SPECIAL TERMS AND CONDITIONS FOR INDIVIDUAL VOLUNTARY HEALTH INSURANCE

I INTRODUCTORY PROVISIONS

Article 1

(1) General Terms and Conditions for Voluntary Health Insurance (hereinafter: General Terms and Conditions) and Special Terms and Conditions for Individual Voluntary Health Insurance (hereinafter: Special Terms and Conditions) of Dunav Insurance Company a.d.o. (hereinafter: the Insurer) shall form an integral part of the concluded Contract on Individual Voluntary Health Insurance (hereinafter: the Insurance Contract).

(2) As used in the Special Terms and Conditions hereof, particular words shall have the following meaning:

- Sum insured/Sublimit – maximum pecuniary amount and/or the number of services provided or the days used that represent the limit of liability of the Insurer under a particular insurance cover and/or a medically justifiable treatment of the Insured during the year of insurance, as specified under the Insurance Contract,

- Outpatient treatment – medically justified treatment that the Insured has received from the healthcare service provider without having spent 24 consecutive hours in such institution (an overnight stay and/or hospital bed occupancy),

- Hospital treatment – medically justified healthcare service rendered by the healthcare service providers during the treatment in a day hospital and/or inpatient treatment (where the Insured occupies a hospital bed for the purpose of undergoint the treatment). The inpatient treatment in a day hospital is carried out in a special department of a healthcare institution established to perform surgical interventions, therapeutic procedures and observations that do not require inpatient treatment. Hospital treatment shall not be deemed accommodation of the Insured in inpatient type institutions such as the institutions for drug addiction rehabilitation, health institutions for the treatment of psychiatric patients, spas and hydro clinics (except in the case of prolonged rehabilitation therapy), sanatoriums, nursing homes, old people's homes i.e. geriatric institutions, sanatoriums, centers for rest, treatment centres, centres for rest, weight loss and recovery,

- Patronage care – care provided at Insured's home by qualified medical staff immediately upon hospital treatment and upon a written report and the order of an authorized doctor confirming the necessity of rendering such care in the home of the Insured,

- Reasonable and regular expenses – the expenses not exceeding the cost of the agreed level of service provided by the network of clinics – Classic, Super, VIP - incurred for the same or similar medical treatment rendered by healthcare service providers within the Network of Healthcare Service Providers of the Insurer, that apply at the moment of insured occurrence and/or the medical expenses not exceeding the general level of regular medical expenses in similar medical institutions in the place where such expenses were incurred. All amounts exceeding the reasonable and regular expenses shall be borne by the Insured,

- Medically justifiable healthcare service – a healthcare service, medical and technical aids, implants, medical supplies or a medically justified medicine if:

1. appropriate and necessary for the diagnosis or treatment of a disease or injury of the Insured in line with the Insurance Contract (Policy),
2. necessary for the coverage of expenses of pregnancy amd childbirth (provided such cover has been agreed),
3.required for prevention of occurrence and early detection of diseases within a general check-up (if such cover has been agreed),
4. prescribed by an authorized doctor and if there is a clear medical indication for a particular medical treatment,
5. incurred during the term of the insurance contract,
6. in accordance with widely accepted professional standards of medical practice and in line with the Policy and the Special Terms and Conditions hereof,
7. not primarily intended for personal comfort or convenience of the patient, family, doctor or another healthcare service provider,
8. not part of a patient's education or professional training or related to those,
9. not experimental or in the phase of research,
10. agreed in conformity with the Special Terms and Conditions hereof and defined under the Policy,
11. it does not exceed in the scope, period or intensity the level of protection required for the provision of safe and adequate treatment according to the professional estimate of a doctor in line with the Guidelines on good clinical practice (implemented procedures must be relevant for the symptoms of the disease and their implementation must be justified by the actual clinical picture),

- First entry into insurance – date when the Insured first acquired the capacity of the Insured: under the Special Terms and Conditions hereof (relative to continuous insurance) and/or under other Terms and Coditions of the same type of the same or of another Insurer, by way of exception,

- Continuous insurance – re-entry into an Insurance Contract for a person that has already been covered under an earlier insurance Policy issued by the same or, exceptionally, by another insurer, with no interruption of cover between the two Policies,

- Previous health condition – any health condition arising from any chronic or recidive (recurring) illness or injury suffered before the first entry into insurance which, after the inception of the insurance cover, calls for a continuous or occasional medical care and treatment, including the drug therapy and hospital treatment. Previous health condition can be determined on the basis of medical records obtained from the Insured or healthcare service providers when using medically justified treatments covered by insurance or when delivering an additional medical examination upon request of the Insurer,

- Co-pament – Insured's share in the payment of the agreed cost of healthcare service for which the Special Terms and Conditions hereof stipulate the mandatory participation, unless otherwise agreed,

- Accident – any sudden event occurring beyond the will of the Insured that by a generally external and sudden impact on the body of the Insured results in the Insured's death, total or partial disability, temporary work incapacity or health impairment requiring medical assistance.

II GENERAL PROVISIONS
Eligibility for Insurance

Article 2

(1) Under the Terms and Conditions hereof, eligible for insurance shall be all persons who already possess the status of the Insured under the Mandatory Health Insurance as well as the persons who are not covered by the Health Insurance or have not joined the Mandatory Health Insurance Scheme.

(2) The insurance hereof may include only the persons with reported residence/stay in the Republic of Serbia in accordance with the regulations governing this area.

Conclusion of Insurance Contract
Article 3

(1) Under the Insurance Contract, the Policyholder shall undertake to pay the Premium to the Insurer and the Insurer shall undertake to indemnify reasonable and regular medical expenses of medically justifiable treatment incurred on the territory of the Republic of Serbia up to the level of the sum insured and individual sub-limits stipulated under the Insurance Contract. All amounts in excess of reasonable and regular expenses shall be borne by the Insured.

(2) The Insurance Contract shall be signed following a previous written proposal. An integral part of the Proposal shall be a Questionnaire on the health condition of the Insured (hereinafter: The Questionnaire). The Questionnaire includes general identification data on the Insured and questions on the health condition of the Insured relevant to the Insurer for risk assessment, definition of the desired coverage and Premium amount. Based on the results of the Questionnaire, the Insurer shall be entitled to propose insurance cover to persons with increased risk under amended conditions, charging an additional insurance Premium or introducing the limits and/or exclusions of liability under some insurance coverages.

(3) Upon acceptance of the Proposal, the Insurer shall issue the Policy to the Policyholder. The Insurance Contract shall be deemed concluded if the Premium has been paid and the Policy issued. The Policyholder shall confirm that he has accepted the General and Special Terms and Conditions that form an integral part of the Insurance Contract.

(4) The rights under the Policy shall not be assignable and can be exercised upon presentation of a relevant identification document.

Insurance Cover and Insured Event

Article 4

(1) For the purpose of the Insurance Cover defined under the Special Terms and Conditions hereof, the Insured Event shall be deemed any future event occurring beyond the will of the Insured during which the Insured has been rendered a medically justifiable healthcare service in a healthcare institution, private practice or by another healthcare provider, following an illness or an injury or medical condition, which event is the subject matter of Insurance Contract and the expenses of which need to be settled.
(2) Illness or injury or medical condition must be diagnosed by an authorized doctor of a relevant specialty.

(3) The chosen sum insured shall be agreed by consent between the Contracting Parties and defined under the Policy and the Schedules thereto. The scope of the insurance cover shall be agreed depending on the chosen sum insured and may include various healthcare services and covers, within the following:

- Outpatient treatment,
- Hospital treatment,
- Prescription medicines,
- Medical rehabilitation in outpatient treatment,
- Ophthalmologist services,
- Dental services,
- Preventive healthcare (general check-up),
- Costs of pregnancy and childbirth.

The agreed sum insured, scope of cover, volume of healthcare services and sublimits shall be declared under the Policy and Schedules thereto.

(4) The amount of individual sublimits for the agreed level of cover and services is defined depending on the chosen sum insured. Individual sublimits shall be included in the agreed sum insured and not increase the maximum liability of the Insurer according to the sum insured.

(5) The agreed sum insured and individual sublimits shall be the maximum limit of the liability of the Insurer any one insured occurrence for the entire agreed insurance period and shall be declared in the Proposal/Policy in euros and exhausted and/or reduced by the costs of rendered healthcare services charged in euros at the mean exchange rate of the NBS as of the date of claim settlement.

(6) In case the expenses incurred upon occurrence of the Insured Event are less than the sum insured stipulated under the Insurance Contract, the Insured shall not be entitled to the payment of the balance.

Obligations of Insurer

Article 5

(1) The Insurer shall undertake to remunerate medically justifiable, reasonable and regular medical expenses incurred for a single or multiple medical treatments rendered under the agreed insurance covers for healthcare services, as stipulated under the Insurance Policy and the Schedules thereto and within the following proposed services:

1. Outpatient treatment

•Examinations by authorized doctor (general practitioner and medical specialist),
•Home visits by an authorized doctor in emergency medical cases,
•Examination by a nutritionist delivered upon recommendation of an authorized doctor of the relevant specialty, limited only to the following diseases first diagnosed after the first entry into insurance: diabetes mellitus, metabolic syndrome, cancer, arthritis,
•Laboratory tests, testing and analyses (excluding the genetic testing),
•Diagnostic procedures, testing and analyses upon a medical indication set by an authorized specialist doctor,
•Diagnostic procedures, laboratory testing, tests and analyses necessary for infertility testing,
•Emergency medical or medically justified transportation that includes the transport by ambulance to the health care provider upon a life-threatening illness or injury of the Insured, as well as transport by ambulance that is not an emergency, but is justified and medically required,
• Outpatient interventions that include:
- outpatient surgical interventions on the skin and subcutaneous tissue under local anesthesia and other outpatient therapeutic procedures:
• removal of benign and malignant changes (melanocytic moles, lipomas, fibromas, hemangiomas, basal cell carcinoma, squamous cell carcinoma, malignant melanoma, seborrheic keratosis, viral warts),
• incision and drainage of inflammatory changes (abscess, furuncles, carbuncles, subcutaneous cysts),
• immobilization after injury or accident,
• immobilization by applying plaster,
• extraction of a foreign body, parasite or tick,
• surgical treatment of minor wounds (washing, edge treatment and sewing),
• wound treatment and treatment of burns,
• bending, removing stitches,
• wrist puncture.

- indications for the removal of benign and malignant changes as well as for incision and drainage of inflammatory changes in the skin and subcutaneous tissue are set by a specialist dermatologist.
- the removal of melanocytic moles, lipomas, fibromas, subcutaneous cysts and viral warts is limited to medically justified cases that require enclosing to the Insurer along with the request for prior consent for the treatment, the medical documentation from where medical justification can be established,
• Prescription drugs (injection, inhalation and infusion) - drug therapy with registered drugs during outpatient treatment, which includes outpatient administration of the drug in a health care provider by injection, infusion or inhalation, with coverage of the cost of the drug, administration of therapy, sanitary materials, medical supplies and infusion or inhalation solution. Coverage includes the use of drugs registered for use in human medicine according to the valid national drug register of the Republic of Serbia.
•Emergency dental care following an accident for the restoration or replacement of teeth damaged in the accident,
•Chemotherapy and radiotherapy (for diseases occurring for the first time during the insurance period). If insurance coverage is agreed for outpatient and inpatient treatment, there is a single sublimit for chemotherapy and radiotherapy services for both the inpatient and outpatient treatment (sublimits for outpatient and inpatient treatment are not summed up),
•Patronage care provided by health professionals immediately after the hospital treatment at recommendation of an authorized doctor, provided that there is an ongoing treatment delivered by the authorized doctor and the Insured is temporarily or permanently unable to move (immobile),
•Services of a psychiatrist or psychologist and/or all healthcare services related to mental health and problems, including psychotherapy, provided they are medically necessary. Such services include compensation for consultations with a psychiatrist, psychologist or, if necessary, a doctor of other specialties in connection with mental health problems,
• Complementary medicine methods (homeopathy, quantum medicine and acupuncture), if they are performed by health workers who have a license from the Ministry of Health of the Republic of Serbia to practice complementary medicine methods and who, in accordance with the Law, are engaged by health service providers with a permit to expand their activity to a specific method of complementary medicine, provided they are applied for the purpose of treating medical conditions covered under the Terms and Conditions hereof and insurance contract,
• Medical-technical aids within the outpatient treatment only if prescribed by an authorized doctor, namely, prostheses (including prosthesis for upper and lower limbs as well as ocular prostheses), orthotic devices, aids to facilitate movement (crutches, sticks, walking stand), belts, sanitary devices, therapeutic contact lenses in case of corneal injuries, typhlotechnical aids, hearing aids and aids for enabling voice and speech,
• Treatment rendered in emergency department - covers the costs of treatment of a critical injury or illness of the Insured, which may lead to permanent deterioration of the Insured's health or death, without an urgent medical intervention. Emergency medical intervention includes emergency medical assistance provided to the Insured during the first 12 hours of the Insured's admission to the emergency ward.

2. Hospital treatment

•Hospital accommodation, medical care and nutrition upon indication of authorized doctor during hospital treatment in healthcare institutions of secondary and tertiary level,
• Examinations by and services of a licensed doctor and medical staff,
•Diagnostic procedures,
•Laboratory tests, testing and analyses (excluding genetic testing),
•Emergency dental care following an accident for the restoration or replacement of healthy teeth damaged in the accident,
•Prescription medication - drug therapy with registered drugs during hospital treatment, which includes all methods of drug administration with the health service provider, inclusive of the coverage of the cost of the drug, sanitary material, medical supplies and infusion, i.e. inhalation solution. Coverage comprises the use of drugs registered as human medication according to the valid national drug register of the Republic of Serbia,
• Medical rehabilitation that includes the application of physical, work, occupational, speech therapy and defectology therapy and is delivered during hospital treatment, by authorized therapists,
•Therapy in spa conditions (extended rehabilitation), rendered upon indication of an authorized doctor of the relevant specialty as a type of extended rehabilitation that is carried out after the treatment initiated in hospital, i.e. institutions of secondary or tertiary level and which is limited exclusively to diseases and conditions that were first diagnosed after the first entry into the insurance,
•Chemotherapy and radiotherapy (for diseases that occur for the first time during the insurance period). If insurance coverage for outpatient and inpatient treatment has been agreed, there is the single sublimit for chemotherapy and radiotherapy services for both the inpatient and outpatient treatment (sublimits for outpatient and inpatient treatment are not summed up),
•Surgical interventions, which include costs incurred during treatment in a day hospital, from the moment of admission to hospital for the treatment to a discharege from hospital. Such costs are the costs of: pre-operative preparation, surgical intervention, treatment in the intensive care ward and post-operative care and treatment. Surgical interventions shall be deemed traditional open surgery, microsurgery, minimally invasive surgical therapeutic techniques (laparoscopy, endoscopy, thoracoscopy, hysteroscopy, arthroscopy, angioplasty, etc.), laser surgery, vascular surgery, surgery of the vascular structures of the anal region, etc. Coverage includes emergency interventions by a maxillofacial/oral surgeon to repair the consequences of an accident.
•Medical technical aids,
•Treatment in the emergency ward covers the costs of treating a serious injury or illness of the Insured, which may lead to permanent impairment of the Insured's health or his death without an emergency medical intervention. Emergency medical intervention includes emergency medical assistance provided to the insured during the first 12 hours of his admission to the emergency ward,
•Emergency medical or medically justified transportation that includes the transportation by ambulance to the health care provider due to a life-threatening illness or injury of the Insured, as well as the transportation by ambulance that is not an emergency, but is justified and medically necessary,
•Surgical implants prescribed by the authorized doctor upon a clear medical indication.

3. Prescription drugs

The coverage of the costs of prescription drugs includes the incurred costs of drugs prescribed by an authorized doctor of a relevant specialty for a particular medical indication. The Insurer shall cover the costs of prescription drugs that are prescribed in therapeutic doses for not more than 60 (sixty) days.

The coverage also includes the cost of purchasing drugs that are administered by a healthcare provider during outpatient or inpatient treatment.

The Insurer shall admit the costs of drugs registered for use in human medicine according to the valid national register of medicines of the Republic of Serbia, as well as medicines that are not registered in the Republic of Serbia but are imported based on the approval of the Medicines and Medical Devices Agency of Serbia.

4. Medical rehabilitation in outpatient treatment

Physical therapy in outpatient treatment includes the administratnion of physical, work, occupational, speech therapy and defectology therapy. Medical rehabilitation is delivered by authorized therapists (physiotherapist, work/occupational therapist, speech therapist, defectologist).

Physical therapy includes kinesitherapy, electrotherapy, laser therapy, magnetotherapy, ultrasound therapy, thermotherapy and spinal decompression.

Physical therapy is limited to diseases and injuries that were first diagnosed after the first entry into the insurance coverage: degenerative joint diseases (spondylosis, gonarthrosis, coxarthrosis), disc herniation, inflammatory rheumatism (rheumatoid arthritis, polyarthritis, Bechter's disease), diseases of the nervous system (Below's paralysis, carpal tunnel syndrome, tarsal tunnel syndrome, Parkinson's disease, multiple sclerosis, conditions after a stroke or brain injury), conditions after injuries (bone fractures, spinal column injuries, contusion and distortional joint injuries, joint dislocations, strains and ruptures of tendons, ligaments and muscles), conditions after joint operations.

Physical therapy can be administered at home only when the Insured is immobile, upon mandatory priar approval of the Insurer and in the event that the Insured has had a fracture of the lower extremities or a spinal injury, or a cardiovascular insult (heart attack), at recommendation of the authorized doctor who previously treated the Insured.

Work and occupational therapy include conditions resulting from developmental disorders, illnesses, injuries, emotional disorders or aging, which require training for independent performance of daily life activities and work.

Speech therapy includes disorders of speech, language and communication skills.

Defectology therapy includes motor obstructions and disorders, prevention and treatment of behavioral disorders, visual and hearing disruptions and disorders, disorders and disruptions in sensorimotor development.

5. Ophthalmological services (in outpatient treatment)

Under the coverage of an ophthalmologist, the following services are possible during one year of insurance:
• One examination for dioptre determination,
• Procurement of one frames,
• Procurement of glasses / lenses.
The procurement of frames and glasses/lenses shall be admitted only for the dioptres exceeding the range of ± 0.99. The purchase is also possible if the specified diopter is determined in only one eye. The purchase of contact lenses is possible in quantities that correspond to medical needs, the type of lenses and the duration of insurance, at the discretion of the doctor.

6. Dental services

Coverage for dental expenses may include the following services:
• **Preventive treatment** – includes routine examinations and dental instructions once per year,
•**Standard restorative treatment** - includes amalgam and composite fillings, compromise restorations,
•**Big restorative treatment** - includes root filling, crown and filling bridges (including laboratory costs and anaesthesia),
•**Periodontal descaling** - allowed once a year,
•**Periodontal pocket treatment**,
•**Oral-surgical interventions** - tooth extraction (routine, complicated and surgical).

Coverage includes the cost of anaesthesia and dental X-rays.

7. Preventive healthcare (general check-up)

The preventive healthcare shall be deemed a set of health services (general check-up) that are performed preventively in order to check the health condition of the Insured, by the healthcare provider with whom the Insurer has agreed the provision of such services to the specified agreed scope and content. The costs of the general check-up shall be covered for one general check-up during the year of insurance.

Standard general check-up provided within the Insurer' network shall include:

1. For persons older than eighteen:
• Laboratory analyses: Qualitative examination of urine with sediment, complete blood count (Er, Le, Hb, Hct, Le formula), sedimentation, glucose, AST, ALT, urea, creatinine, triglycerides, cholesterol (total cholesterol, HDL, LDL),
• Examination by an internal medicine doctor with an ECG,
• Ultrasound examination of the upper abdomen,
• Ophthalmological examination of eyes and sight,
• Spirometry - lung function test,
• Urologist examination and prostate ultrasound, PSA included for men older than 40,
• Gynaecological examination with colposcopy, ultrasound gynaecological examination, Papanicolaou test, VS and ultrasound examination of the breast - for women,
• Final examination and findings.

2. For persons from one to eighteen years of age:

• Laboratory analyses: Qualitative examination of urine with sediment, complete blood count (Er, Le, Hb, Hct, Le formula), sedimentation,
• Nasal and throat swab,
• Anthropometric measurements - body height, weight, determination of body mass index, measurement of waist and assessing body composition,
• Examination by an ophthalmologist or otorhinolaryngologist or physiatrist (of choice),
• Examination by a paediatrician.

3. For infants under one year of age:
• Laboratory analyses: Qualitative examination of urine with sediment, complete blood count (Er, Le, Hb, Hct, Le formula), sedimentation,
• Anthropometric measurements - body height, weight, determination of body mass index, measurement of waist and assessment of body composition,
• Ultrasound of the hips,
• Examination by a paediatrician.
The Policyholder and the Insurer shall jointly agree on the schedule for implementation of preventive healthcare. In the case of a request for a different scope of health services within a general check-up, this can be delivered only at the prior consent of the Insurer or the Medical Call Centre, within the agreed dynamics and the agreed sub-limit. The services of a general check-up are used fully, within the agreed scope. Exceptionally, at the request of the Insured, the Insurer may allow the use of a separate examination/diagnostic procedure within the agreed scope of a general check-up. After the use of even one separate service, the agreed cover of Preventive Healthcare (general check-up) shall be considered fully used up.

8. Costs of pregnancy and childbirth

Depending on the chosen sum insured, the pregnancy and childbirth costs may include the following:

- Examinations, including the first control examination after childbirth no later than 60 days after childbirth, swabs, laboratory analyses (CBC, basic biochemistry, urine analyses), according to the recommendation of the authorized doctor (gynaecologist) who controls the pregnancy,
- Prenatal vitamins and drug therapy prescribed by an authorized gynaecologist,
- Additional ultrasound in high-risk pregnancies,
- Regular ultrasound examinations of the foetus,
- Expert foetal ultrasound,
- Prenatal diagnostics:
  - biochemical screening and/or non-invasive prenatal diagnostics from the mother's blood, in order to detect chromosomal aberrations and analysis of foetal DNA, as per medical indication
  -invasive diagnostics (amniocentesis, chorionic villus sampling, cordocentesis),
- Childbirth, which includes the incurred costs for doctors, epidural, medical technicians, anaesthesiologists, delivery room, medicines, additional diagnostics, etc. The costs of a caesarean section are covered only if the caesarean section is medically indicated,
- Apartment accommodation at childbirth,
- Cardiotocography (CTG),
- Presence of a close person at delivery,
- Medical expenses of an infant in the first month – per infant,
- Patronage care in the first month of life of a child, per child, rendered by healthcare professionals (midwife), but not to exceed the first month of the life of a new-born,
- Pregnancy complications and abortion - coverage includes the costs of hospital treatment of medical conditions that may lead to pregnancy complications, the costs of hospital treatment of pregnancy complications and/or the costs of outpatient or hospital treatment of an abortion done for medical or ethical reasons.

(2) During the agreed insurance period and according to the agreed level of coverage under the Special Terms and Conditions hereof, the Insurer shall enable the Insured to use healthcare services rendered by the healthcare service provider chosen from the Network of Healthcare Institutions with which the Insurer has concluded a business cooperation agreement.
Within the insurance cover, the Insurer shall provide necessary information of the Insured in connection with the insurance cover and organise the provision of a healthcare service via the Medical Call Centre available throughout the year 00-24h. According to the concluded Insurance Contract, the Insured shall choose the healthcare institution within the network of healthcare service providers of the Insurer or outside such network (provided that the treatment outside the Network has been agreed). Healthcare institution shall be responsible for the quality of provided healthcare services.

(3) Upon the payment of the appropriate insurance premium, the Policyholder shall select the desired standard of a healthcare service:
- that the examination may be performed by a healthcare service provider not included in the Insurer's Network of Healthcare Service Providers,
- examination and treatment by a professor holding a Doctorate in Medicine,
- level of services for the network of clinics – Classic, Super, VIP, according to the List of Healthcare Service Providers of the Insurer,
- inclusion of the previous health condition that can be contracted only when the sums insured are higher than, or equal to 5.000 EUR.

If the service of examination by a professor of medicine is not contracted, the Insurer will refund the costs of the provided healthcare services up to the average amount of the examination by a specialist doctor in a given healthcare institution and/or in the contracted network of healthcare institutions if such a healthcare institution does not provide for an examination by a specialist doctor. In the case of an examination by a professor of medicine in an institution outside the network of health institutions, the Insurer will reimburse the costs of the provided healthcare services up to the average amount of an examination by a specialist doctor under the Classic level of services provided by the network of clinics.

(4) The Insurer shall undertake to update and make available on its website the list of all healthcare service providers included in the Insurer's Network of the Healthcare Service Providers with which the Insurer has concluded a business cooperation agreement.

(5) Upon call of the Insured, the Insurer's Medical Call Centre shall verify the scope and level of coverage and shall schedule an appointment for a specific healthcare service. A medical report or a referral issued by the attending physician from the health institution, on the basis of which additional health services are scheduled, must not be older than 6 months, unless its validity is defined differently on the referral itself.

(6) The Insurer shall reimburse to the Insured medical expenses for provided healthcare services, according to the contracted scope of cover, pursuant to the Special Terms and Conditions hereof, upon submission of the claim for reimbursement, provided that the Insured:
- has used and paid healthcare services provided by a healthcare service provider with which the Insurer has not concluded a business cooperation agreement, or
- has paid, for any reason, the service to the healthcare service provider with which the Insurer has concluded a business cooperation agreement.

(7) When using healthcare services, the Insured shall pay a mandatory participation amounting to 15% of the agreed price of service, except for the preventive healthcare.

The stipulated participation may be excluded (participation buy-back) if specially agreed, and provided that the additional premium has been paid, but only when the sums insured are higher than, or equal to 5000 EUR. The Policyholder may contract the payment of participation for the use of services of a healthcare service provider, with the reduction of insurance premium.

Depending on the agreed service level for the network of clinics – Classic, Super, VIP, the appropriate participation shall be applied, which shall be summed up with the amounts of other envisaged participations, unless such participations have been bought back. The subject participation shall not be applied to the services of preventive healthcare and to the costs of prescription drugs.

The Insured shall pay the stipulated amount of participation directly to the healthcare service provider following the use of a healthcare service, depending on the price of healthcare services agreed between the Insurer and the healthcare service provider.

In the event of reimbursement, the stipulated amount of participation shall be applied in the claim settlement process.

Territorial Scope

Article 6

(1) The stipulated insurance coverage shall be valid on the territory of the Republic of Serbia.

Insurance Period

Article 7

(1) The Insurance Contract shall be concluded for the definite term. Insurance may be stipulated to a period not longer than one year, with the option to extend the term of the Insurance Contract.

(2) The insurance shall begin at 24:00 hours on the date indicated in the policy as the inception date of the insurance contract, provided that by that time the insurance premium has been paid, unless agreed otherwise. The insurance shall terminate at 24:00 hours on the date indicated in the policy as the date of insurance expiry.

(3) In the event when the insurance terminates in relation to the insurance contracts concluded for the term of one year, the premium return shall be calculated in proportion to the remaining insurance period, provided that there were no claims during the insurance period and, if claims occurred during the insurance period, no premium return shall be made. Premium return shall not be made when the insurance is concluded for a period shorter than one year.

(4) In the event that the insurance terminates prior to the agreed expiry thereof, the Policyholder or the Insured shall be obliged to deliver/return to the Insurer the Document evidencing insurance.

(5) For the agreed cover of pregnancy and childbirth expenses, the waiting period shall be 4 (four months). The liability of the Insurer shall start running from the twenty-fourth hour of the waiting period expiry date.

(6) The waiting period shall not apply to persons with continuous insurance coverage, except for the persons for whom the waiting period has not completely expired during the previous policy period, in which case the remaining waiting period shall be carried forward to the subsequent insurance period indicated in the new policy.

(7) If the pregnancy occurs before the inception of the Insurance Contract or within the waiting period, the Insurer shall not be obliged to cover the healthcare expenses for pregnancy and childbirth.

Premium Payment

Article 8

(1) Insurance premium shall be calculated according to the Insurer's effective rates.

(2) The Policyholder shall be obliged to regularly pay the due premium to the Insurer, within the deadlines stipulated in the Insurance Contract/Policy.

Exclusion of Insurer's Liability

Article 9

(1) The liability of the Insurer shall be excluded in the following cases:
1) for costs of any healthcare service which is not agreed and for which the insurance premium has not been paid,
2) for treatment costs incurred for previous health conditions, unless specially agreed with the payment of additional insurance premium. The liability of the Insurer shall be in any case excluded for: Alzheimer's disease, Parkinson disease, paralysis, diabetes mellitus with chronic complications, aneurysm (of brain arteries and big arteries), all forms of coronary (ischemic) heart diseases, condition after coronary stent implantation, stroke, transient ischemic attack, ventricular tachycardia, ventricular fibrillation), bradycardia with implanted pacemaker, aortocoronary bypass, cardiac insufficiency, heart valve disease, severe elevation of blood pressure requiring inpatient treatment, aplastic anaemia, all blood coagulation disorders, congenital heart defects, pemphigus, myasthenia gravis, systemic lupus erythematosus, multiple sclerosis, sclerodermia, motor neurone disease, muscular dystrophy, osteoarthritis, rheumatoid arthritis, surgical replacement of a hip joint, knee, shoulder, elbow, ankle joint, wrist joint, sleep apnoea, psychoses, psychotic personality disorders, liver cirrhosis, hepatitis chronica, ulcerative colitis, Crohn's disease, syphilis, tuberculosis, as follows: bilateral fibrothorax, epididymitis and spinal tuberculosis, cancer, benign brain tumour, chronic obstructive pulmonary disease, end-stage renal disease - dialysis, transplantation. If these diseases occur for the first time during the insurance period, the Insurer shall bear the costs of their treatment according to the agreed insurance cover.

The Insurer shall not reimburse the costs incurred relative to pre-existing conditions for services of medical rehabilitation in outpatient treatment. The costs for prescription drugs shall be covered for previous health conditions, provided that such previous health condition is the subject matter of the insurance cover.

In case of continuous insurance, previous health condition shall not be considered the condition occurred during the previous Insurance Contract, however, the Insurer shall have the right to propose the contract renewal based on the claims history of the Insured under the previous policy, with the adjustment of the insurance premium or limitation or exclusion of liability for particular insurance covers.

In the event that after the expiry of the insurance contract a new insurance contract is concluded with a more extensive insurance cover compared to the previous contract, the previous health condition shall be considered any disease which was not covered by the previous policy and which occurred during the previous policy period.

3) HIV, AIDS and other immunodeficiency syndromes,
4) injuries and illnesses as a consequence of wars, internal riots, rebellions, terrorism and the like,
5) injuries and illnesses caused by epidemics and pandemics,
6) injuries and illnesses caused by catastrophes and natural disasters,
7) any deterioration of health caused by ionizing radiation (nuclear radiation),
8) injuries and illnesses caused by attempted suicide or intentional self-inflicted injuries,
9) sport risks from the professional, amateur or recreational pursuit of hazardous (extreme) sports such as: hunting, go-kart racing, acrobatic stunts, parkour, street board, freestyle roller skating, diving, rock climbing, handling of pyrotechnics, fireworks, ammunition and explosives, ski jumps, bobsledding, freestyle skiing, motor and motorcycle races, hang-gliding, sky-diving, paragliding, bungee jumping, rafting, inline skating, sailing, water scooter rides and the like,
10) injuries and illnesses occurred as a result of perpetration of or involvement in a crime,
11) injuries and illnesses occurred as a result of abuse of alcohol, narcotics, intoxicants (hallucinogens) or as a result of addiction treatments (alcohol, drugs, medications and the like),
12) injuries and illnesses caused by voluntary exposure to hazards (except in the case of saving someone's life, but not for taking part in search parties),
13) application of experimental medical methods or methods used for research purposes,
14) removal of physical handicaps or anomalies, cosmetic treatment, aesthetic procedures, except for implants in total mastectomy,
15) costs of nasal septum surgery, except when it is performed for medical reasons, and only for children younger than 18,

16) in experimental medical research or healthcare services which are not scientifically or medically recognized, such as sleep studies and obstructive sleep apnoea treatments,
17) costs of birth control (contraception), infertility treatment, artificial insemination and treatment of sexual dysfunction, as follows:
- all contraceptive methods for women and men and consequences thereof (mechanical, hormonal and surgical contraception, that is, sterilization by vasectomy or tubal ligation),
- termination of pregnancy at the personal request of the insured and consequences thereof, except in medically justified cases or abortion caused for medical or ethical reasons,
- all infertility treatment methods,
- sterilisation reversals (tubal ligation reversal, vasectomy reversal),
- preparation for artificial insemination and medications, as well as any artificial insemination procedure,
- treatment of sexual dysfunction,
- treatment with Viagra or a generic alternative,
- sex reassignment, including psychotherapy and hormonal therapy, sex and breast reconstruction surgery,

18) for prenatal classes and preparation for childbirth,
19) dental services (within the dental services cover) of cosmetic dentistry procedure, teeth whitening, teeth jewellery placement (zirconium) for fixed braces, mobile braces - orthodontic treatments, total and partial braces for the upper and lower jaw, for implants, splints, retention foils for teeth straightening and retainers and others that are not included in this coverage,
20) costs of compulsory preventive vaccination, immunoprophylaxis and chemoprophylaxis that are compulsory according to the programme of compulsory and recommended immunization of population against certain contagious diseases in the Republic of Serbia, except for the costs of post-exposure active and passive immunisation against: rabies, tetanus in injured persons, hepatitis B in newborns, HBsAg-positive carrier mothers, persons who had an accident with infectious materials, and pregnant women with liver damage if they have been exposed to infection,
21) for relaxation massages in physical outpatient and inpatient therapy, therapy with acoustic waves (Shockwave), High Intensity Laser (HIL), T-care therapy, endermologie (LPG), INDIBA therapy, ozone and plasma therapy,
22) for weight loss treatments or programme of weight reduction by gastric balloon surgery,
23) for PRP- platelet-rich plasma therapy,
24) for 3 Tesla MR (3T) magnet scan,
25) for costs of cryopreservation and implantation and re-implantation of living cells,
26) for rejuvenation treatment, regardless of whether prescribed by an authorised doctor or not,
27) for Autonomic Nervous System Testing, syncope,
28) for costs in connection with the treatment of astigmatism and strabismus, myopia, hypermetropia and presbyopia, including surgical procedure of radical certotomy,
29) for surgical procedures of organ and tissue transplantation, regardless of whether the Insured is a recipient or a donor,
30) for temporomandibular joint disorders, examinations and treatments of occlusal disturbances,
31) for removal of moles, growths and other dermatological changes at one's own discretion,
32) for circumcision (foreskin removal) if not medically indicated,
33) for treatment of fungal nail infections of hands and feet, as well as examinations and treatment of ingrown toenails and cuticles,
34) for costs in connection with the concrete feet injuries such as: callus, foot corns, hyperkeratoses and bunions,
35) for illnesses or injuries occurred during professional and amateur pursuit of sports and professional and amateur sports competitions,
36) for illnesses or injuries occurred as a result of involvement in a fight (except in cases of self-defence),
37) for all medical services which are not prescribed and/or performed by the authorised doctor,
38) performed treatments, that is, healthcare services, medications, medical supplies, medical and technical aids and implants not indicated by the doctor of an appropriate speciality,
39) use of emergency service of a healthcare service provider in cases which do not represent a medical emergency,
40) in the event when the Insured has refused to follow the instructions obtained from a medical team,
41) procurement of medications not prescribed by the authorised doctor,
42) if the Insured refuses to relieve the doctor and the medical team, that have diagnosed his/her disease, from the obligation of medical confidentiality and thus makes impossible for the Insurer to obtain necessary information,
43) reimbursement of medical expenses which are reimbursable under any other contract or right,
44) in the event of document misuse, in which case the costs incurred following the insured event shall be borne by the Insured,
45) other costs:
- exceeding reasonable and customary expenses within the meaning of these Special Terms and Conditions,
- for the purchase of personal care products and all cosmetic preparations,
- for taking and preserving stem cells and all other related expenses,
- for herbal medications, traditional medications and traditional herbal medications, as well as biologic medications, except for the expenses of post-exposure active and passive immunisation against: rabies, tetanus in injured persons, hepatitis B in newborns, HBsAg-positive carrier mothers, persons who had an accident with infectious materials, and pregnant women with liver damage if they have been exposed to infection, advanced therapy medicines, extemporaneous drug formulations and stock preparations used for treatment of cold, medications in experimental and research phase, therapy waters and mineral waters, medicinal wines, nutritives and immunizers, invigorants and the like, if prescribed by an authorised doctor,
- for all medical devices, except for medical and technical aids if agreed in accordance with these Terms and Conditions, compression stockings for varicose veins, maternity belly bands if pregnancy and childbirth expenses coverage has been agreed,
- for mucous membrane hygiene agents, topical antiseptics, preparations for problematic skin treatment, dietary and vitamin supplements other than prenatal vitamins if pregnancy and childbirth expenses coverage has been agreed,
- for original prescription drug (under patent protection) when there is a generic alternative, except when the doctor has indicated that the specified drug is necessary,
- expenses incurred because the hospital has actually become or could be perceived as home or permanent residence of the insured person,
- all expenses that are not medically related,
- adjustment of a vehicle, bathroom or accommodation facility to personal needs,
- all medical and technical aids issued without an indication of the attending physician,
- following devices: additional wheels, room crane, items for increasing comfort (such as telephone holders and over the bed trays), items used to change the quality of air or temperature (such as air conditioners, humidifiers, seasoners and air purifiers), insulin pumps, exercise bikes, sunlamps or heat lamps, heating pads, bidets, saunas, elevators, Jacuzzi, training equipment and similar products;
- for frames and glasses for sunglass and/or related accessories,
- for consumer goods,
- for transport, except for emergency patient transport or medically justified transport,
- examination by a general practitioner or a specialist doctor for the purpose of issuing the certificate for the kindergarten,

recreational classes, driving licence, travelling abroad, visa, and other administrative purposes,
• preventive examinations, screening tests and diagnostic procedures and medical interventions indicated by age, positive family history or upon personal request of the Insured, regardless of medical indication,
46) for any other expenses not referred to in Article 5 of the Special Terms and Conditions hereof.

(2) If the Insured or the Policyholder has provided incorrect data or if there is a fraudulent intention or intention of misuse, all liabilities of the Insurer shall be excluded.

(3) In accordance with these Special Terms and Conditions, the Insurer shall not reimburse the costs incurred due to the medical treatment which has begun prior to the beginning of the Insurer's liability or which lasted after the termination of the Insurer's liability, despite the fact that the treatment has started during the term of the Insurance Contract.

Obligations of the Insured

Article 10

(1) The Insured or the Policyholder shall:
• report to the Insurer any circumstances which are known or could not have stayed unknown to him and which are relevant for the risk assessment,
• during the term of the Insurance Contract, report to the Insurer any relevant circumstances affecting the information provided upon the conclusion of the Insurance Contract,
• pay the agreed insurance premium.

(2) Upon the occurrence of the insured event, the Insured shall be obliged to:
• call the Medical Call Centre of the Insurer and provide necessary identification details (number of insurance document or first and last name, date of birth, name of the Policyholder and the sum per policy, as well as the type of illness or injury) in order to exercise the rights arising from the concluded Insurance Contract, and accept the treatment at the healthcare service provider's included in the Network of Healthcare Service Providers of the Insurer, unless the treatment is agreed outside the Network,
• enable the authorised person the perusal of policy or the Insurance Document at the healthcare service provider's premises,
• independently pay the costs of healthcare services incurred at the healthcare service provider's with which the Insurer has concluded the business cooperation agreement,
• if he has paid the costs of healthcare services independently, for the purpose of establishing the existence and scope of liability, file the request for the reimbursement of costs within one month from the date of treatment completion and provide to the Insurer any necessary information and documents evidencing the occurred insurance event. Otherwise, the Insurer shall not be obliged to bear the increased costs,
• in connection with the insured event, authorise his/her treating doctors and healthcare service providers to, at the Insurer's request, provide all necessary information in connection with his/her treatment,
• in connection with the insured event, authorise his/her treating doctors and healthcare service providers to, at the Insurer's request, provide all necessary information in connection with his/her previous health condition,
• as necessary, undergo the examination by a doctor assigned by the Insurer, in order to establish the circumstances relevant for the grounds and amount of liability arising under the Insurance Contract,
• at the invitation of the healthcare service provider or the Insurer, pay the amount exceeding the amount of the agreed sum insured.

(3) If, due to his or her medical condition the Insured is not able to immediately act in the manner stipulated in the Article hereof, he/she shall act as soon as his or her medical condition allows him or her to do so. In place of the Insured, this liability may be fulfilled by another person (relative, travel companion, healthcare service provider who admitted the Insured and the like).

Settlement of Liability

Article 11

(1) In the liability settlement process:
1) upon the occurrence of the insured event, the costs of the provided healthcare service shall be credited to the account of the healthcare service provider who provided the Insured with the healthcare service,
2) upon the occurrence of the insured event in the manner stipulated in Article 10 paragraph 2 indentation 3 of the Special Terms and Conditions hereof, the right to the cost compensation shall be decided after the receipt of necessary documents in connection with the occurred insured event and the approved compensation shall be paid to the Insured.

(2) In the event of reimbursement for the purpose of exercising the right to compensation, the Insured shall deliver to the Insurer the request for the compensation of treatment costs, complete medical documents with the doctor's report containing the diagnosis of illness or injury or description of the medical condition and bills for medical services, medicines and other rendered services contracted under insurance coverage (original bills must be submitted when the Insurer considers this necessary), from which the relevant facts may be established as regards the occurrence of the insured event and/or the contact telephone number. The date of issue must be recorded on the submitted medical documentation and on all the bills.

(3) The Insurer shall have the right to ask from the insured person, Policyholder, or other person, the additional explanations or documents in order to establish relevant circumstances in connection with the reported insured event.

(4) If participation has been agreed, the Insured shall pay such portion to the healthcare service provider and in the event of reimbursement, the Insurer shall reduce the compensation by the amount stated on the bill as the agreed participation percentage. If the amount so obtained is lower than the limit/sublimit, the limit shall be exhausted for the said amount i.e. the compensation shall be granted in the refund process. If the obtained amount is higher than the agreed limit/sublimit, the compensation shall be equal to the limit/sublimit amount i.e. to the remaining unexhausted limit/sublimit amount if such limit has already been the subject of exhaustion.

(5) The Insurer shall not be liable for the expenses incurred in the course of using a healthcare service of treating the illnesses, injuries or medical conditions excluded as a pre-existing condition or for the illnesses, injuries or medical conditions of a pre-existing condition that have not been previously agreed, for which there is an option to specially contract the inclusion in insurance in accordance with the Special Terms and Conditions hereof. For the amount of the expenses so incurred, the Insurer shall have the right of recourse against the Insured.

(6) If the Insured is a foreign national who:
- at the time of claim settlement resides in the Republic of Serbia, the settlement of claim shall be paid in Dinars, to the current account of the Insured or of the authorised person,
- at the moment of claim settlement resides in a country other than the Republic of Serbia, the compensation shall be paid to the Insured in Euros at the mean exchange rate of the National Bank of Serbia ruling as at the date of claim settlement. In such case, the payment shall be made to the foreign currency account

of the Insured or authorised person which must be opened in the Republic of Serbia.

III CLOSING PROVISIONS

Article 12

(1) Claim compensation in cases of multiple insurance shall be resolved in accordance with the Law of Contract and Torts.

Article 13

(1) Anything not regulated by the terms and conditions hereof shall be subject to the provisions of the General Terms and Conditions hereof, unless they are in contravention to these Special Terms and Conditions.

Article 14

(1) The Insurer may amend these Special Terms and Conditions according to the procedure and in the manner in which they have been adopted.

(2) The amended terms and conditions shall be applicable only to the newly concluded insurance contracts.

(3) The Special Terms and Conditions, which were in force at the moment of the currently effective insurance contracts, shall continue to stay in force until the expiry of the current insurance year, unless the terms and conditions were changed because of the amendments to legal regulations that were beyond the control of the Insurer.

Article 15

(1) In the event of any dispute in connection with the application of these terms and conditions, the court in Belgrade shall have jurisdiction.

Article 16

(1) Upon entry into force of the Special Terms and Conditions hereof, the Special Terms and Conditions for Individual Voluntary Health Insurance ("Official Bulletin of the Company", No. 33/20) shall cease to apply.

(2) The Special Terms and Conditions shall be published on the official website of the Insurer. The Special Terms and Conditions shall come into force on the subsequent day from the date of their publishment in the Company's Bulletin.

THIS VERSION OF THE TERMS AND CONDITIONS SHALL APPLY AS OF 23 DECEMBER 2022