INDIVIDUAL VOLUNTARY HEALTH INSURANCE
SPECIAL TERMS AND CONDITIONS

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CAUTION

ATTENTION!

SUM INSURED
PREMIUM

OPENING PROVISIONS AND DEFINITIONS

Voluntary Health Insurance General Terms and Conditions (hereinafter: General Terms and Conditions) and these Individual Voluntary Health Insurance Special Terms and Conditions (hereinafter: Special Terms and Conditions) are an integral part of the voluntary health insurance contract signed between the Policyholder and the Insurer.

Certain terms used herein shall have the following meaning:

- **ACUTE ILLNESS** – symptoms arise suddenly, don't last long, medium to moderate pain requiring medical treatment that can't be postponed for long;
- Alternative and complementary medicine – traditional methods and procedures used for prevention, diagnosis, treatment, and rehabilitation, which have a beneficial effect on human health and which, according to relevant medical standards, are not part of conventional medical methods and procedures, and which are performed only in a healthcare facility or private practice established as an office of a general practitioner / medical specialist, a dentist, a polyclinic, a medical clinic or a rehabilitation clinic, and provided solely by a medical professional licensed to perform treatments using alternative and complementary medicine methods and procedures;
- **PRE-AUTHORIZATION OF TREATMENT** – written confirmation by the Insurer, before a health service is rendered, that the costs of the service will be covered in accordance with the approval given and these Special Terms and Conditions, which indicate the cases in which authorization is required. Making an appointment via Medic Call Center is not considered authorization unless the entire procedure required under these Special Terms and Conditions has been carried out.
- **HEALTHCARE PROVIDER** – primary, secondary, and tertiary healthcare facilities (health center, pharmacy, institute, hospital, clinic, medical-hospital center, clinical center), private practice (practice, polyclinic, laboratory, pharmacy, outpatient unit), and other healthcare providers in accordance with the law. Legal entities, entrepreneurs, and counseling centers registered for the provision of speech therapy services or consultations with a psychologist and psychotherapist, and opticians for the services covered under "Vision correction" coverage are also considered healthcare providers hereunder.
- **OTHER QUALIFIED MEDICAL AND HEALTHCARE PROFESSIONALS** – persons with relevant university, college, or secondary school medical degrees (psychologists, special education and rehabilitation specialists, speech therapists, pharmacists, medical technicians, physical therapists) practicing medicine at a healthcare provider's facility, in accordance with these Special Terms and Conditions and regulations in the country where the coverage applies;
- **INSURANCE YEAR** – a period of twelve (12) months starting from the date of inception of insurance coverage provided for under the policy.
- **MEDICAL EMERGENCY** – a disease or injury which could, without direct/immediate medical attention, endanger the life of an Insured, i.e. cause irreparable or severe deterioration or impairment of their health or death. Medical emergency shall mean medical attention provided within 12 hours from the moment the Insured is admitted, in order to avoid the expected occurrence of an urgent medical condition;
- **IMPLANTS** – medical devices that are surgically built into the human body.
- **HEALTH QUESTIONNAIRE** – health details provided by the Insured to the Insurer before signing the policy;
- **TREATMENT** – medically justified treatment considered according to generally recognized rules of medical practice to be adequate for the illness or injury symptom relief, recovery, or prevention of deterioration of health, which is covered by the policy. Treatment also includes medical procedures and medications used in alternative and complementary medicine in compliance with laws regulating the field of alternative and complementary medicine;

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- **MEDICINE** – a product placed on the market, having certain potency, pharmaceutical form, and packaging, containing a substance or a combination of substances that have been shown to have the effect of treating or preventing diseases in humans or animals, as well as a substance or a combination of substances that can be used or applied to humans or animals, either to restore, improve or alter physiological function through the pharmacological, immunological or metabolic effect or to make a medical diagnosis;
- **MEDICAL CENSOR** – a person with a medical, dental, or another relevant degree, performing voluntary health insurance risk assessment and/or claim settlement tasks for the Insurer in accordance with the Insurer's internal regulations and these Terms and Conditions;
- **SUBSTANDARD RISK** – a person (high-risk individual) who, due to current health condition, medical history, high-risk profession, or unhealthy lifestyle, can be expected to need more treatments compared to a standard-risk individual. A standard-risk individual is a person of average health, average habits, no disease and/or with a low-risk disease which, according to the Insurer, doesn't indicate either relapses or consequential diseases. The degree of substandard risk is determined by the Insurer based on information from the Health Questionnaire, all medical reports and/or results of medical exams available to the Insurer in accordance with the risk assessment procedure;
- **LIMIT** – maximum amount, i.e. a number of services that are the Insurer's maximum liability per policy or per coverage for each Insured over the course of an insurance year. The exceptions are the „Healthcare for Pregnant Women and Newborns" and „Healthy Child" coverage, where the limits apply to an individual pregnancy or child's age, but not to the insurance year (provided that the policy is renewed). Limits are stipulated in the policy;
- **MEDIC CALL CENTER** – the Insurer's telephone service working 24/7, 365 days a year, with medically trained personnel available to the Insured, providing insurance-related assistance, as specified in these Terms and Conditions.
- **MEDICAL DEVICES** – medical and technical aids and implants;
- **MEDICALLY JUSTIFIED TREATMENT** – a health service, a medical device, medical supplies or medicine are medically justified if:
  - they are necessary for the diagnosis, treatment, and management of a disease or injury of the Insured, if they meet their medical needs in scope, dosage, and duration, and are in compliance with the policy;
  - they are necessary for healthcare for pregnant women or for prevention of onset or early detection of disease during an annual physical exam (if such coverage is stipulated);
  - they are negotiated in accordance with these Special Terms and Conditions and set out in the policy;
  - they have been prescribed by a licensed physician and if there is a clear medical indication;
  - their primary purpose is not the personal comfort of the patient, family, physician, or another healthcare provider;
  - they are not a part of related to the patient's educational or professional training;
  - they are not experimental or in the research phase;
  - they comply with widely accepted professional standards of medical practice in the country where the coverage is in force, and don't exceed - in scope, duration, or intensity – the level of protection required to provide safe and adequate medical treatment according to the professional judgment of the Insurer's medical censor or to good clinical practice guidelines (procedures must address the symptoms of a disease and be required based on the current clinical presentation);
- **MEDICAL AND TECHNICAL AIDS** – medical devices used for the functional and aesthetic replacement of lost parts of the body, that is, providing support, preventing deformities and correcting existing deformities, and facilitating the performance of basic life functions;
- **HEALTHCARE PROVIDERS' NETWORK** (hereinafter: Network) – all healthcare providers that are under a service contract with the Insurer during the period of insurance, the services of which the Insured may use in the manner set out in General and Special Terms and Conditions;
- **ACCIDENT** – any sudden event, not under the control of the Insured, unpredictable, and caused by an external factor, leading to the Insured's injury or health issues.
- **NEW INSURED** – a person subsequently added to the insurance policy because they became eligible after the policy inception date;
- **ONLINE CONSULTATION** – remote consultation with a licensed physician (by telephone or via the telemedicine Internet platform) conducted solely within the Network.
- **INSURANCE IN CONTINUATION** – taking out an insurance policy again for the person who has already been insured under the policy with the same insurance plan and in accordance with these Terms and Conditions, without interruption between the periods of insurance.

  The insurance in continuation is not a transfer from insurance:
  - contracted under other terms and conditions,
  - having different insurance plans under these Special Terms and Conditions, unless otherwise stipulated in the policy,
  - of other insurers;
- **INSURER** – Generali Osiguranje Srbija a.d.o.
- **LICENSED PHYSICIAN** – a person with a medical, dental, or another relevant university degree, providing health services independently, working with a healthcare provider, and practicing medicine in compliance with the law;
- **INSURANCE PLAN/COVERAGE** – stipulated combination of health services, coverage levels, and limits set out in the policy;

- **COPAYMENT** – Insured's share in the costs of medically justified treatment covered by the Insurer, under these Terms and Conditions; Copayment is shown as a percentage or as a fixed amount;
- **COVERAGE** – health services, medicines, and medical supplies listed in these Special Terms and Conditions, stipulated under the insurance contract (policy and its schedules);
- **HEALTH DISORDER** – any health disruption that causes health issues for the Insured. Under these Special Terms and Conditions, mental health disorders shall mean cognitive, emotional, and behavioral conditions that impede the emotional and social functioning of the Insured. All health issues arising from mental health disorders can only be covered under outpatient treatment as „Mental Health Service" coverage.
- **PRE-EXISTING CONDITION** – any health condition resulting from any chronic illness or injury that occurred before the first enrollment, including congenital diseases;
- **CUSTOMER PORTAL** – the Insurer's website that can only be accessed by authorized users and which provides an overview of insurance information for each individual Insured;
- **REASONABLE AND CUSTOMARY FEES** – the costs not exceeding the negotiated price for the same or similar medical treatment within the Network, at the time the insured event occurs. These costs shall apply to the use of services at in-network and out-of-network healthcare providers.
- **MEDICAL TRANSPORT** – transport by private practice ambulance or local ambulance, for the necessary medical treatment within the borders of the Republic of Serbia. Transport by any vehicle other than an ambulance is not considered medical transport, and it doesn't include any costs of rescue;
- **CLAIM FORM** – filed to the Insurer by the Insured or by the in-network healthcare provider.

General Provisions

Article 1

(1) Under these Special Terms and Conditions, the Insurer provides supplemental, additional, and private health insurance, as well as a combination of the said types of insurance in accordance with the law.

(2) Under the insurance contract the Policyholder is required to pay the premium to the Insurer, and the Insurer is required to pay reasonable and customary fees for medically justified treatment in the Republic of Serbia, up to the amount of the sum insured, i.e. the limit specified in the insurance contract (policy and its schedules), in line with the present Special Terms and Conditions. All amounts above the reasonable and customary fees shall be borne by the Insured.

(3) The contractual relationship, according to the present Special Terms and Conditions, can be established with payment of the premium only in case of remote contracting, in which case the proof of contractual relationship is an insurance certificate issued by the Insurer. By accepting the insurance contract, the Policyholder undertakes to pay the premium to the Insurer for the entire policy period regardless of whether the payment method is a single payment, made at the time of contract signing, or installments.

(4) The insurance is contracted for a period specified in the insurance policy and cannot be terminated unilaterally, except in cases provided for under the Law of Contract and Torts and the Law on Voluntary Health Insurance.

Commencement and Termination of the Insurer's Liability

Article 2

(1) The insurer's liability shall commence at 24.00 hours on a date indicated as the insurance inception date for each Insured, provided that the full premium or the first installment of the premium is paid for the Insured unless it is agreed that the premium is paid upon execution of the policy. The Insurer's liability shall last until the expiry of the last day of the term of the Insurance Contract and as specified in the policy.

(2) For any coverage which includes the waiting period, the Insurer's liability shall start from 00.00h on the waiting period end date.

(3) Insurer's liabilities end on the 24th hour on the day specified in the policy as the insurance expiry date – or sooner, if:
3.1. death of the insured occurs,
3.2. other cases specified in the General Terms and Conditions occur.

(4) Termination of insurance for the Insured also means termination of insurance for their family members, regardless of the reason for termination. Exceptionally, if the premium is paid for the remaining policy period and the death of the Insured occurs, the insurance for family members will last until the expiry of the current policy.

(5) In case of termination of insurance before the stipulated expiration date, the Policyholder, i.e. the Insured is required to return the card to the Insurer.

(6) In case of termination of insurance before the stipulated expiration date, the Insurer shall be only entitled to the premium until the date by which the policy was in force, unless the insured event occurred before the termination date, in which case the Insurer is entitled to charge the full annual premium.

(7) The Insurer shall not pay for a medical treatment that started before the commencement of the Insurer's liability or during the waiting period, nor the costs of treatment carried out after the Insurer's liability ends, even if it started during the policy period.

Eligibility

Article 3

(1) According to the relevant regulations, only persons with a registered place of residence / temporary residence in the Republic of Serbia are eligible for this insurance.
(2) Under these Special Terms and Conditions, one person and their family members can be insured.
(3) If the premium has been written and paid, the person can become the new Insured:
   3.1. if a person has the status of Insured's spouse or common-law partner after the commencement of the insurance contract – in which case the Insurer must be provided with a marriage certificate or, in case of a common-law marriage, proof of residence at the address of the Insured;
   3.2. as the Insured's child born after the commencement of insurance (hereinafter: Insured's newborn child) – in which case a birth or adoption certificate issued by authorities must be submitted to the Insurer.
(4) The Insurer may ask the Policyholder for additional documentation as proof of insurability, or grounds for exclusion (e.g. a statement certified by a public notary indicating the beginning and termination of a common-law marriage).
(5) The Policyholder is required to enroll a person within 30 days from the date insurability has changed, i.e. disenroll them within 3 business days.
(6) For the newly insured persons who are subsequently enrolled, the sum insured and limits shall apply in full. The insurance premium is calculated according to the remaining number of days until the policy expiry date, except in the case of annual physical exam coverage, for which the Policyholder is required to pay the full annual premium.
(7) At the time of insurance contract signing or renewal of an existing contract the Insurer is entitled to ask the Insured to fill out a Health Questionnaire and/or undergo a medical check-up. The cost of the medical check-up shall be borne by the Insured.
(8) At the time of insurance renewal, the Insurer is entitled, based on the Health Questionnaire or claims history under a previous policy, to propose a contract renewal with a higher premium or limitation, i.e. exclusion of liability for some covers, including disorders that were diagnosed for the first time over the course of the previous insurance contract.
(9) In case of exclusion of a person before the stipulated expiration of the period of insurance, the Insurer shall be entitled to a premium only until the date by which such insurance was valid for that person unless otherwise agreed.

Pre-existing Condition

Article 4

(1) The Insurer's medical censor may determine the pre-existing condition based on diagnosis or indication for treatment, or based on etiology and pathophysiology of an illness (cause and mechanism of the onset of illness), the onset of symptoms and signs of an ailment listed in the medical records. The pre-existing condition is established at the time of stipulation or renewal of the policy when undergoing medically justified treatments covered under the policy or an additional medical exam at the request of the Insurer.
(2) Congenital diseases and conditions shall be considered pre-existing conditions.
(3) In case of insurance in continuation, the pre-existing condition shall not mean any medical condition that occurred during the term of the previous policy with the same insurance plan, unless agreed otherwise, but at the time of renewal, the provision of Article 3, paragraph (8) may apply.
(4) In case after the expiration of one policy another policy is written (in continuation) with the same insurance plan but a new coverage, a pre-existing condition under the new coverage shall include all the conditions that occurred before the effective date of the policy with new coverage.
   If the policy continues with the same coverage and higher scope of coverage, the Insured shall have new, additional rights.
(5) If the policy doesn't continue after the end of the previous one, under the same insurance plan, all illnesses that occurred before the re-conclusion of the policy, including the conditions that occurred during the term of the previous policy that expired, shall be considered pre-existing conditions.
(6) The costs of treating the following pre-existing conditions are completely excluded from insurance, for all coverages: psychoses, chronic diabetes with complications, Alzheimer's disease, post-stroke condition with functional disorders, cirrhosis, brain tumors with neural dysfunction, chronic renal insufficiency (hemodialysis), malignancies of all organs, multiple sclerosis, motor neuron disease, paralysis/paraplegia, Parkinson's disease, muscular dystrophy, presenile dementia, rheumatoid arthritis.

Health Questionnaire and Insurance Proposal with Amended Terms and Conditions

Article 5

(1) The statement shall be filled in on the Insurer's form, in the form of a Questionnaire. At the request of the Insurer, additional documentation is provided with the Questionnaire, and the Insured may be referred to additional medical exams. As a rule, the Questionnaire is filled out only at the first-time enrollment, but at the Insurer's request, it can also be filled out at the time of insurance renewal.
(2) The Questionnaire shall be filled out by each Insured, while the Heath Questionnaire for minors is filled out by parents/guardians.
(3) The degree of substandard risk shall be determined by the Insurer based on the information from the Health Questionnaire, all medical reports, and/or the results of medical exams available to the Insurer, according to the risk assessment procedure.
(4) The Insurer shall be required to accept to insure the substandard risk individual but may offer amended terms and conditions. The amended terms and conditions for substandard risk may be:
    4.1. limitation or exclusion of certain coverages;
    4.2. waiting period for certain coverages;
    4.3. premium increase.
(5) If it is determined that a person poses a substandard risk and the Insurer decides to offer that person the amended terms and conditions, the Insurer shall be required to send them an insurance proposal with the amended terms and conditions by mail or e-mail, within eight days upon receipt of the statement (Health Questionnaire).
(6) If the insurance proposal with amended terms and conditions includes a premium increase after the Insured accepts it and informs the Insurer in writing (by mail or e-mail), the Insurer shall send the proposal to the Policyholder for approval.
(7) If the Insured or the Policyholder accepts the Insurer's proposal, the insurance proposal with amended terms and conditions shall become an integral part of the policy. The persons for whom the amended insurance terms and conditions are stipulated are listed in the policy. Specific exclusions and details about the Insured's health are stated in a separate document, which is a part of the policy, provided only to the Insured.
(8) If the Insured or the Policyholder doesn't accept the proposed amendment to the terms in writing within eight days after the receipt of the Insurer's proposal, they shall be considered to have withdrawn from insurance on their own behalf, i.e. on behalf of the high-risk individual.
(9) In case of an individual health risk assessment, the Insurer shall have the right, when renewing the policy for a particular Insured, to propose premium increase, limitation, or exclusion of liability for certain coverages, including health conditions that were first diagnosed during the previous policy period.

Notifying the Insurer

Article 6

(1) The Insured is required to report to the Insurer all the circumstances relevant for risk assessment that are known or could not have been unknown to them.
(2) An important circumstance is any circumstance the Insurer asked about in the application form or the Questionnaire, or in some other way at the time of the contract signing, as well as any other circumstance known to the Insured and relevant to the insured subject matter. An important circumstance at the time of insurance renewal is also a possible health disorder diagnosed during a check-up performed without the use of the contracted insurance, which the Insurer can learn about only if informed by the Insured.
(3) During the term of the insurance contract, the Policyholder/Insured shall be required to report to the Insurer new circumstances related to the Insured, such as a change in compulsory health insurance status, change of address, occupation, or marital status, and to provide information on any other relevant changes that affect the information provided at the time of signing of the insurance contract or of the first enrollment of that Insured.
(4) If it turns out that the Insured, i.e. the Policyholder concealed important information that affected the signing of the insurance contract, and if that person failed to provide all the information relevant for determining the risk, and an insured event occurs, the Insurer can deny payment of the claim related to the concealed or undisclosed circumstance, suspend the policy or increase the premium.

Waiting Period

Article 7

(1) Waiting period (qualifying period) is specified in the insurance policy and/or its schedules.
(2) For each Insured, the waiting period starts at the inception of insurance coverage stated on the insurance card.

(3) If the due premium or a premium installment was not paid by the insurance inception d of stated on the policy, the waiting period (qualifying period) shall start at 24.00 h of the date when the first premium was paid, unless stipulated otherwise.
(4) The waiting period shall not apply to persons with insurance in continuation coverage, except in the case referred to in item (6) of this article.
(5) Exceptionally, if a waiting period has not fully expired for a certain insured person during the period of the previous policy, the remaining term of the previous waiting period shall be transferred to the following period of insurance under the new policy.
(6) If, after the insurance contract termination a new contract is signed, with a higher coverage compared to the previous contract, and in case of enrollment of a new Insured, the right to a higher coverage shall commence on the waiting period end date, which starts on the effective date of the new insurance contract, i.e. the effective date of insurance for the new Insured.

Insured Event

Article 8

(1) An insured event is a medically justified treatment of an Insured's health disorder, provided for in the policy terms and conditions, the costs of which must be paid to the healthcare provider.
(2) A health disorder must be diagnosed by a licensed physician. All medical indications from a licensed physician shall be provided in writing.
(3) An annual physical exam and healthcare for pregnant women and newborns are also considered insured events.
(4) Emergency dental treatment of multiple injuries resulting from an accident, including oral surgery, in order to stop the bleeding, reduce pain, remove injured teeth, or repair fractured jaw bones. Injuries resulting from an accident excluded under these Special Terms and Conditions or from food consumption are excluded. Any further treatment of injuries, including definitive dental treatment such as artificial teeth, metal/ceramic crowns, dental implants, etc., is hereby excluded.
(5) Insured event starts with the beginning of medical treatment and ends when, from a medical point of view, there is no longer a need for treatment because the patient has been cured or their health has stabilized.
(6) In any case, an insured event shall end on the date of termination of insurance for each Insured.

Reimbursement of the Costs of Treatment

Article 9

(1) If an insured event occurs, the Insurer shall pay the costs of treatment the Insured underwent up to the amount of the sum insured or up to the limit for the medically justified treatment set out in the policy.
(2) The sum insured is specified in the insurance plan and set out in the policy.
(3) The sum insured and the limits will gradually reduce during the period of insurance by the amount of expenses paid.
(4) If the Insured is insured under more than one policy by the same Insurer, the cost of treatment shall be reimbursed only based on one policy. There is an exception when the cost exceeds the limit of one policy, so the limits of multiple policies can be combined; however, the Insurer's liability shall not exceed the amount of the annual maximum sum insured under these Special Terms and Conditions.
(5) In any case, the Insurer's maximum liability under these Special Terms and Conditions (annual maximum sum insured) may not exceed EUR 100,000 per Insured during one insurance year, regardless of the number of policies.
(6) The Insurer shall not cover the costs of treatment if the Insured has exercised his or her right to reimbursement of the costs of treatment under compulsory health insurance or under a voluntary health insurance contract signed with another Insurer for the insured event in question.

Coverage

Article 10

(1) Under these Special Terms and Conditions, insurance plans can include the following coverage:
   1.1. Outpatient treatment
   1.2. Inpatient treatment
   1.3. Surgical and other procedures,
   1.4. Healthcare for pregnant women and newborns,
   1.5. Annual physical exam
   1.6. Medicines
   1.7. Vision correction
   1.8. Dental care

(2) These Special Terms and Conditions describe all available coverages. Specific coverages, services included, limits, and restrictions are set out in the insurance policy. The Insured claims the right to use only those coverages included in these Terms and Conditions, the insurance policy, for which the premium has been paid.
(3) The insurance plan containing medically justified treatments/health services, sums insured, limits, and restrictions, is specified in the insurance policy and/or its schedules.
(4) Outpatient treatment coverage or inpatient treatment coverage can be stipulated independently.
(5) Insurance covers the following expenses:
    5.1. treatment of acute and chronic illnesses that occur for the first time during the period of insurance. Exceptionally, the policy can cover the treatment of a pre-existing condition, provided that:
        – that the condition is not listed in article 4, paragraph 6 hereof;
        – that the Insured reported the condition and provided accurate information about it in the Health Questionnaire;
        – that the Insurer did not exclude the condition indicated in the Health Questionnaire by offering insurance with amended terms and conditions. The insurance proposal under amended terms and conditions agreed to by the Policyholder and the Insured is an integral part of the policy;
    5.2. preventive healthcare of children through preventive exams according to the relevant schedule;
    5.3. healthcare for pregnant women and newborns;
    5.4. medically justified treatments for disease prevention with an annual physical exam.
(6) Except for the exclusions set out in the articles describing individual coverages, all coverages are also subject to the general exclusions and limitations set out in Article 25.

Outpatient Treatment

Article 11

(1) Outpatient treatment is a medically justified treatment an Insured undergoes at a healthcare provider's facility without spending consecutive 24 hours in such facility.
(2) An Insured may use the services under this coverage only in the event of a health disorder. For all services, except for a medical exam by a licensed physician, exam under „Mental Health Services" coverage, and the services under „Alternative and Complementary Medicine" coverage, referral by the relevant doctor is required.
(3) "Outpatient treatment" covers the following medically justified treatments and services:
    3.1. A medical exam by a licensed physician, which may include the following services: medical exam, follow-up, or consultation, including an online consultation. Medical exams by neuropsychiatrists, psychiatrists, psychologists, special education and rehabilitation specialists, and other doctors, due to mental health issues, are covered solely within the scope of „Mental Health Services", if stipulated in the policy.
    3.2. lab services and diagnostic procedures;
    3.3. diagnostic procedures and interventions conducted for reproductive health exams (sterility, causes of miscarriage, and preparation for pregnancy);
    3.4. medical transport:
        3.4.1. emergency medical transport to the nearest doctor or hospital (i.e. to a healthcare facility that can provide adequate medical attention to the Insured) by local ambulance or private practice ambulance, only in cases of medical emergency and provided that such transportation is ordered by a licensed physician providing first aid to the Insured, but the Insurer is not required to arrange emergency medical transport;
        3.4.2. necessary medical transport which is not urgent, but is medically necessary because transport by any other means of transportation could put the life and health of the Insured at risk. It covers transportation to a healthcare facility providing justified and medically necessary health care and transportation from the healthcare facility to the person's home, only on condition that, upon discharge from the healthcare facility, the Insured is not able to walk on his/her own. The Insurer must approve the decision on this type of medical transport either orally or in writing.
    3.5. therapies, covering the fees of medical and other professional staff carrying out the treatment, use of instruments, and other technical resources. Therapy can be:
        3.5.1. therapy with medicines, injections, inhalation, and infusion, where the administration of therapy is covered, but the medicine itself is paid only under the „Medicines" coverage if stipulated in the policy;
        3.5.2. physical therapy and kinesiotherapy, performed solely by a qualified therapist or chiropractor. It can be performed at home only if the Insured is immobile due to a fracture of lower limbs, spinal injury, or cerebrovascular stroke;
        3.5.3. speech disorder therapy (performed solely by a speech therapist or special education and rehabilitation specialist);
        3.5.4. oculomotor exercises;
        3.5.5. occupational therapy;
        3.5.6. other special education and rehabilitation therapies (except for mental health services, which is included if „Mental Health Services" coverage is stipulated).

All types of massages not prescribed by a doctor as part of physical therapy (e.g. relaxation and aesthetic massage), exercise therapy (except kinesiotherapy and oculomotor exercises), rehabilitation therapy lasting more than a month, and ambient therapy are excluded;

3.6. mental health services provided that they are medically necessary. These services include psychotherapy, consultation with a psychiatrist, neuropsychiatrist, psychologist, special education and rehabilitation specialist, or, if necessary, another specialist;

3.7. home care, immediately following inpatient treatment if the Insured is temporarily or permanently immobile;

3.8. emergency dental treatment due to an accident;

3.9. medically justified treatments in the field of alternative and complementary medicine, if performed in accordance with the laws regulating this field and these Special Terms and Conditions;

3.10. medical and technical aids:

3.10.1. prosthetics – prostheses for missing parts of the body, namely prostheses for the upper and lower limbs, breast and aesthetic prostheses for the ear, nose, and face;

3.10.2. orthotic devices – orthoses for the upper and lower limbs, for the treatment of dislocated hips, for the spine (spinal orthosis) if registered as medical and technical aids and purchased at a certified specialized medical equipment store or a pharmacy;

3.10.3. special types of aids and medical devices:

3.10.3.1. devices to facilitate movement – crutches (wooden and metal underarms and forearms), metal walking stick, and walking stand (walker);

3.10.3.2. hernia belts and maternity belts (only if healthcare for pregnant women is stipulated);

3.10.3.3. medical devices:

3.10.3.3.1. disc pad with bags and self-adhesive one-piece kit for ileostomy, colostomy, and urostomy;

3.10.3.3.2. pen syringe needles, urine ocular sugar and acetone reading strips, blood glucose meter, and test strips for the lancet unit;

3.10.4. optical aids (except diopters): prism foil, therapeutic contact lenses, full and flaky eye prosthesis, occlusive patches for the treatment of strabismus;

3.10.5. technical aids;

3.10.6. hearing aids - only one or a pair of aids, depending on the indication, over the course of a lifetime;

3.10.7. other aids – compression socks for varicose veins, limited to two pairs over the course of the insurance year. Orthopedic shoes, orthopedic insoles, or other aids for deformed, weak, overstressed, unstable, and lowered feet, tarsalgia, or metatarsalgia are excluded.

3.11. outpatient procedures – primary outpatient procedures: primary wound treatment, dressing, and stitching, primary treatment of burns, removal of sutures with bandaging, removal of ticks and other foreign bodies from the skin, ear, nose, and throat, plaster casts, joint fixation, and immobilization, irrigation of the ear and nose, aspiration of nasal secretions, vaginal irrigation, nasal tamponade, applying gauze with medicine, abscess incision, therapeutic puncture of joint and connective tissue, orthopedic repositioning of luxations and fractures without anesthesia;

3.12. examination at an outpatient clinic for diagnosis, without surgical and other procedures.

(4) The Insurer shall cover exams, diagnostic procedures, and spa therapies. Insurance doesn't cover any other spa costs.

(5) All home-based services are covered only if necessary and approved by the Medic Call Center.

(6) All medically justified treatments performed after the waiting period related to outpatient treatment of diseases diagnosed during the waiting period are covered, unless otherwise agreed.

Inpatient Treatment

Article 12

(1) Inpatient treatment is a medically justified treatment in a secondary or tertiary healthcare facility where the Insured occupies a bed for more than 24 hours, to be diagnosed or treated.

(2) Under these Special Terms and Conditions, inpatient treatment doesn't include staying in inpatient facilities such as rehab facilities, mental hospitals, inpatient healthcare facilities specializing in rehabilitation, hydro-clinics, sanatoriums, nursing homes for the sick, nursing homes for the elderly, health retreats, resorts, weight loss, and recovery centers.

(3) The following services are covered under inpatient treatment:

3.1. accommodation in standard rooms available at the healthcare provider's facility. Private room on the personal request of the Insured will be covered only if stipulated in the policy and if the healthcare provider has one;

3.2. permitted diet during inpatient treatment, recommended by a licensed physician;

3.3. a medical exam by a licensed physician;

3.4. medical technicians and other medical staff fees;

3.5. laboratory and diagnostic procedures performed during inpatient treatment, except for surgical procedures for the purpose of diagnosis;

3.6. therapy performed during inpatient treatment
  3.6.1. therapy with medicines, injections, inhalation and infusion,
  3.6.2. physical and kinesiotherapy
  3.6.3. speech disorder therapy (performed solely by a speech therapist or a special education and rehabilitation specialist); Mental health disorder therapies are covered only if authorized by the Insurer and in the event of a mental health disorder occurring after surgery;
  3.6.4. chemotherapy and radiotherapy;
3.7. medicines, medical material and supplies, blood and blood products used during inpatient treatment (hospitalization);
3.8. medical and technical aids used during hospital treatment;
3.9. treatment provided in the emergency room;
3.10. emergency dental treatment, due to an accident;
3.11. parental escort for children under 18 years of age.

(4) All medically justified treatments incurred after the expiration of the waiting period related to inpatient treatment of diseases diagnosed during the waiting period are not covered by insurance, unless otherwise agreed.

Surgical and Other Procedures

Article 13

(1) Surgical and other procedures include invasive medical procedures performed manually or with instruments to diagnose or treat a patient, whether performed in a hospital or an outpatient setting.
(2) Surgical procedure is also the removal of changes on the skin (moles, lipomas, atheroma, fibromas, warts, capillaries, cherry angiomas, keratosis, condylomas, and similar widespread skin lesions) that threaten the health of the patient.
(3) The costs of surgery and other procedures including blood and blood components for transfusion, medical and technical aids and implants needed for the procedure, medicines, medical supplies used for the procedure, the costs of preoperative preparation, intensive and postoperative care in an inpatient setting.
(4) The following costs are excluded:
  4.1. radial keratotomy or any other surgical procedure for vision correction (including laser treatments);
  4.2. sex reassignment surgery
  4.3. organ and tissue transplant surgery;
  4.4. nasal septum surgery for persons over the age of 18;
  4.5. circumcision, if not medically indicated;
  4.6. gastric balloon insertion.
  The costs of preoperative preparation and postoperative care are not covered if they are carried out in an outpatient setting, and outpatient treatment coverage is not stipulated.
(5) All medically justified treatments incurred after the expiration of the waiting period related to surgical and other interventions for diseases diagnosed during the waiting period are not covered by insurance, unless otherwise agreed.

Healthcare for Pregnant Women and Newborns

Article 14

(1) Healthcare for pregnant women and newborns covers the cost of pregnancy care, childbirth, and postnatal treatment of the newborn.
(2) If the Insured doesn't spend the entire amount under this coverage in one year, the Insurer's liability in the following year of the insurance in continuation shall not exceed the remaining limit under the previous policy.
(3) The Insurer shall not be liable for the pregnancy which started before the inception of insurance for that Insured or during the waiting period, if agreed. In the case of insurance in continuation, this limitation applies only to the first-time enrollment of the Insured, provided that this coverage was also stipulated under the previous policy.
(4) A pregnancy shall be considered to have occurred before the inception of insurance if the gynecologist of the Insured has determined that the due date is before the end of a nine-month period, starting from the date of the first enrollment of that person or the waiting period end date, if stipulated.
(5) In accordance with the stipulated coverage, the following medically justified treatments and services shall be paid:
  5.1. exams by a gynecologist;
  5.2. lab tests such as swabs, complete blood count, basic blood biochemistry tests, urine tests, and other specific tests required for pregnancy care;
  5.3. fetal ultrasound;
  5.4. expert ultrasound;
  5.5. fetal echocardiography;
  5.6. CTG;

5.7. biochemical screening for chromosomal aberrations (double, triple, and quadruple test);
5.8. invasive and non-invasive prenatal diagnostics;
5.9. progesterone and tocolytic therapy and other medicines to prevent preterm birth in high-risk pregnancies, including the cost of medication administration and of the medicine itself. Other pregnancy-related medications are covered only if medicine coverage is stipulated.
5.10. prenatal vitamins – supplements, a combination of vitamins and minerals used only during pregnancy and intended for proper development of the fetus. If the doctor prescribes specific minerals and vitamins for general use, they will be covered only if they are registered as a medicine, i.e. if listed in the National Medicines Registry. The liability starts the moment pregnancy is confirmed by a doctor and ends on the date of childbirth;
5.11. in case of a high-risk pregnancy, medically justified treatments for prevention of preterm birth, hospital stay for maintenance of pregnancy, interventions in case of miscarriage or termination of pregnancy for medical reasons, including room and board, doctors and medical staff fees, indicated diagnostics and treatments, necessary medications and medical supplies;
5.12. childbirth, including preoperative preparation for childbirth, costs of anesthesia, private room, partner's presence at childbirth, doctors', medical technicians' and anesthesiologists' fees. Cesarean delivery (C-section) costs are only covered if the C-section is medically indicated;
5.13. care for a newborn in the first month of life, which includes treatment of infants' health disorders, but not exams or other services carried out routinely in the first month of life;
5.14. home care up to one month after birth, as recommended by a licensed physician;
5.15. one complete routine pelvic exam up to six months after childbirth;
5.16. one follow-up exam and related lab and diagnostics procedures in case of miscarriage or termination of pregnancy for medical reasons.

(6) This cover also includes the costs of treatment of other pregnancy-related health issues, i.e. medical treatment costs that would not be indicated if the Insured was not pregnant.

Example:

Follow-up exams by an endocrinologist, due to a previous thyroid gland disorder diagnosis, which is performed more often than usual because the Insured is pregnant.

(7) Birth preparation courses and hospital accommodation for a companion during hospitalization for childbirth or maintenance of pregnancy are not covered.

(8) All limits relating to a newborn may also be used from the other parent's policy if this coverage is stipulated and if the pregnancy occurred during the father's insurance policy period.

(9) The services under this coverage don't apply to any insureds included as children of the insurance holder.

Annual Physical Exam

Article 15

(1) Annual physical exam is a set of preventive health services and treatments provided to examine the Insured's health condition.

(2) Annual physical exam shall be performed at the facility of a healthcare provider which has agreed on an annual physical exam plan with the Insurer, subject to the mandatory appointment via Medic Call Center.

(3) If the Insured uses only part of the services under the stipulated plan, they shall be deemed to have used the whole plan and cannot use the remaining services later.

(4) If specifically agreed, the costs of the annual physical exam may cover vaccines that are not mandatory under the national immunization program, as well as some diagnostic procedures for the purpose of analysis of family history, as indicated by a licensed physician.

(5) The insurance policy can include the preventive healthcare of children, which covers the costs of visits to a licensed physician (regular medical exams according to the schedule for check-ups and vaccines that are not mandatory under the national immunization program). Children up to the age of two shall exercise the rights granted under this coverage through the „Healthy Child" program in accordance with the policy.

(6) In case of insurance in continuation, the „Healthy Child" program may be used only for services that are age-appropriate and have not been used under the previous policy. In cases where mandatory vaccination is performed later than the intended age, the insurance shall cover pre-vaccination tests.

Medicines

Article 16

(1) This coverage includes the costs of medicines registered in the Republic of Serbia and listed in the National Medicines Registry (NRL) of the Medicines and Medical Devices Agency of Serbia.

(2) The Insurer shall cover both magistral and galenic medicinal products (produced at the pharmacy).

(3) The Insurer shall not cover the following:
   3.1. biological, immunological, blood and plasma medicines, and advanced therapy medicines, while traditional and homeopathic medicines are only included in „Traditional medicine" coverage if stipulated;
   3.2. medical cosmetics;
   3.3. medical supplies (including syringes, needles, and bandages) not covered by these Special Terms and Conditions, as well as dietary supplements, except:
      3.3.1. probiotics with antibiotic therapy and for the duration of therapy;
      3.3.2. anemia iron preparation (with a medical report proving that the Insured has a bad reaction to the preparation registered as medicine),
      3.3.3. eye preparations (artificial tears) for the diagnosis of dry eye or conjunctivitis.

(4) The Insurer shall only cover the cost of medicines if they are prescribed in therapeutic doses for a period of up to ninety (90) days.

(5) This coverage also includes the cost of medicines administered in an outpatient setting as part of outpatient treatment.

(6) This coverage doesn't cover any medicine given at the hospital during inpatient treatment or during a surgical or other procedure, as well as during hospital stay for high-risk pregnancy and maintenance of pregnancy.

Vision Correction

Article 17

(1) The following medical services and supplies are included in this coverage:
   1.1. exam by an ophthalmologist for eyesight/vision check to determine or check the existing refractive anomalies and to prescribe optical aids;
   1.2. frames and prescription glasses:
      1.2.1. one frame and one pair of glasses a year or two frames and two pairs of glasses for the Insured with two different diopters;
      1.2.2. in the case of insurance in continuation, the Insured shall have the right to change frames and glasses if there is a diopter change;
      1.2.3. if there has been no diopter change, the Insured shall have the right to change the frame and glasses two years after the last purchase;
      1.2.4. in case of a diopter change in the same insurance year, after the devices have been procured, the Insurer may approve the purchase of additional glasses within the stipulated limit;
   1.3. sufficient amount of contact lenses according to medical needs, type of lenses, and period of insurance according to medical censor.

(2) If the Insured loses or damages the device (aid), insurance doesn't cover the cost of a new one.

(3) Sunglasses, glass accessories, glasses and lenses without a diopter, and all other optical aids not listed herein are excluded.

Dental Care

Article 18

(1) Depending on the plan, dental care coverage may include the following services:
   1.1. preventive treatment – includes regular check-ups and dental instructions once a year, fluoride treatment for persons under the age of 18, fissure filling, anti-bruxism (teeth grinding) splints;
   1.2. basic restoration – includes amalgam and composite fillings;
   1.3. major restoration – includes root canal filling, crowns, fillings, and dental bridges (including retroalveolar imaging, lab, and anesthesia costs);
   1.4. periodontal scaling – once a year;
   1.5. periodontal surgery;
   1.6. oral surgery – tooth extraction (routine, complex and surgical);
   1.7. orthodontic treatment – includes prototypes for analysis (including dental X-rays - orthopan), molds, all removable braces. The age limit for this coverage is stipulated under the policy. Orthodontic treatment is only allowed with the Insurer's written consent (authorization).
   1.8. teeth X-ray image – when necessary and medically justified for the treatment.

(2) For all treatments performed, there must be a written medical indication and a service report. The report shall include the number of teeth subject to the treatment, and the Insurer shall have the right to request X-rays (OTP, 3D, retroalveolar, retrocoronary, etc.) if needed. For metal and ceramic crowns and dental bridges, digital photographs of the condition before and after such treatment are to be provided.

(3) The insurance doesn't cover cosmetic and aesthetic treatments of teeth, artificial teeth, dental implants, ceramic restorations on dental implants, fixed braces (including retention foils), teeth-straightening foils, veneers with any associated costs, teeth whitening, or any other dental devices.

Rights under the Insurance Policy

Article 19

(1) Health services under these Special Terms and Conditions may only be used at healthcare providers' facilities.
(2) The following may be stipulated under the policy:
  2.1. the use of insurance services:
    2.1.1. solely within the healthcare providers' Network (all or part thereof, as specified in the policy);
    2.1.2. at in-network and out-of-network healthcare providers;
  2.2. making an appointment for a medically justified treatment:
    2.2.1. mandatory appointment via Medic Call Center;
    2.2.2. no mandatory appointment via Medic Call Center.

  Exceptionally, making an appointment via Medic Call Center is always mandatory for medically justified treatments at home (house calls), regardless of how the insurance is used. In addition, the Insurer may require appointments via Medic Call Center for individual services or at some healthcare providers, even if they are in-network;
  2.3. method of payment by the Insurer:
    2.3.1. directly to the in-network provider or, if the Insured uses out-of-network services, by reimbursement to the Insured;
    2.3.2. only by reimbursement to the Insured;
    2.3.3. only directly to the in-network provider.
(3) For the in-network treatments provided to the Insured, the Insurer shall pay the costs directly to the provider, if it's in accordance with the terms and conditions.
(4) If the Insured uses in-network health service, but doesn't register as an Insured and pays for the service charges not agreed with the Insurer, they will receive reimbursement of costs the Insurer has negotiated for that service with that healthcare provider.
(5) The Insurer reserves the right to add new and remove existing providers without notifying the Policyholder and the Insured.
(6) The Insurer reserves the right to refuse or exclude from the health service contract certain in-network healthcare providers' charges for the services included in the policy. Such services shall be covered up to the amount of reasonable and customary fees.
(7) The list of in-network healthcare providers' facilities is posted on the Insurer's website and regularly updated.
(8) Insured persons must use the services in accordance with the contract. In case of non-compliance, the Insurer may refuse to reimburse the cost:
  8.1. when the option of mandatory appointment via Medic Call Center is stipulated, but the Insured has not done so, nor have they reported the service they would receive out-of-network;
  8.2. when only in-network service is stipulated, and the Insured has sent a claim form for services rendered out-of-network.

This doesn't apply:
    8.2.1. when medical treatment is necessary in case of an emergency, as determined by a relevant licensed physician;
    8.2.2. for the supply of medicines and medical and technical aids.
    8.2.3. when an out-of-network services option is stipulated, in which case there is a 30% copayment;
(9) The Insured is considered to have fulfilled the obligation of calling the Medic Call Center if:
  9.1. they call the Medic Call Center before using health services;
  9.2. they answer the Medic Call Center's questions about their current health condition or provide the requested documentation regarding the service concerned;
  9.3. they confirm the appointment.

Medic Call Center

Article 20

(1) Medic Call Center is a telephone service that provides the Insured with information on how to exercise their rights under the policy and stipulated coverage (services, remaining limits, exclusions, etc.) and authorizes outpatient treatment services at home.
(2) At the request of the Insured, the Medic Call Center shall make an appointment for medical exams at in-network healthcare providers' facilities. When making an appointment, the Medic Call Center employee will consider the coverage of such service, available medical indications, as well as the remaining limits in relation to the expenses paid up until that moment and

any claims received. If in the process of claim payment, it is established that there are facts different from those available to the Medic Call Center at the time the appointment for the health service was made, the Insurer shall reserve the right not to pay the costs incurred if the amount exceeds the sum insured / limit or if the service is not in line with the coverage.

(3) Medic Call Center shall mediate between the Insured and the Insurer's medical censor during the mandatory authorization process.

(4) Every conversation of the Insured with any Medic Call Center employee shall be recorded.

Copayment

Article 21

(1) If copayment is included, the amount or percentage of the copayment (coinsurance) shall be specified in the policy.

(2) If two or more copayments are applied to a particular service, each subsequent copayment shall apply to the portion of the cost remaining after the previous copayments have been applied.

(3) If the Insured uses any service, the cost of which exceeds reasonable and customary fees, the Insurer shall cover the amount of the reasonable and customary fees, minus the copayment amount.

Authorization

Article 22

(1) Authorization is required in the following cases.
- 1.1. when the person seeking the consent is aware that the cost of treatment shall exceed EUR 300 in RSD equivalent;
- 1.2. planned inpatient treatment;
- 1.3. childbirth;
- 1.4. all planned or scheduled surgical and other procedures;
- 1.5. prenatal diagnosis;
- 1.6. other cases stipulated under the policy and schedules.

(2) Other cases for which authorization is required may be specified in the policy.

(3) Authorization must be requested from the Insurer at least 14 days before the medically justified treatment date.

(4) Authorization may be requested by the Insured or the representative of the healthcare provider's facility where a medically justified treatment is to be carried out, and the Insured must be informed of the authorization request and the Insurer's response.

(5) The Insurer shall be provided, along with the authorization request, with all relevant documents (medical records, proforma invoices, and any other additional documentation requested by the Insurer).

(6) The Insurer's written approval shall specify whether the proposed medically justified treatment is in accordance with the terms and conditions and the agreed coverage or whether in the case in question it is excluded.

(7) In the event of non-compliance with the provisions of this Article, the Insurer shall have the right to reduce the indemnity and limit its liability to reasonable and customary fees.

(8) Services in case of a medical emergency when the Insured's life is at risk are not subject to authorization.

Insurer's Liability and Claim Filing

Article 23

(1) A claim can be filed by the Insured or by the representative of the healthcare provider that performed the medically justified treatment, as stipulated.

(2) At the time of claim filing the Insurer shall be provided with a request for reimbursement of costs on the Insurer's claim form, complete medical documentation and receipts based on which relevant facts regarding the occurrence of an insured event shall be determined.

(3) If deemed necessary in order to determine the circumstances of the claim, the Insurer shall have the right, in the claim settlement process, to require from the Insured access to all documents available to them or to third parties about the current and pre-existing medical condition (medical documentation and reports, medical records and medical history, police reports, etc.). The Insurer may hire an expert or seek an additional medical exam by a relevant specialist to determine the facts.

(4) If the Insured is unable to provide the required documentation or when they think it is in their interest, they may withdraw the claim.

(5) At the request of the Insurer, the Policyholder shall be required to provide all evidence relevant to the assessment of eligibility for exercising rights under the insurance contract and determining the Insurer's liability

(6) The Insurer shall accept any documentation in Serbian and English. In case translation is required, the costs thereof shall be borne by the Insured.

(7) If a copayment is included, the Insurer shall deduct the amount of copayment from the total amount it is required to pay.
(8) If the costs based on insurance rights are below the maximum limits for specific coverage, i.e. below the sum insured under the policy, the Insured shall not be entitled to a payout of the difference upon termination of insurance.
(9) If a claim is incomplete, inaccurate, contains services not covered or services which, according to the medical censor, are not adequate for the treatment of the Insured, or the claimant's statement is not confirmed by the supporting documentation or other sources which the Insurer may use to determine liability, in case of fraud and misuse of rights under the insurance contract, the Insurer has the right to refuse to pay the claim.

Obligations of the Insurer

Article 24

(1) In accordance with the policy, the Insurer must make:
1.1. direct payment of the costs of treatment to an in-network healthcare provider's facility;
1.2. reimbursement of the costs of treatment to the Insured.
(2) The Insurer must reimburse the costs of treatment, in accordance with these Special Terms and Conditions, within 14 days from the date of receiving relevant documents. If the Insurer requires additional documents, it must reimburse the costs of treatment, in accordance with these Special Terms and Conditions, within 14 days from the date of receiving those additional documents.
(3) The insurer's obligation shall be considered fulfilled on the date the bank payment is confirmed, i.e. when the Insurer's bank executes an order on the transfer of funds to the account of the Insured or the healthcare provider.

Exclusions and Limitations of the Insurer's Liability

Article 25

(1) The Insurer's liability for any coverage and medical services not specified in the policy or its schedule, and for which no premium has been paid shall be excluded.
(2) Any event that is not considered an insured event under these Special Terms and Conditions and the policy, as well as the consequences of such events, shall be excluded. Exceptionally, primary wound treatment and wound dressing after the surgical procedure will be covered, regardless of whether the operation is covered or not, provided that outpatient treatment is included.
(3) Medical treatments performed, i.e. health services, medicines, medical supplies, medical and technical aids, or implants not indicated by a relevant specialist, are excluded.
(4) Medical treatments completed, if not medically justified, shall be excluded under these Special Terms and Conditions.
(5) The Insurer's liability for the costs of filing a claim for damages incurred by the Insured for hiring a lawyer or on any other grounds shall be excluded.
(6) The Insurer is not required to pay for the costs of preventive immunization programs and chemoprophylaxis, which are mandatory under the law regulating the protection of the population against communicable diseases in the Republic of Serbia or in the country where regional coverage applies, if stipulated. No vaccine shall be covered if it contains a component that is legally required, regardless of the manufacturer and the brand name.
(7) All health services, medicines, and medical devices shall be excluded:
7.1. unless they are medically necessary for examination, treatment, or alleviation of disease symptoms, and unless they have been indicated by the relevant specialist;
7.2. if applied for aesthetic purposes, whether for psychological reasons or not, as well as any consequences of such treatments, with the exception of implants which will be covered in case of total mastectomy.
7.3. if resulting from engaging in high-risk sports and activities shall be excluded, including the following: participation of the Insured in aviation, automobile, motorcycle, nautical and other speed competitions, racing and training for the above, test runs and test flights; engaging in sports and activities requiring the use of special equipment, such as diving at depths exceeding 40 m, parachuting, kitesurfing, acrobatics, freeflying, skysurfing, freestyle, paragliding, bungee jumping, mountain climbing, a artificial rock climbing, acrobatic skiing, speleology, rafting, base jumping, jumps from height; training and taking part in sports competitions as a registered member of a sports organization, namely: boxing, kickboxing, muay thai, and other martial arts; handling pyrotechnics, ammunition and explosives; trips to polar regions and expeditions, as well as engaging in all other sports and similar physical activities that carry an increased risk of endangering life and health, in particular those requiring protective equipment or involving the use of special equipment;
7.4. if they are a result of training and competitions as a professional athlete;
(8) The following shall not be covered:
8.1. any costs incurred after the insurance expiry date, and which are a result of an accident, illness, or pregnancy that occurred during the insurance year. Exceptionally, supplies are permitted for prescribed medications and all other

agents in therapeutic doses and quantities required for a maximum of ninety (90) days after the insurance expiry date, provided that they have been purchased during the period of insurance;

8.2. when the hospital has practically become or could be considered a home or permanent residence of the Insured;

8.3. any costs of services performed in facilities that are not considered healthcare providers under these Special Terms and Conditions, such as gyms, fitness centers, sports clubs, counseling centers, beauty salons, etc., even if some of the services they provide may be considered medical;

8.4. any costs of treatments that aren't in accordance with the treatment protocol (good clinical practice guidelines) for a particular diagnosis, or are inadequate according to the medical censor i.e. unrelated to the symptoms and not required based on the current clinical presentation;

8.5. any costs of new methods of treatment, diagnostics and therapies, medicines and other health services that did not exist on the market of the Republic of Serbia at the time of application of these Special Terms and Conditions, unless the Insurer decided to cover a particular service;

8.6. general purpose items, beauty products, services and items for personal care and hygiene;

8.7. transportation for the purpose of obtaining medical treatment, except in the case of transportation defined by „Medical transport" coverage.

(9) All costs for the treatment of the following diseases and disorders shall be excluded: addiction, obesity, AIDS, AIDS-related complex (ARCS), and all diseases caused by and/or associated with HIV.

(10) The following shall be excluded:

10.1. reproductive treatments, as follows:

10.1.1. prevention of conception for men and women (contraception and its effects);

10.1.2. vasectomy and sterilization, as well as pre-sterilization status restoration;

10.1.3. sexual dysfunction, treatment with Viagra or generic replacement;

10.1.4. medically unjustified termination of pregnancy at the Insured's personal request, and consequences thereof;

10.1.5. infertility treatment, all preparatory treatments for assisted reproduction and medicines, as well as all forms of assisted reproduction (insemination, in vitro fertilization, etc.);

10.2. all therapeutic procedures (including implants and corrective medical and technical aids) and surgical procedures that are not medically justified, necessary, or indicated;

10.3. treatments in a hyperbaric chamber, unless otherwise stipulated in the policy;

10.4. rejuvenation treatment, whether or not prescribed by a licensed physician;

10.5. any nutritional advice, except for the diagnosis of diabetes and cancer, if in accordance with the Terms and Conditions;

10.6. cryopreservation and implantation or re-implantation of tissues and cells, blood plasma and autologous serum therapies (e.g. PRP, orthokine and related therapies), unless otherwise stipulated in the policy. An exception is blood transfusion, which shall always be covered when medically necessary;

10.7. stem cell collection and storage costs and any other related costs;

10.8. genetic testing, except in the case of:

10.8.1. diagnostic procedures performed for testing of reproductive health;

10.8.2. family history as indicated by a licensed physician;

10.9. examination and treatments of sleep disorders, sleep apnea, snoring and chronic fatigue;

10.10. artificial life support, when the relevant licensed physician confirms that recovery is not possible;

10.11. any other medical device, except those specified in these Special Terms and Conditions and the policy, provided that the related coverages are agreed upon and that an additional premium is paid;

10.12. all non-medical expenses;

10.13. training costs for the use and maintenance of durable medical equipment;

10.14. the cost of adapting a vehicle, bathroom, or home to personal needs;

10.15. Medical exams with the sole purpose of issuing a certificate for returning to work following an absence.

Obligations of the Policyholder

Article 26

(1) The Policyholder shall notify the Insured of the content of pre-contractual information provided by the Insurer, in full compliance with the law.

(2) The Policyholder is required to provide the Insurer, upon request, with information on whether the Insured holds a mandatory health insurance policy in accordance with the law, as well as information on the change in status, if any.

(3) The Policyholder is required to notify the Insurer if the Insured is to be removed from the insurance plan, as soon as possible, and no later than three working days after the date when there are no longer any grounds for insurance. In cases where, due to untimely cancellation of insurance, the services covered by the insurance policy have been provided to the Insured, regardless of whether an appointment was made via Medic Call Center or not, the cost of medically justified treatment shall not be borne by the Insurer.

Obligations of the Insured

Article 27

(1) The Insured (or in case the Insured is a minor, the parent) shall:
- 1.1. be informed of the coverages agreed for him or her, so as not to receive any service at the expense of insurance unless covered under the policy;
- 1.2. comply with all provisions of the policy relating to the Insured;
- 1.3. show the healthcare provider's representative an identification document and the insurance card before using a service of an in-network facility;
- 1.4. notify the Insurer that the card has been lost, as soon as possible;
- 1.5. not give the card to other persons for use and always and anywhere give true information and act in accordance with the law in the process of exercising insurance rights;
- 1.6. cooperate fully at the Insurer's request for the purpose of:
  - 1.6.1. obtaining additional documentation to determine the Insurer's liability and undergo any additional medical exam at the Insurer's expense, if requested by the Insurer;
  - 1.6.2. treatment authorization procedure.

(2) If the Insured happens to receive any service that is not covered by insurance or exceeds the agreed limits, they are required to reimburse the cost of the uncovered service received. This provision shall also apply in case an appointment for service was made via Medic Call Center if such appointment is made due to incomplete information available to the Medic Call Center at the time of the appointment.

Final Provisions

Article 28

(1) The Insurer shall post the updated version of these Special Terms and Conditions on its web page.

(2) The effective date and the implementation date of these Voluntary Health Insurance Special Terms and Conditions is December 31, 2022. As of the date of implementation of these Special Terms and Conditions, the Individual Voluntary Health Insurance Special Terms and Conditions, dated April 1, 2020, no longer apply.