement. In addition, the Insurer, in compliance with the conditions of the Insurance Agreement, shall reimburse the cost of the medical service. In order to receive compensation following documents should be presented to the insurance company during 30 (thirty) calendar days since receiving medical services or they should be uploaded in private space- https://online.irao.ge/login:

10.2.2.1. Insurance card;

10.2.2.2. Identification Documentation;

10.2.2.3. a receipt, together with the list of purchased medications;

10.2.2.4. original of cash register receipt or printout of POS-terminal;

10.2.2.5. medical documentation of the obtained service prescribed by licensed doctor (Form IV-100a filled in according to the rules of the Ministry of labor, health and social defense, confirmed with seal of the institution and signature of the doctor or the diagnosis and prescription, results of the conducted examinations confirmed with an authorized person's signature and seal, in case of need medical card);

The Insurer shall make the payment via non-cash within 1 (one) working day after receiving all the necessary documents stipulated in the contract if the estimated amount to be paid does not exceed 200 (two hundred) GEL. Payment in excess of the above amount is made via non-cash payment within 5 (five) working days after receiving all the necessary documents stipulated in the contract. Documents can be placed in boxes placed in the company's offices and/or by uploading them in the private space - https://online.irao.ge/login. Insurance reimbursement is not paid by cash.

In case if documents are sent electronically, the insured is obliged to keep the original documents for 6 (months) months.

11. Dental Services

11.1. **Dental Services include**:

11.1.1. **Emergency Dental Services** - provides reimbursement of the costs in case of acute tooth pain diagnostical measures (dent gram/Visio), primary dental care (opening of the root and extraction) and the relief of acute dental pain (anesthesia). **Service can be received in provider and non-provider dental clinics.**

11.1.2. **Planned Dental Services** - provides reimbursement of the costs according Medical Evidence of consultation of dentist (therapy, surgery), diagnostical measures (dentogram/Visio), therapeutic services (dental filling procedure, tooth decay, pulpitis, periodontitis, professional dental cleaning in case of prophylactic and medical evidence with ultrasound method twice in a year (once in six months),

planned dental surgery (extracting of tooth, planned surgical manipulations) and local anesthesia. Treatment of Periodontics and mucosal treatment with application method only in provider dental institutions. **Service can be received only at provider dental clinics.**

11.1.3. **Dental Implantation, orthopedic/orthodontic dental services** - provides discount in provider medical institutions for orthopedic, orthodontic dental services and dental implants.

11.2. Terms of Receiving Insurance Service

11.2.1. **In order to receive urgent and planned dental services** while addressing provider dental institution of the Insurer the Insured pays (based on the presenting insurance card and document confirming the identity) only part of his/her share defined in the Insurance Policy (if any)

11.2.2. **In order to receive urgent dental services** - while addressing to non-provider dental institution, Insured pays for the services fully and then addresses the Insurer for reimbursement. In addition, the Insurer, in compliance with the conditions of the Insurance Agreement, shall reimburse the cost of the medical service. In order to receive compensation following documents should be presented to the insurance company during 30 (thirty) calendar days since receiving medical services:

11.2.1.1. Insurance card;

11.2.1.2. Identification Documentation;

11.2.1.3. Medical documentation confirmed with the seal of institution/doctor and doctor's signature, with detailed description of conducted services;

11.2.1.4. X ray /Visio taken before and after the services; Presentation of this is not mandatory for children under 12 years of age, pregnant women and oncology patients;

11.2.1.5. original of cash register receipt or printout of POS-terminal;

The Insurer shall make the payment via non-cash within 1 (one) working day after receiving all the necessary documents stipulated in the contract if the estimated amount to be paid does not exceed 200 (two hundred) GEL. Payment in excess of the above amount is made via non-cash payment within 5 (five) working days after receiving all the necessary documents stipulated in the contract. Documents can be placed in boxes placed in the company's offices and/or by uploading them in the private space - https://online.irao.ge/login. Insurance reimbursement is not paid by cash.

In case if documents are sent electronically, the insured is obliged to keep the original documents for 6 (months) months.

11.2.3. **In order to receive orthopedic/orthodontic, implantation dental services** the insured addresses only provider medical institution indicated in the annex of this agreement. Based on presented insurance card and document confirming identification, the Insured pays discounted price of the service.

11.2.3.1. On **services**, on which provider dental institution does not offer discounts, likewise, service received in non-provider dental institution is not subject to compensation.

12. Treatment Abroad

Provides for reimbursement of costs for medical care abroad with methods that are unavailable in Georgia or/if the Health Insured has a desire to perform it abroad. Herewith, reimbursement occur according average price of Insurers three provider medical institutions on the performed medical care, in case if this procedures can not be performed in provider medical institutions reimbursement occur according average price of three medical institutions existing in Georgia and in accordance with the limit and co-payment defined in Card (despite the costs paid abroad for treatment) in case when treatments is possible in Georgia, when treatment is not possible in Georgia reimbursement shall be paid according to the calculation presented to the Insurer in the range of limits and co-payment given in the card. This coverage spread on the following services: planned inpatient service, cardiology, and planned outpatient service.

12.1. Terms of Receiving Insurance Service

Expenses of planned In-Patient services, cardiology services received abroad will be reimbursed only with prior agreement with the Insurer, based on presenting relevant documentation in service center. In the event of misinformation of the Insurer or not presenting full-required documentation, the Insurer is exempt from obligation of any compensation payment. After receiving consent from the Insurer, in the event of treatment abroad the Insured pays full amount of treatment. In the event of planned outpatient services, prior agreement with the Insurer is not necessary.

In order to receive compensation following documents should be presented to the insurance company during 60 (sixty) calendar days since receiving medical services or they should be send uploaded in private space- https://online.irao.ge/login:

12.1.1. documentation of conducted services (diagnosis and prescription confirmed with signature and seal, in the event of outpatient services - conclusion of conducted examinations/tests and list of manipulations; in case of In-Patient services extract from history in regard of diagnosis and conducted medical services).

12.1.2. detailed calculation of medical service, documentation confirming the payment;

12.1.3. The Insurer is entitled to request translation (on Georgian) of presented medical documents/receipts.

The payment of sums shall be made only via non-cash payment by the Insurer within 5 (five) days since receiving all the necessary documents under the Insurance Agreement.

In case if documents are sent electronically, the insured is obliged to keep the original documents for 6 (months) months.

13. Inspection of materials taken in Georgia abroad

Provides for reimbursement of costs for laboratory tests of biological liquids and tissue taken in Georgia.

13.1. Terms of Receiving Insurance Service

13.1.1. In case service is available in Georgia, reimbursement shall be paid according local price for this test/procedure of the medical institution where test/procedure was performed if such test/procedure is done in this clinic and in case if this procedure cannot be performed in the same medical institutions reimbursement occur according average price of three provider and/or three medical institutions existing in Georgia

13.1.2. In case service is not available in Georgia, reimbursement shall be paid according to the calculation presented to the Insurer in the range of limits and co-payment given in the card.

The Insurer shall make the payment via non-cash within 1 (one) working day after receiving all the necessary documents stipulated in the contract if the estimated amount to be paid does not exceed 200 (two hundred) GEL. Payment in excess of the above amount is made via non-cash payment within 5 (five) working days after receiving all the necessary documents stipulated in the contract. Documents can be placed in boxes placed in the company's offices and/or by uploading them in the private space - https://online.irao.ge/login. Insurance reimbursement is not paid by cash.

In case if documents are sent electronically, the insured is obliged to keep the original documents for 6 (months) months.

14. Travel Insurance

Provides issuance of travel insurance policy, according to insurance period indicated in the Insurance Policy. Conditions of travel insurance is given in details in the Travel Insurance Policy. In order to activate coverage/receive travel insurance policy the Insured should address JSC Irao's service center or send information on travel@irao.ge, the Insurer issues relevant travel insurance based on presenting passport by the Insured.

Part 2 – Exclusions

1. According to the health insurance conditions the following is not covered/compensated:

1.1. Any type of self-harm; self-endangerment, unless aim of such actions is saving other person's life; moreover, intentional actions of the Insured, fraud or results/complications of such actions; expenses of self-treatment and/or its complications;
1.2. Costs for such cases, which resulted directly or indirectly by being under the influence of narcotics or/and toxic substances; Also, costs related to medical services caused by accident, which happened during driving car under the influence of alcoholic, narcotic and/or toxic substances; Costs for treatment of drug addiction, alcoholism and toxic mania; Costs for treatment of aggravation of health condition as a result natural disaster;
1.3. Costs for treatment of the physical injuries suffered during committee of an illegal act provided for by the Criminal Code; Costs for treatment of injuries suffered as a result of participation in a civil war, any kind of military operations, anti-state appearances, armed conflicts, acts of terrorism;
1.4. Examination and treatment of chronic hepatitis (except A hepatitis), HIV, AIDS and their complications. (herewith, Primary diagnostics of chronic hepatitis is subject to reimbursement including only doctors consultation and easy-fast test).
1.5. Costs for examination and treatment of pancreatic diabetes or diabetes insipidus, renal and/or liver chronic failure examination and treatment of their complications;
1.6. Costs for examination and treatment of Epilepsy, multiple sclerosis and amyotrophic lateral sclerosis, sarcoidosis, systemic diseases (including: polyarteritis nodosa, necrotizing vasculopathies, lupus erythematosus, dermatopolymyositis, systemic sclerosis, other systemic involvement of connective tissue).
1.7. Costs for examination and treatment of congenital and genetic diseases, defects, pathologies and their complications; (Herewith, will be reimbursed only doctors consultation); Costs associated with the examination and treatment of inflammatory polyarthropathies (M05-M14 according 10th revision of the International Statistical Classification of Diseases)
1.8. Costs for examination and treatment of Mental and behavioral disorders (including: Organic disorders, including symptomatic ones; Mental and behavioral disorders due to psychoactive substance use; Schizophrenia; schizotypal disorders; Neurotic, stress-related and somatoform disorders; Mood [affective] disorders; Behavioral syndromes associated with physiological disturbances and physical factors; Disorders of adult personality and behavior (psychopathy); Mental retardation; Disorders of psychological development; Behavioral and emotional disorders with onset usually occurring in childhood and adolescence; Also, Nervousness, Restlessness and agitation (F00-F99, R 45.0-45.1 according 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD 10);
1.9. Costs for contraceptive/Contraception; costs for sterilization (or its cancelation), fertilization, vasectomy, abortion without medical evidence, sex change; costs for

examination and treatment of reproductive function, sexual disorders and in vitro fertilization;

1.10. Costs for examination and treatment of gonorrhoea, syphilis, chancroid, venerial granuloma – donovanosis, chlamydial infections, genital herpes, Cytomegalovirus, trichomoniasis, vulvovaginal candidiasis, bacteriac vaginosis and urethritis; (Primary diagnostics is subject to reimbursement, including doctor consultation and smear bacterioscopy).

1.11. Costs for any type of oncological problems (both benign and malignant) existed before the insurance period (including after the expiration of the waiting period);

1.12. Events related to the participation of the Health Insured in any kind of professional sports or in sports as sportsmen (sports competition, training, demonstration show etc.)

1.13. Costs for treatment by means of alternative an experiment medicine, manual therapy, acupuncture, plasmapheresis, ozonotherapy, homeopathy, mesotherapy, speech therapist (logopedist); physician-homeopath; medical exercises and medical massage; physiotherapy, rehabilitation and sanatorium-and-spa treatment; Genotyping, Mole Computer Diagnostics (FotoFinder), palliative treatment, plastic and reconstruction surgery, medical services done for cosmetic purposes; Costs related to metabolic syndrome and weight correction (Including postoperative complications); immunization, vaccinations (except of antitetanus, antirabies, antibotulinum and anti-viper and those defined in card); Costs for therapeutic and surgical dental care which is needed for preparation by means of orthodontical and orthopedical treatment; (except those defined in card);

1.14. Expenses related to purchase of psychotropic medicines, para treatment, nonregistered medicines, immunodulators, immunostimulators, immunosupresants, monoclonal antibodies, agents acting on metabolism in tissues, biologically active additives and homeopathic remedies, systemic enzymotherapy, Growth factor (PRP) injection, medicines used for alcohol dependence / alcoholism treatment;

1.15. Costs for additional and exclusive services during hospitalization (except delivery) (for example: nonstandard room, hired doctor etc.)

1.16. Costs of dialysis itself and costs related to dialysis;

1.17. Expenses related to obtaining any medical notice and expenses of tests connected it (unless defined in under agreement terms);

1.18. Costs for exoprosthesis (including dental health service), transplantation (including transplants), refraction anomalies and strabismus correction; Expenses related to the following condition of transplantation.

1.19. Costs for purchasing of hearing aids, (eye)glass frames, contact lenses (including intraocular lence), medical devices for corrective purposes, supporting devices, Internal fixing devices (including metal construction, plate, bolts, etc.), prothesis, implants (except stent, the brand and model of which will be determined by the insurer), artificial rhythm directive equipment, artificial rhythm directive equipment; Costs of osteoplastic material and platelet-rich fibrin (APRF (Advanced Platelet Rich Fibrin)) membrane;

Note: In cases when medical service is provided for/covered by any federal/ referral program(s), any screening programme, the Insurer undertakes to cover/reimburse the Health Insured's Share of the costs per such program in accordance with co-payment share stipulated by the insurance agreement. Also, if the Health Insured enjoys medical services at a medical institution where corresponding state programs are not operating, the Insurer takes responsibility to cover fully the costs for medical services enjoyed by the Health Insured in accordance with the terms of the insurance Agreement. In addition, if the insured receives medical services in a medical institution where the relevant program does not operate or if a specific doctor does not participate in the relevant program or if the insured himself refuses to use the program(s) while receiving services, the insurer will not reimburse the costs of such medical services, except for the cost which the insurer would have to reimburse if the insured received services at a medical institution and specific doctor participating in the relevant program or if the insured did not refuse to use the program(s) while receiving services. In addition, in case of new coronavirus (SARS-CoV-2) infection (Covid-19) and its complications, both urgent and planned, the Insurer undertakes to reimburse only those services / interventions that are not funded by the state / referral program (s) and which complies with state management standards / protocols (payment will be made within the limit and co-payment for the relevant service).

Note: These important terms are the standard terms of a health insurance contract.