SPECIAL TERMS AND CONDITIONS OF COLLECTIVE VOLUNTARY HEALTH INSURANCE

DEFINITIONS

IMPORTANT DOCUMENTS

CAUTION

ATTENTION!

SUM INSURED PREMIUM

THESE CONDITIONS ARE FOR INFORMATIONAL PURPOSES ONLY.
IN THE EVENT OF A LEGAL DISPUTE, THE CONDITIONS IN THE SERBIAN LANGUAGE ARE VALID.

OPENING PROVISIONS AND TERMS

(1) The General Terms and Conditions of Voluntary Health Insurance (hereinafter referred to as: the General Terms and Conditions) and these Special Terms and Conditions of Collective Voluntary Health Insurance (hereinafter referred to as: the Special Terms and Conditions) shall be an integral part of the Collective Voluntary Health Insurance Contract which is concluded between the Policyholder and the Insurer.

Certain terms used herein shall mean as follows:

- **ALTERNATIVE AND COMPLEMENTARY MEDICINE** – traditional methods and procedures for the prevention, diagnosis, treatment and rehabilitation, which have a beneficial effect on human health or health status and which, in accordance with applicable medical doctrine, are not covered by conventional medicine methods and procedures performed exclusively in a healthcare facility or private practice established as a general or specialist practice by a medical doctor, dental doctor, polyclinic, healthcare clinic or rehabilitation clinic and provided exclusively by a healthcare service provider licensed to perform alternative and complementary medicine methods and procedures.
- **HEALTHCARE SERVICE PROVIDER** – health facilities at primary, secondary and tertiary level (health center, pharmacy, institute, hospital, clinic, clinical and hospital center, clinical center), private practice (practice, polyclinic, laboratory, pharmacy, outpatient unit) and other healthcare service 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 by „Ophthalmologic Services" are also considered to be healthcare service providers within these Special Terms and Conditions.
- **OTHER QUALIFIED HEALTHCARE PROFESSIONALS AND ASSOCIATES** – persons with relevant medical university, college or secondary school degree (psychologists, defectologists, speech therapists, pharmacists, medical technicians, physiotherapists) carrying out healthcare activities at a healthcare service provider in accordance with these Special Terms and Conditions and applicable regulations in the country of coverage.
- **INSURANCE YEAR** – a period of twelve (12) months starting from the date of inception of insurance cover provided for under the Policy.
- **GROUP OF POLICYHOLDERS** – related legal entities in accordance with the law or legal entities and entrepreneurs that entered into Contract and ensuring application of Insured Persons for insurance.
- **URGENT MEDICAL EVENT** – an illness or injury which could, without direct, immediate medical aid, endanger life of the Insured Person, i.e. which could cause irrecoverable or severe deterioration or damage to their health or death. Urgent medical aid shall mean medical aid provided within 12 hours after the moment of reception of the Insured Person in order to avoid expected occurrence of urgent medical condition.
- **IMPLANTS** – medical devices that are surgically built into the human body.
- **STATEMENT OF HEALTH STATUS** – health details provided by the Insured Persons to the Insurer prior to the conclusion of the Policy.
- **SINGLE INDEMNITY** – single indemnity paid to the Insured Person if they chose this option instead of cover for the cost of treatment, in accordance with these Special Terms and Conditions and the Policy.
- **CARD** – Voluntary Health Insurance Certificate.
- **TREATMENT** – medically justified treatment considered in accordance with generally accepted rules of medical profession to be appropriate for the relief of symptoms of illness or injury, restoration of health or prevention of deterioration of health, which is covered by the Policy. Treatment also includes medical procedures and medicines of alternative and complementary medicine in accordance with legal regulations governing the field of alternative and complementary medicine.

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GENERALI

- **CURE** – a product containing a substance or combination of substances manufactured and intended to treat or prevent disease in humans, to diagnose, improve or change physiological functions, and to achieve other medically justified objectives and which has been granted marketing authorization in accordance with the law governing the field of medicines.
- **MEDICAL ADVISER** – a person with completed medical, dental or other appropriate faculty who performs activities for the Insurer in connection with risk assessment and/or claims handling within voluntary health insurance in accordance with the internal acts of the Insurer and these Special Terms and Conditions.
- **PERSON AT INCREASED RISK** – a person who, due to his or her physical condition, medical history, risky occupation or unhealthy lifestyle, may be expected to have a greater need for treatment than a standard-risk person. A standard-risk person is a person of average physical condition with an average life habits with no disease and / or with a disease with an insignificant risk that, in the Insurer's view, involves neither relapse nor consequent illness.
- **LIMIT** – an amount of money or a number of services representing maximum liability of the Insurer under the Policy or under the cover for each Insured Person during the insurance year. The exceptions are the coverage of „Healthcare for Pregnant Women and Newborns" and „Healthy Child" program under „General Medical Examination" coverage, where the limits apply to an individual pregnancy or child's age, but not to the year of insurance (provided the Policy is renewed).
- **MEDIC CALL CENTER** – the Insurer's telephone service that operates 24/7, 365 days a year, with medically trained personnel available to the Insured Persons, aimed at providing assistance in realization of insurance, as specified in these Special Terms and Conditions.
- **MEDICAL DEVICES** – medical and technical aids and implants.
- **MEDICALLY JUSTIFIED TREATMENT** – health service, medical device, medical material or medicine which is medically justified if:
  - they are necessary for the diagnosis, treatment and control of a disease or injury of the Insured Person, if they meet their clinical 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 an onset or early detection of a disease during general medical examination (if such cover is agreed upon);
  - they are negotiated in accordance with these Special Terms and Conditions and defined by the Policy;
  - they have been prescribed by a licensed doctor and if there is a clear medical indication for them;
  - their primary purpose is not personal comfort or convenience of the patient, family, physician or other medical service provider;
  - they are neither a part of educational nor professional training of the patient nor have they been related to such;
  - they are not experimental or in research phase;
  - they are in accordance with widely accepted professional standards of medical practice in the country of cover and do not exceed in scope, duration or intensity the level of protection required to provide safe and adequate treatment according to the professional judgment of the Insurer's medical advisers or to good clinical practice guides (procedures must be related to the symptoms of a disease and their performance must be justified by the current clinical picture).
- **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 performance of basic life functions.
- **HEALTHCARE SERVICE PROVIDER NETWORK (HEREINAFTER REFERRED TO AS: THE NETWORK)** – all healthcare service providers that have an effective service provision contract with the Insurer during the period of insurance, the agreed services of which the Insured Person may use in the manner defined by the General and Special Terms and Conditions.
- **ACCIDENT** – any sudden event, independent from the Insured Person's will, unpredictable and caused by external influence, leading to an accident or a health disturbance of the Insured Person.
- **NEW INSURED PERSON** – a person subsequently included in insurance because such person has acquired basis for insurance upon inception, as specified in the Policy.
- **CLAIM** – report of an insured event filed to the Insurer by the Insured Person or healthcare service provider from the Network.
- **ONLINE CONSULTATION** – consultation with a licensed remote physician (by telephone or via the telemedicine internet platform) conducted exclusively within the Network.
- **INSURED PERSON** – a natural person who has a voluntary health insurance contract concluded with the voluntary health insurance provider and who uses the rights set out in the voluntary health insurance contract, as well as any family member of such Insured Person if covered by the voluntary health insurance contract.
  The Insured Persons are:
  - insurance holder – a person who is in direct relation with the Policyholder (employee, student, service beneficiary, member, long-term contractual entity, etc.);
  - family members – the spouse or extramarital partner and children of the insurance holder, listed in the Insurance Policy with a premium paid for them. Children hereof shall mean the children born in a wedlock or out of a wedlock, adopted children, fostered children and children taken care of by the age of 18, or by the age of 26, in case they are full-time students. Age restriction does not apply to children who are unable to live independently due to physical or mental disabilities.

- **LICENSED DOCTOR** – a person with a completed medical, dental or other relevant faculty, who independently provides healthcare services at a healthcare service provider and performs healthcare activities in accordance with the law.
- **PARTICIPATION** – participation of the Insured Person in expenses of medically justified treatment. Participation is expressed either as a fixed amount of money or as a percentage of the cost incurred through the exercise of insurance rights.
- **COVERAGE** - health services, medicines and medical supplies listed in these Special Terms and Conditions.
- **HEALTH DISORDER** – any impairment of the organism's health expressed through the occurrence of health problems with the Insured Person. In terms of these Special Terms and Conditions, mental health disorders shall mean cognitive, emotional and behavioral conditions that impede emotional and social functioning of the Insured Person. Any health problems arising from mental health disorders can only be covered under outpatient treatment as „Mental Health Service".
- **CLIENT PORTAL** – the Insurer's web site that can only be accessed by authorized users and which provides an overview of insurance information for each individual Insured Person.
- **PRE-AUTHORIZATION OF TREATMENT (AUTHORIZATION)** – written confirmation by the Insurer prior to the implementation of healthcare service that the costs of the service will be covered by insurance in accordance with the given approval and these Special Terms and Conditions. The situations which require authorization are prescribed by these Special Terms and Conditions. Authorization may not mean making an appointment for service provision through Medic Call Center unless the entire procedure prescribed by these Special Terms and Conditions has been carried out.
- **PRE-EXISTING CONDITION** – any medical condition resulting from a chronic illness or injury prior to first insurance contract coming into force.
- **REASONABLE AND USUAL COSTS** – costs not exceeding the agreed service level for the same or similar medical treatment within the Network at the time of occurrence of the insured event. These costs shall apply to the use of services at healthcare service providers outside the Network.
- **MEDICAL TRANSPORT** – transport by private practice ambulance vehicle or local ambulance for the purpose of necessary medical treatment within the borders of the Republic of Serbia or, in case of regional coverage being agreed, the country of temporary residence of the Insured Person. Medical transport shall not mean transport by means of transportation other than an ambulance, costs of any rescue of the Insured Person and of the return of the Insured Person from the country of its temporary residence to the Republic of Serbia (repatriation) in case of regional coverage agreed.
- **POLICYHOLDER** – a legal person or other legal entity that has an interest in conclusion of an insurance policy on behalf and for the Insured Person and that undertakes to pay the premium from own funds or at the expense of the Insured Person's funds. Policyholder may also be a natural person if insurance contract is concluded for his or her family members.

GENERAL PROVISIONS

Article 1

(1) In accordance with these Special Terms and Conditions, the Insurer implements supplemental, additional and private health insurance, as well as a combination of the above types of insurance in accordance with the law.
(2) Insurance contract shall be concluded exclusively as collective insurance, with possible inclusion of family members.

PERIOD OF INSURANCE

Article 2

(1) The Policy may be concluded for a period of at least one year, which may be shorter in the following cases:
  1.1. if concluded with a group of policyholders or for family members of an existing Insured Person. These policies are concluded when the basis for inclusion of new Insured Persons arises, while they expire simultaneously with other policies of the same group of policyholders;
  1.2. in other cases in accordance with the General Terms and Conditions;
(2) The commencement and expiration of insurance coverage for each Insured Person shall be displayed on the Insurer's Client Portal.

COMMENCEMENT AND TERMINATION OF THE INSURER'S LIABILITY

Article 3

(1) The Insurer's liability shall commence at 00.00 on the date specified as the commencement of insurance for each Insured Person, provided that the total agreed premium or the first installment of the insurance premium for the Insured Person has been paid, unless premium payment is made upon conclusion of the Policy. The Insurer's liability shall last until the expiry of the last day of the term of Insurance Contract and as specified in the Policy.

(2) For any cover with the waiting period, the Insurer's liability shall start running from 00.00 on the date of expiry of the waiting period.
(3) The Insurer shall not reimburse the costs of medical treatment or treatment that started prior to the commencement of the Insurer's liability or during the waiting period, or the costs of treatment carried out after the termination of the Insurer's liability, even if it commenced during the Policy term.
(4) For each Insured Person, regardless of period of insurance, the insurance shall terminate:
    4.1. for family members, in case of suspension of insurance of the insurance holder. In the event of death of the insurance holder, family members may be insured until the expiry of the existing Policy, with payment of premium for the remaining period of insurance;
    4.2. when the basis of acquiring the status of Insured Person ceased for the Insured Person;
    4.3. when other cases defined by the General Terms and Conditions arise.

TERRITORIAL SCOPE

Article 4

(1) Unless otherwise agreed, coverage shall be valid in the territory of the Republic of Serbia.
(2) In addition to the Republic of Serbia, regional coverage may be negotiated through payment of an increased premium.
(3) Regional coverage shall mean coverage in Croatia, Bosnia and Herzegovina, Macedonia, Albania, Bulgaria, Montenegro, Romania, Hungary and Slovenia.
(4) Regional coverage may be negotiated solely by the employer for an employee who is sent abroad for work, temporary work, professional development or specialization at the behest of the Policyholder, as well as for his or her family members.
(5) In the event of occurrence of insured event, the Insurer shall reimburse the eligible costs incurred abroad to the account of the Insured Person in the Republic of Serbia, in dinar equivalent, according to the NBS middle rate valid on the date of claim settlement. The Insured Person is obliged to support the claim with all necessary documentation for establishing the liability of the Insurer, as well as a proof that he or she has been sent abroad by the Policyholder.
(6) Regional coverage may be negotiated for all or only certain Insured Persons under the Policy, but it must be agreed for the entire period of insurance specified as Policy validity.
(7) The standards, registers of medicines and legislation of the country of service provision shall apply to regional coverage services.
(8) Regional coverage shall not cover any hospital treatment, surgical or other non-urgent interventions, that is, any intervention which may be postponed until return to the Republic of Serbia.

ELIGIBILITY

Article 5

(1) Only persons with registered place of residence in the Republic of Serbia in accordance with the regulations governing this area may be insured under this insurance.
(2) A group which is collectively insured shall mean a group of at least five persons who are in direct relationship with the Policyholder or group of policyholders, excluding family members.
(3) A mandatory group is a group made up of persons included in insurance by the Policyholder in accordance with predefined criteria, with the consent of the Insurer.
(4) A voluntary group shall be considered a group to which the Insured Persons applied by personal statement.
(5) Exceptionally, a group of at least three persons may be insured when the Policyholder is the employer and insures all employees as a mandatory group.
(6) After the Policy enters into force, a new person may be included in the insurance only if, after the inception of the Policy, he or she has acquired the basis for inclusion in the insurance under such Policy, i.e. if he or she is:
    6.1. entered into employment or other contractual relationship with the Policyholder;
    6.2. fulfilled the criteria necessary for inclusion in the insurance (e.g., acquired the right to voluntary health insurance through promotion);
    6.3. has become a member, student, beneficiary of the Policyholder or in a direct relationship with them;
    6.4. has acquired family member status (by birth or marriage or common-law marriage).
(7) The exclusion of the Insured Person from the insurance prior to the expiry of the contractual insurance period is possible when the Insured Person loses the status on the basis of which he or she has acquired the basis for inclusion in the insurance (e.g. termination of employment or contractual relationship, termination of membership, divorce or termination of common-law marriage) and in other cases defined by the General Terms and Conditions.

(8) The Insurer may request from the Policyholder additional documentation as a proof of the acquisition of basis for inclusion or exclusion of the Insured Person in accordance with the specific case (eg a statement certified by a public notary for the beginning and termination of a common-law marriage).
(9) The Policyholder shall be obliged to carry out insurance registration within thirty days after the change of the basis for insurance, i.e. insurance deregistration within three working days.
(10) In case of exclusion of a person from insurance prior to the expiration of the contractual insurance period, the Insurer shall be entitled to a premium only until the date on which such insurance is valid for that person, unless otherwise agreed.

PRE-EXISTING CONDITION

Article 6

(1) The Insurer's medical adviser may determine pre-existing medical condition on the basis of diagnosis or indication for treatment, or on the basis of etiology and pathophysiology of an illness (causes and mechanism of the onset of illness), the onset of symptoms and signs of disease listed in the medical records. The pre-existing medical condition is determined at the conclusion or renewal of the Policy, when using medically justified treatments covered by insurance or when performing additional medical examination at the request of the Insurer.
(2) Congenital diseases and conditions shall be considered pre-existing medical condition, except in case of mandatory groups, i.e. when the Insured Person's children are included in insurance immediately after birth.
(3) In case of continuous insurance, the pre-existing medical condition shall not mean any medical condition that occurred during the term of the previous Policy.
(4) In case of re-inclusion in the insurance after suspension, the pre-existing medical condition shall mean any illness that occurred before re-inclusion in insurance, including any condition that occurred during the validity of the Policy before suspension.
(5) In the event that a policy with a new cover is concluded after the expiry of one Policy, the pre-existing medical condition regarding such new coverage shall mean any condition that occurred before the Policy with the new cover takes effect. In case of negotiating a policy with the same coverage, but a larger scope of rights, the Insured Person shall acquire new, increased rights.
(6) The costs of treatment of the pre-existing medical condition shall not be covered under „Hospital treatment" and „Surgical and other interventions" coverage, unless otherwise agreed under the Policy.
(7) The costs of treating the following pre-existing medical conditions are completely excluded from insurance and for all coverages: psychoses, chronic diabetes mellitus with complications, Alzheimer's disease, post-stroke 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, rheumatic arthritis, unless otherwise agreed.

STATEMENT OF HEALTH STATUS AND INSURANCE PROPOSAL WITH AMENDED TERMS

Article 7

(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 statement, while the Insured Person may be referred to additional examinations. As a rule, the statement is filled out only in case of first inclusion in insurance, but at the Insurer's request it can also be filled out in case of insurance renewal.
(2) The statement shall be completed by each Insured Person, while the statement shall be completed by parents / guardians for minor children.
(3) The level of increased risk shall be determined by the Insurer on the basis of the information from the statement, all medical reports and / or the results of medical examination available to the Insurer.
(4) The Insurer shall be obliged to accept the person at increased risk for insurance, but may offer amended terms. The amended terms of Policy conclusion for persons at increased risk may be:
    4.1. limitation or exclusion of certain coverages;
    4.2. application of waiting period for certain coverages;
    4.3. premium increase.
(5) If it is determined that the person is at increased risk and the Insurer decides to offer such person the amended terms, the Insurer shall be obliged to send him or her an insurance proposal with the amended terms by mail or e-mail within eight days after the receipt of the statement.
(6) If the amended insurance proposal includes premium increase, after the acceptance thereof by the Insured Person and informing the Insurer in writing (by mail or e-mail), the Insurer shall submit the proposal to the Policyholder for approval.

(7) In the event that the Insured Person or the Policyholder accepts the Insurer's proposal, the insurance proposal with amended terms shall become an integral part of the Policy. The Policy specifies persons with amended insurance terms agreed. Specific exclusions and details about health status of the Insured Person are stated in a separate document, which is an integral part of the Policy, provided only to the Insured Person.
(8) If the Insured Person or the Policyholder does not accept the proposed amendment to the terms in writing within eight days after the receipt of the Insurer's proposal, he or she shall be considered to have withdrawn from insurance for himself or herself or for the person at increased risk.
(9) In case of an individual health risk assessment, the Insurer shall have the right, when renewing the Policy for particular Insured Person, to propose premium increase, limit or exclusion of liability for certain coverage, including health disorders that were first diagnosed during the previous Policy.

WAITING PERIOD (BENEFIT QUALIFYING PERIOD)

Article 8

(1) Waiting period is specified in the Insurance Policy.
(2) Waiting period shall be calculated from the agreed inception of insurance for each Insured Person.
(3) Waiting period shall not apply to persons with continuous insurance.
(4) In any case, if waiting period for the Insured Person has not expired during the term of the previous Policy, the remaining term of the previous waiting period shall be transferred to the next period of insurance under the new Policy.
(5) If after expiration of the Policy, a policy with new coverage to which waiting period applies is stipulated, waiting period for the services used within new cover, shall start from the inception date for the Insured Person under the new Policy.
(6) All medically justified treatments after the expiry of waiting period in connection with treatment of an illness diagnosed during waiting period shall be covered by insurance in accordance with these Special Terms and Conditions.

INSURED EVENT

Article 9

(1) An insured event is a medically justified treatment of an Insured Person's health disorder, provided for by the Policy, the costs of which are to be borne by health care service provider.
(2) Health disorder shall be determined by a licensed doctor. All medical indications from a licensed doctor shall be provided in writing.
(3) General medical examination and healthcare for pregnant women shall also mean an insured event.
(4) Emergency dental treatment shall also mean treatment of multiple injuries resulting from an accident, including oral surgeon interventions, to stop bleeding, reduce pain, remove injured teeth, or repair fractured jaws. Injuries resulting from an accident excluded by 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 at the point when, from a medical point of view, there is no longer a need for treatment because cure or health status stability has been achieved.
(6) In any event, insured event shall end on the date of termination of insurance for each Insured Person.

INDEMNITY FOR TREATMENT EXPENSES

Article 10

(1) In case of insured event occurrence, the Insurer shall indemnify the Insured Person against any treatment costs up to the amount of the sum insured or up to the limit for the medically justified treatment provided by the Policy.
(2) The sum insured and the limits shall be reduced for the period of insurance by the value of the expenses paid.
(3) If the insurance for one Insured Person lasts less than one year, the total sum insured shall remain the same, while the annual coverage limits may be reduced proportionally in accordance with the period of insurance in the manner defined by the Policy.
(4) Any person excluded during the term of the Policy and subsequently re-included in insurance under the same Policy shall be entitled to one annual sum insured, with the costs paid before suspension of insurance calculated for all the limits.
(5) In the event that the Insured Person is insured under more than one Policy with the same Insurer, the cost of treatment shall be reimbursed only under one Policy. An exception is when the cost exceeds the limit of one Policy, so the limits of multiple

policies can be combined, however, maximum liability of the Insurer may not exceed the amount of annual maximum sum insured under these Special Terms and Conditions.

(6) 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 Person during one insurance year, regardless of the number of policies stipulated.

(7) The Insurer shall not cover the costs of treatment if the Insured Person has exercised his or her right to reimbursement of the costs of treatment from compulsory health insurance or on the basis of voluntary health insurance concluded with another Insurer for a specific insured event.

PAYMENT OF SINGLE INDEMNITY INSTEAD OF COVERING TREATMENT COSTS

Article 11

(1) Payment of single indemnity may be negotiated under Insurance Policy instead of covering the cost of treatment for the following coverage:
- 1.1. for outpatient interventions if the coverage of „Surgical and other interventions" is stipulated,
- 1.2. for interventions in hospital conditions if the coverage of „Surgical and other interventions" and „Hospital treatment" are stipulated,
- 1.3. for hospital treatment if "Hospital treatment" coverage is stipulated,
- 1.4. for childbirth if childbirth coverage is stipulated within the scope of the coverage of „Healthcare for pregnant women and newborns"

(2) Single indemnity may be paid instead of covering the cost of treatment only for those medically justified treatments:
- 2.1. which can be implemented in the Republic of Serbia,
- 2.2. which are recognized as insured event under these Special Terms and Conditions,
- 2.3. the total cost of which is below the stipulated limit applicable to the specific service and
- 2.4. for which authorization was initiated under these Special Terms and Conditions.

(3) The insured may claim a single indemnity only before the covered medical treatment has been performed. Accordingly, for emergency treatments for which no authorization has been carried out, a single indemnity cannot be claimed after the treatment has been performed.

(4) Single indemnity is expressed as the total amount payable under cover, except for the coverage of „Hospital treatment" where indemnity is expressed per day and is paid depending on the number of days spent in hospital for treatment (as a daily fee). The above payment methods may not be combined.

(5) The amount of single indemnity shall be determined in the manner defined by the Policy.

(6) Through single indemnity payment the agreed limit, that is, the sum insured shall be reduced. The Insurer's maximum liability for indemnity payment may not exceed the stipulated limit for specific coverage.

(7) If the Insured Person chooses this option, the Insurer shall not cover the cost of medically justified treatment on the basis of which indemnity payment is claimed, nor pay any other costs associated with the treatment for which the Insured Person received indemnity, including preparation for surgery or childbirth and postoperative care, unless otherwise agreed.

(8) The Insurer's liability to pay single indemnity does not exist unless the Insured Person has received medically justified treatment for which he or she claims indemnity payment. The Insured Person is obliged to submit documentation proving that medically justified treatment has been performed.

COVERS

Article 12

(1) „Outpatient treatment" is compulsory coverage. Any other coverage is additional and is covered by insurance only if they are stated in the Policy and if an additional premium is paid.

(2) Additional coverage shall mean the following:
- 2.1. Hospital treatment,
- 2.2. Surgical and other interventions,
- 2.3. Healthcare for pregnant women and newborns,
- 2.4. General medical examination,
- 2.5. Medicines,
- 2.6. Ophthalmologic services,
- 2.7. Dental services,
- 2.8. Analysis of genetic predispositions for cancer (hereinafter referred to as: DNA Cancer Screening).

(3) Selected insurance coverage (package coverage) shall be determined by agreement of the Parties.

(4) The agreed insurance package coverage with the content of medically justified treatments is defined by the Insurance Policy.

(5) The sum insured, limits and restrictions applicable to each coverage or to any of the medically justified treatments within the coverage are specified in the Insurance Policy.
(6) In addition to the exclusions specified in the Articles describing individual coverages, all coverages are also subject to general exclusions and restrictions referred to in Article 28.

OUTPATIENT TREATMENT

Article 13

(1) Outpatient treatment is a medically justified treatment received by an Insured Person at a health care service provider without spending consecutive 24 hours in such institution.
(2) Insured Person may use the services under this coverage only in the event of a health disorder. For all services, except for examination by a licensed doctor, examination under „Mental Health Services" and the services covered by „Alternative and Complementary Medicine", referral by the relevant doctor is required.
(3) „Outpatient treatment" covers the following medically justified treatments and services:
- 3.1. examination by a licensed doctor, which may include the following services: examination, follow-up or consultation, including an online consultation. Examinations by neuropsychiatrists, psychiatrists, psychologists, defectologists and other doctors due to mental health problems are covered solely within the scope of „Mental Health Services", if agreed by the Policy;
- 3.2. laboratory services and diagnostic procedures;
- 3.3. diagnostic procedures and interventions conducted for the purpose of examination of reproductive health (sterility, causes of miscarriage and preparation for pregnancy);
- 3.4. medical transport:
  - 3.4.1. urgent medical transport to the nearest doctor or hospital (i.e. to a health care facility that can provide adequate medical assistance to the Insured Person) by local ambulance or private practice ambulance, only in emergency medical cases and provided that such transportation is ordered by a licensed doctor providing first aid to the Insured Person, excluding the Insurer's liability to arrange urgent medical transport;
  - 3.4.2. required medical transport which is not urgent but is medically necessary because transport by any other means of transportation could endanger the life and health of the Insured Person. It covers transportation to a health care facility providing justified and medically necessary health care and transportation from the health facility to the home, only on condition that, upon discharge from the health facility, the Insured Person 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. therapeutic treatments, which covers the cost 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 covered exclusively from the coverage of „Medicines", if agreed under the Policy;
  - 3.5.2. physical therapy and kinesiotherapy conducted exclusively by a qualified therapist or chiropractor. At home it can only be performed if the Insured Person is immobile due to fracture of the lower extremities, spinal injury or cerebrovascular stroke;
  - 3.5.3. speech disorder therapy (performed exclusively by speech therapist or defectologist),
  - 3.5.4. oculomotor exercises,
  - 3.5.5. occupational therapy and
  - 3.5.6. other defectology therapies (except for mental health services, to be covered if the coverage of „Mental Health Services" 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 from insurance;
- 3.6. mental health services, provided they are medically necessary. These services include psychotherapy, consultation with a psychiatrist, neuropsychiatrist, psychologist, defectologist, or, where appropriate, a doctor specialized in other fields;
- 3.7. field nursing care, immediately after hospital treatment or treatment in the event that the Insured Person 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 carried out in accordance with legal regulations governing 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 extremities, breast prostheses, and aesthetic ear, nose and face dentures;

3.10.2. orthotic aids - orthoses for the upper and lower extremities, for the treatment of dislocated hips, for the spine (spinal orthoses) if registered as medical and technical aids and purchased at an authorized specialized store for sale of medical equipment or a pharmacy;
3.10.3. special types of aids and medical devices:
3.10.3.1. auxiliary aids for movement - crutches (wooden and metal underarms and forearms), metal rod and walking stand (walker);
3.10.3.2. hernia belts and belts for pregnant women (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, test strips for the lancet unit;
3.10.4. eye aids (except diopters): prism foil, therapeutic contact lenses, full and flaky eye prosthesis, occlusive patches for the treatment of strabismus;
3.10.5. tiflotechnical aids;
3.10.6. hearing aids - only one or a pair of aids, depending on the indication during life;
3.10.7. other aids and compression socks for varicose veins, limited to two pairs during the year of insurance.
Orthopedic shoes, orthopedic insoles or other aids for deformed, weak, overstressed, unstable and lowered feet, tarsalgia or metatarsalgia are excluded form insurance;
3.11. primary outpatient interventions: primary wound treatment, dressing and stitching, primary treatment of burns, removal of stiches with dressing, removal of ticks and other foreign bodies from the skin, ear, throat and nose, plastering, fixation and immobilization of the joint, flushing of the ear and nose, aspiration of nasal secretions, vaginal douche, nasal tamponade, special gaze application with medicine, abscess incision, therapeutic puncture of joint and connective tissue, orthopedic repositioning of luxations and fractures without anesthesia;
3.12. examination under day hospital conditions for diagnosis, excluding surgical and other interventions.

(4) The Insurer shall cover examinations, diagnostic procedures and therapies in a spa. Any other expenses in a spa are not covered by insurance.

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

HOSPITAL TREATMENT

Article 14

(1) Hospital treatment shall mean medically justified treatment in a secondary or tertiary- type health facility where the Insured Person occupies a bed for more than 24 hours in order to be diagnosed or treated.

(2) In terms of these Special Terms and Conditions, hospital treatment shall not mean accommodation of the Insured Person in dispensary facilities such as: addiction treatment facilities, mental hospitals, dispensary health facilities specialized in rehabilitation, hydro-clinics, sanatoriums, nursing homes for sick people, nursing homes for elderly people, health resort, centers for relaxation, weight loss and recovery.

(3) The following services are covered under hospital treatment:
3.1. accommodation in standard rooms available with the healthcare service provider. Private apartment accommodation on personal request by the Insured Person will be covered only if stipulated under the Policy and if it exists with the healthcare service provider;
3.2. medically permitted nutrition during hospital treatment recommended by a licensed doctor;
3.3. examinations by licensed doctors;
3.4. fees of medical technicians and other medical staff;
3.5. laboratory and diagnostic procedures performed during hospital treatment, except for surgical interventions for diagnosis purposes;
3.6. therapy performed during hospital treatment:
3.6.1. drug, injection, inhalation and infusion therapy;
3.6.2. early physical therapy and kinesiotherapy;
3.6.3. speech disorder therapy (conducted exclusively by a speech therapist or defectologist), life training and other defectology therapies. 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 hospital treatment;
3.8. medical and technical aids used during hospital treatment;
3.9. treatment provided in the emergency department;
3.10. urgent dental treatment due to an accident;
3.11. presence of parental escort during hospital treatment for children under the age of 18.

SURGICAL AND OTHER INTERVENTIONS

Article 15

(1) Surgical and other interventions shall include invasive medical procedures performed manually or with the help of instruments to diagnose or treat a patient, whether performed in a hospital or in an outpatient setting.
(2) The costs of surgery and other interventions (including blood and blood components for transfusion, medical and technical aids and implants needed for the intervention, medications, medical supplies used during the intervention) are covered, while the costs of preoperative preparation, intensive and postoperative care are paid within the coverage of „Outpatient treatment" or „Hospital treatment" in accordance with the Policy and these Special Terms and Conditions.
(3) The following costs shall be excluded from insurance:
   3.1. radial keratotomies or any other surgical procedure for vision correction (including laser treatments);
   3.2. sex reassignment surgery;
   3.3. organ and tissue transplant surgery;
   3.4. nasal septum surgery for persons over the age of 18 years;
   3.5. removal of condyloma if the sample was not sent for HP analysis or HPV typing;
   3.6. removal of moles, lipomas, atheroma, fibromas, warts, capillaries, cherry angiomas, keratoses and similar widespread skin lesions which, in the opinion of a medical adviser, do not endanger patient's health. Coverage is limited to emergencies and medically indicated cases where the change is prone to injury or requires PH analysis due to suspected malignancy;
   3.7. circumcision, if not medically indicated;
   3.8. installation of a gastric balloon.

HEALTHCARE FOR PREGNANT WOMEN AND NEWBORNS

Article 16

(1) Healthcare for pregnant women and newborns shall cover the cost of management of pregnancy, childbirth and postnatal treatment of the newborn.
(2) If the Insured Person does not fully use the limit for this coverage in one year, maximum liability of the Insurer in the following year of continuous insurance shall be equal to the remaining limit under the previous Policy.
(3) The Insurer's liability shall not exist for the pregnancy which started before the inception of insurance for such Insured Person or during the waiting period, if agreed. In case of continuous insurance, this limitation applies only to the first inclusion of the Insured Person in the insurance, 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 Person has determined the term of delivery before the expiration of nine months after the date of the first inclusion in insurance for that person or the date of expiry of the waiting period, if agreed.
(5) In accordance with the stipulated coverage, the following medically justified treatments and services shall be indemnified:
   5.1. gynecologist examinations;
   5.2. ultrasound fetus examinations;
   5.3. expert ultrasound;
   5.4. laboratory tests such as swabs, complete blood count, basic biochemistry, urine tests and other specific analyzes necessary to pregnancy management;
   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 drugs to prevent premature birth in at- risk pregnancy, including cost of administration and of the drug itself. Other pregnancy-related drugs are covered only if medicine coverage is stipulated;
   5.10. prenatal vitamins – medical device which represent a combination of vitamins and minerals that are used exclusively in pregnancy and are intended for proper fetus development. If the doctor prescribes individual minerals and vitamins for general use, they will be covered only if they are registered as a medicine, ie. if listed in the National Registry of Medicines. The liability begins at the moment pregnancy is determined by a doctor and ends on the day of childbirth;
   5.11. in case of risky pregnancies, medically justified treatments for prevention of preterm birth, hospital stay for pregnancy maintenance, interventions in case of miscarriage or termination of pregnancy for medical reasons, including accommodation and nutrition, fees of doctors and medical staff, indicated diagnostics and treatments, necessary medications and medical supplies;
   5.12. childbirth, including preoperative childbirth preparation, costs of anesthesia, apartment accommodation, partner attendance at childbirth, fees for doctors, medical technicians and anesthesiologist. Cesarean delivery costs are only covered if cesarean section is medically indicated;

5.13. newborn baby healthcare in the first month of life, which includes treatment of infant health disorders, but not screening or other services routinely performed in the first month of life;
5.14. field nursing care up to one month after birth, as recommended by a licensed doctor;
5.15. one complete routine gynecological examination up to six months after birth;
5.16. a single check-up and associated laboratory and diagnostic procedures in case of miscarriage or termination of pregnancy for medical reasons.

(6) This cover shall also include the costs of treatment of other health problems resulting from pregnancy, i.e. medical treatment costs that would not be indicated if the Insured Person was not pregnant.
(7) Pregnancy classes (preparation for childbirth) and hospital accommodation of a companion during hospitalization due to childbirth or pregnancy maintenance shall be excluded from insurance.
(8) All limits relating to an infant may also be used from the other parent's Policy if this coverage is stipulated and if the pregnancy occurred during the period of the father's insurance.
(9) The services under this coverage do not apply to any Insured Persons included in insurance as children of the insurance holder.

GENERAL MEDICAL EXAMINATIONS

Article 17

(1) A general medical examination package shall mean a set of health services that are performed preventively for the purpose of health check.
(2) General medical examination shall be performed at a healthcare service provider the Insurer has agreed such general medical examination package with, subject to mandatory appointment through Medic Call Center.
(3) If the Insured Person uses only part of the services under the stipulated package, he or she shall be deemed to have used the whole package and cannot use the remaining services subsequently.
(4) Multiple general medical examination packages may be agreed under one Policy, but the Insured Person may only use each agreed package once during the insurance year.
(5) Unless specifically agreed, the costs of general medical examination may cover vaccines not required by the Republic immunization program, as well as certain diagnostic procedures for the purpose of examination of family history as indicated by a licensed doctor.
(6) Children up to the age of two shall exercise the rights granted under this coverage through „Healthy Child" program in accordance with the Policy.
(7) In case of continuous insurance, „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, insurance shall cover pre-vaccination examinations.
(8) When new Insured Persons, including newborn children, are included during the insurance year, those persons shall be entitled to full general medical examination coverage regardless of the actual period of insurance for them, subject to the obligation of the Policyholder to pay the full annual premium for general medical examination for such persons.

MEDICINES

Article 18

(1) This cover shall mean the costs of medicines registered in the Republic of Serbia and listed in the National Register of Medicines (NRL) of the Medicines and Medical Devices Agency of Serbia.
(2) If regional coverage is agreed upon, this coverage shall also include the costs of medicines registered in the country of regional coverage where the Insured Person uses health services.
(3) The Insurer shall cover both main and galenic medicine (medicines made at the pharmacy).
(4) The Insurer may not cover the following:
4.1. biological, immunological, blood and plasma medicines, advanced therapy medicines, while traditional and homeopathic medicine are exclusively covered by „Traditional medicine", if stipulated;
4.2. medical cosmetics;
4.3. all medical devices (including syringes, needles and bandages) not covered by these Special Terms and Conditions, as well as dietary supplements, except:
4.3.1. probiotics with antibiotic therapy and for the duration of therapy,
4.3.2. anemia iron preparation (with a medical report proving that the Insured Person responds negatively to the preparation registered as medicine),
4.3.3. eye preparations (artificial tears) for the diagnosis of dry eye or conjunctivitis.

(5) The Insurer shall only cover the cost of medicines if they are prescribed in therapeutic doses for a maximum of the next ninety (90) days.
(6) This coverage also includes the cost of ordered medicines (medicines given in outpatient setting) as part of outpatient treatment.
(7) This coverage does not cover any medicine given at the hospital during hospital treatment or during surgical or other intervention, as well as during hospital stay for risky pregnancy and pregnancy maintenance.

OPHTHALMOLOGIC SERVICES

Article 19

(1) The following medical services and supplies are included under this cover:
1.1. examination by an ophthalmologist to control vision, to confirm the existence or control of existing refractive anomalies and to prescribe ophthalmic 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 Person with two different diopters;
1.2.2. in case of continuous insurance, the Insured Person shall acquire the right to change frames and glass if his or her diopter is changed;
1.2.3. if there has been no diopter change, the Insured Person shall acquire the right to change the frame and glass two years after the last purchase;
1.2.4. in case of change in diopter after the aids have been procured in the same year of insurance, the Insurer may approve purchase of additional glasses within the agreed limit;
1.3. contact lenses in quantities appropriate to the medical needs, type of lenses and period of insurance, as assessed by a medical adviser.
(2) In case the Insured Person loses or damages the aids, he or she may not acquire the right to purchase new ones at the cost of insurance.
(3) Sun glasses, glass accessories, glasses and lenses with no diopter are excluded from insurance.
Dental Services Article 20
(1) Depending on the agreed content, coverage of dental services costs may relate to the
following services:
1.1. preventive treatment - shall include regular examinations and dental instructions once a year, fluoride treatment for persons up to the age of 18, watering fissures;
1.2. basic restorative treatment - shall include amalgam and composite fillings, multi- surface fillings (inlays and onlays), compomer restorations;
1.3. major restorative treatment - shall include root canal filling, crowns, fillings and dental bridges (including laboratory and anesthesia costs);
1.4. periodontal descaling - once a year;
1.5. periodontal surgery;
1.6. oral surgery - tooth extraction (routine, complicated and surgical);
1.7. orthodontic treatment - shall include models for analysis (including panoramic x- rays), prints, mobile and wired appliances (braces). The age limit for using this coverage is stipulated under the Policy. Orthodontic treatment is only allowed with the written consent of the Insurer.
(2) For all treatments performed, there must be a written medical indication and a report on the service performed. The report shall specify the number of teeth subject to the treatment performed, whereas the Insurer shall have the right to request X-rays (OTP, 3D, retroalveolar, retrocoronary, etc.) if necessary. For metal and ceramic crowns and dental bridges, digital photographs of the clinical condition before and after such treatment are to be provided.
(3) The insurance shall exclude cosmetic and aesthetic treatments of teeth, artificial teeth, dental implants, ceramic restorations on dental implants, fixed braces, veneers with any associated costs, teeth whitening and any other dental aids.

DNA CANCER SCREENING

Article 21

(1) DNA cancer screening may be stipulated under the Insurance Policy, which involves the analysis of genetic predispositions for development of the following forms of cancer: breast, ovarian, stomach, kidney, prostate, thyroid and parathyroid gland, pancreas or endometrium, multiple endocrine neoplasia, neurofibromatosis, pheochromocytoma, familial paraganglioma, retinoblastoma, malignant melanoma, chondrosarcoma and colorectal cancer.

(2) DNA cancer screening service can be used by all biological children of the Insured Person if during the period of insurance the Insured Person is diagnosed with one of the cancers defined in paragraph 1 of this Article.
(3) DNA cancer screening service may be used only for the period of insurance of the Insured Person.
(4) Genetic analysis shall be performed by an independent institution the Insurer has a cooperation agreement concluded with.
(5) The institution carrying out such genetic analysis shall send any necessary DNA sampling equipment to the beneficiary by mail. The cost of receipt of equipment and delivery of a DNA sample shall be borne by DNA cancer screening service provider.
(6) The genetic analysis beneficiary (Insured Person's child) shall, in accordance with the instructions, take a sample and fill in the forms received from the institution referred to in the previous paragraph and return the above to the institution performing such genetic analysis.
(7) Upon receipt of the samples and documentation, the institution carrying out such genetic analysis shall conduct the sample analysis procedure in a certified laboratory and shall produce a DNA analysis of the beneficiary.
(8) Having conducted the analysis, the institution carrying out such genetic analysis shall send the results of DNA analysis to the beneficiary.
(9) The Insurer shall not be entitled to any information regarding the results of DNA analysis carried out.
(10) Any Insured Person who chooses to use this service for his or her child shall be obliged to submit, at the request of the institution carrying out such genetic analysis, any medical documentation proving that the basis for using this service in accordance with paragraph 1 of this Article.

METHOD OF USING INSURANCE RIGHTS

Article 22

(1) Healthcare services under these Special Terms and Conditions may only be used at healthcare service providers.
(2) The following may be stipulated under the Policy:
  2.1. method of insurance use:
    2.1.1. exclusively within the Healthcare Service Provider Network (all or part thereof, as defined by the Policy);
    2.1.2. within and beyond the Healthcare Service Provider Network;
  2.2. method of making a medically justified treatment appointment:
    2.2.1. appointment shall always be made through Medic Call Center;
    2.2.2. making an appointment through Medic Call Center is not obligatory. Exceptionally, making an appointment through Medic Call Center shall always be mandatory for general medical examinations and for providing medically justified home treatment (home visits), regardless of the agreed method of use. In addition, the Insurer may prescribe an obligation of making appointments through Medic Call Center with individual healthcare service providers, even if they are within the Network;
  2.3. method of cost covering by the Insurer:
    2.3.1. directly established from the Network or, if the Insured Person uses the services beyond the Network, through reimbursement to the Insured Person;
    2.3.2. solely through reimbursement to the Insured Person;
    2.3.3. directly established from the Network.
(3) For the treatments used by the Insured Person within the Network, the Insurer shall pay the costs directly to the provider, if it is in accordance with the terms and conditions of the contract.
(4) If the Insured Person uses any health service within the Network, but fails to register as an Insured Person and pays for the service according to the price list that is not agreed with the Insurer, he or she will be compensated only for the amount the Insurer has negotiated for such service with that healthcare service provider.
(5) The Insurer shall reserve the right to include new and exclude existing providers without being obliged to send special notification to the Policyholder and Insured Person.
(6) The Insurer shall reserve the right not to accept or include in healthcare service provision contract certain prices of healthcare service providers within the Network, so such services are subject to all provisions applicable to services received beyond the Network.
(7) The list of institutions in the Healthcare Service Provider Network is published on the website of the Insurer and is regularly updated.
(8) Insured Persons are obliged to adhere to the agreed method of use of services. In the event of non-compliance, the Insurer may completely refuse to reimburse the cost:
  8.1. when mandatory appointment option through Medic Call Center is agreed, but the Insured Person fails to comply with it and to report the service to be used beyond the Network;
  8.2. when use of services exclusively within the Network is agreed, but the Insured Person has sent a refund claim for services used outside the Network. This does not apply:
    8.2.1. when medical treatment is necessary in case of emergency treatment, as determined by a competent licensed doctor;

8.2.2. when there is no facility falling within the scope of the Network within the radius of 30 km from the current location of the Insured Person;
8.2.3. for the supply of medicines and medical and technical aids.

(9) The Insured Person is considered to have fulfilled the obligation of calling Medic Call Center if:
9.1. he or she calls Medic Call Center before using any health services;
9.2. he or she answers the questions asked by Medic Call Center about his or her current health status or provides any requested documentation regarding the service concerned;
9.3. confirms the time of use of the health service.

MEDIC CALL CENTER

Article 23

(1) Medic Call Center is a telephone service that provides Insured Persons with information on how to exercise their rights under insurance and agreed coverage (agreed services, remaining limits, exclusions, etc.) and authorizes the provision of outpatient treatment services at home.
(2) At the request of the Insured Person, Medic Call Center shall make an appointment for examinations with service providers within the Network. When making an appointment, Medic Call Center employee shall consider coverage of such service, available medical indications, as well as the remaining limits in relation to the expenses paid up to such moment and any claims received. If in the process of indemnification there are any established facts which are different from those available to Medic Call Center at the time of making an appointment for the respective healthcare service, the Insurer shall reserve the right not to assume such liability to pay the expenses incurred if the amount exceeds the sum insured / limit or if the service does not comply with the agreed coverage.
(3) Medic Call Center shall mediate between the Insured Person and the Insurer's medical adviser during mandatory authorization.
(4) Every conversation of the Insured Person with any Medic Call Center employee shall be recorded.

PARTICIPATION

Article 24

(1) If participation is agreed, the amount or percentage of participation shall be specified in the Policy.
(2) If two or more participations are applied to a particular service, each of the following participation shall be applied to the part of the cost remaining after the previous participations have been applied.
(3) If the Insured Person uses any service, the price of which is higher than reasonable and usual expenses, the Insurer shall indemnify the amount of reasonable and usual expenses, less the amount of participation.

AUTHORIZATION

Article 25

(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. for planned hospital treatment;
1.3. for childbirth;
1.4. for all planned or scheduled surgical and other interventions;
1.5. for prenatal diagnosis;
1.6. for the supply of permanent medical and technical aids;
1.7. to remove any skin changes.
(2) The Policy may define other cases for which authorization is required.
(3) Authorization must be requested from the Insurer at least 14 days before the planned medically justified treatment.
(4) Authorization may be requested by the Insured Person or an authorized person of healthcare service provider where medically justified treatment is to be carried out, whereby the Insured Person must be informed of the request for authorization and the Insurer's response upon request.
(5) The Insurer shall be provided with the request for authorization supported by any relevant documentation (medical records, pro forma invoices and any other documentation additionally requested by the Insurer).
(6) The written approval of the Insurer shall specify whether the proposed medically justified treatment is in accordance with the terms and conditions and with the agreed coverage or whether it constitutes an exclusion in the specific case.

(7) In the event of non-compliance with the provisions of this Article, the Insurer shall have the right to reduce the insurance indemnity and limit its liability to reasonable and usual expenses.
(8) All provisions of this Article shall also apply in the event that regional coverage is agreed upon under the Policy.
(9) Services related to medical emergency when the life of the Insured Person is endangered are not subject to authorization.

DETERMINING THE INSURER'S LIABILITY AND REPORTING AN INSURED EVENT

Article 26

(1) An insured event may be reported by the Insured Person or an authorized person of healthcare service provider where the Insured Person uses the services of agreed medically justified treatment.
(2) When reporting an insured event, the Insurer shall be provided with a claim for indemnity on the Insurer's form, complete medical documentation and receipts, on the basis of which relevant facts regarding the occurrence of such insured event shall be determined.
(3) If deemed necessary in identification of circumstances of the reported event, the Insurer shall have the right, in the process of claim settlement, to require from the Insured Person access to any documentation available to it or to third parties about current and previous medical condition (medical documentation and reports, medical records and medical history, police reports, etc.). The Insurer may hire an expert or seek additional medical examination from relevant specialist to determine the facts.
(4) If the Insured Person is unable to provide the necessary documentation or when he or she considers that it is in his or her interest, the Insured Person may waive the claim.
(5) At the request of the Insurer, the Policyholder shall be obliged to provide all evidence relevant for assessment of eligibility for exercising the rights arising from insurance 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 Person.
(7) In case of an agreed participation, the Insurer shall reduce its liability by the amount of the Insured Person's participation.
(8) If the expenses arising from the exercise of insurance rights are lower than the specified maximum limits for individual coverage, that is, than the sum insured provided by the Policy, the Insured Person may not be entitled to payment of the difference upon expiration of insurance.
(9) If an insured event report is incomplete, inaccurate, contains services not covered by insurance or services which, in the opinion of a medical adviser, are not appropriate for treatment of the Insured Person's problems, or the applicant's claim has no basis in the supporting documentation or other sources which may be used by the Insurer to determine the liability, the Insurer shall have the right to refuse to pay the costs.

INSURER'S FULFILLMENT OF THE LIABILITY

Article 27

(1) In accordance with the Policy, the Insurer shall fulfill its liability by:
1.1. direct reimbursement of the cost of treatment to a health facility within the Network;
1.2. reimbursement of treatment costs to the Insured Person.
(2) The Insurer is obliged to reimburse the costs of treatment in accordance with these Special Terms and Conditions within 14 working days after the date of receipt of claim and any necessary evidence and identification of the liability.
(3) The Insurer's liability is fully discharged on the day of the confirmed payment through the bank.

EXCLUSIONS AND LIMITATIONS OF THE INSURER'S LIABILITY

Article 28

(1) The Insurer's liability for any coverage 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 an insured event in accordance with these Special Terms and Conditions and the Policy, as well as the consequences of such events, shall be excluded.
(3) The Insurer's liability for the costs of filing a claim for damages incurred by the Insured Person for hiring a lawyer or on any other grounds shall be excluded.
(4) The Insurer's liability for reimbursement of costs of preventive immunization programs and chemoprophylaxis, which are obligatory under the law governing the protection of the population against infectious diseases in the Republic of Serbia or in the country of regional coverage, if agreed, shall be excluded. No vaccine shall be covered if it contains component that is legally required, regardless of the manufacturer and the registered name.

(5) All health services, medicines and medical devices shall be excluded:
  5.1. unless they are medically required for examination, treatment or alleviation of health disorders and unless they have been indicated by the relevant specialist;
  5.2. if applied for aesthetic purposes, whether for psychological reasons or not, as well as any consequences of such treatments. An exception are implants to be covered in case of a total mastectomy.
  5.3. Coverage of any treatments of injuries and other health consequences resulting from engaging in high-risk sports and activities shall be excluded, including as follows: participation of the Insured Person in aviation, automobile, motorcycle, nautical and other speed competitions, racing and training for the above, test runs and test flights; engaging of the Insured Person 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, mountaineering, acrobatic skiing, speleology, rafting, base jumping, jumps from height; training and participation of the Insured Person 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 performed with mandatory use of protective equipment or involving the use of special equipment;

(6) The coverage of the following costs shall be excluded:
  6.1. any costs incurred after the expiry date of insurance and which result from 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 expiration of insurance, provided that they have been purchased during the period of insurance;
  6.2. when the hospital has practically become or could be treated as the home or permanent residence of the Insured Person;
  6.3. any costs of services performed in institutions that do not qualify as healthcare service providers under these Special Terms and Conditions such as gyms, fitness centers, sports clubs, counseling centers, beauty salons, etc., regardless of whether any of the services they provide may be considered medical or not;
  6.4. any costs of treatments that do not comply with the treatment protocol (good clinical practice guides) for a particular diagnosis or in the opinion of a medical adviser, that is, any treatments not related to the symptoms of an illness and if their performance is not justified by the current clinical picture;
  6.5. any costs of new methods of treatment, diagnostic and therapeutic treatments, medicines and other health services that did not exist on the market of the Republic of Serbia at the moment of application of these Special Terms and Conditions, unless the Insurer made a decision to cover such particular service;
  6.6. items of general use, cosmetics, services and items for personal care and hygiene;
  6.7. transportation for the purpose of obtaining medical treatment, except in case of transportation defined by „Medical Transport" coverage.

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

(8) The following shall be excluded:
  8.1. reproductive treatments, as follows:
    8.1.1. prevention of conception for men and women (contraception and its effects);
    8.1.2. vasectomy and sterilization as well as pre-sterilization status restoration;
    8.1.3. sexual dysfunction, viagra treatment or generic replacement;
    8.1.4. medically unjustified termination of pregnancy at the Insured Person's personal request, and its consequences;
    8.1.5. infertility treatment, all preparatory treatments for assisted reproduction and medicines, as well as all forms of assisted reproduction (insemination, in vitro fertilization, etc.);
  8.2. all therapeutic procedures (including implants and corrective medical and technical aids) and surgical procedures that are not medically justified, necessary or indicated;
  8.3. treatments in hyperbaric chamber, unless otherwise agreed under the Policy;
  8.4. rejuvenation treatment, whether or not prescribed by a licensed doctor;
  8.5. any nutritional advice, except for the diagnosis of diabetes and cancer, if in accordance with these Special Terms and Conditions;
  8.6. 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 agreed under the Policy. An exception is blood transfusion, which shall always be covered when medically necessary;
  8.7. stem cell collection and storage costs and any other related costs;
  8.8. genetic testing, except in the case of:
    8.8.1. diagnostic procedures performed for testing of:
      8.8.1.1. reproductive health,
      8.8.1.2. family history as indicated by a licensed doctor.
    8.8.2. analysis of genetic predispositions to cancer under „DNA cancer screening", if agreed.
  8.9. sleep disorder treatment and treatments in case of sleep breathing and snoring;

8.10. artificial life support, when the relevant licensed doctor confirms that recovery is not possible;
8.11. any other medical devices, except those directly specified in these Special Terms and Conditions and the Policy, provided that the coverages under which the above is covered are agreed and that an additional premium is paid;
8.12. training costs for the use and maintenance of durable medical equipment;
8.13. the cost of adapting a vehicle, bathroom or home to personal needs.

OBLIGATIONS OF THE POLICYHOLDER

Article 29

(1) The Policyholder shall assume the obligation to inform the Insured Person by e-mail, through the notice board or in another convenient way:
1.1. of the content of pre-contractual information notice provided by the Insurer, in all respects and in the manner prescribed by law;
1.2. upon contract conclusion, of the agreed package, these Special Terms and Conditions and agreed obligations of the Insured Person;
1.3. of the Instructions for the Insured Persons provided by the Insurer.
At the request of the Insurer, the Policyholder is required to provide proof of notifying the Insured Person.
(2) In case of continuous insurance with different Insurers, the Policyholder is obliged to submit a list of Insured Persons supported by information on first inclusion in insurance with the previous Insurer, as well as the contents of the agreed coverage, so that the provisions on pre-existing condition could be applied.
(3) The Policyholder shall be obliged to provide the Insurer upon request with information on whether the Insured Persons are insured within compulsory health insurance system in accordance with the law, as well as information on change in status, if any.
(4) The Policyholder shall be obliged to provide the Insurer with information on exclusion of the Insured Person from insurance as soon as possible, and no later than three working days after the termination of the insurance basis. In cases where due to untimely cancellation of insurance, the Insured Person uses the services on the basis of insurance, regardless of whether the respective service was subject to an appointment made through Medic Call Center or not, the cost of using medically justified treatment may not be borne by the Insurer.

OBLIGATIONS OF THE INSURED PERSON

Article 30

(1) The Insured Person (or the parent in case the Insured Person is a minor) 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 Persons;
1.3. provide the authorized person of service provider with an identification document and the card before using any service in a facility within the Network;
1.4. notify the Insurer of loss of the card as soon as possible;
1.5. not to 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 request of the Insurer for the purpose of:
1.6.1. obtaining additional documentation to determine the Insurer's liability and undergo any additional medical examination at the Insurer's expense, if requested by the Insurer;
1.6.2. treatment authorization procedure.
(2) If the Insured Person happens to receive any service that is not covered by insurance or is beyond the agreed limits, he or she is obliged to reimburse the cost of the uncovered service received. This provision shall also apply in case of making an appointment for service provision through Medic Call Center, if such appointment is made by incomplete information available to Medic Call Center at the time of the appointment.

FINAL PROVISIONS

Article 31

(1) The Insurer shall publish updated version of these Special Terms and Conditions on its web page.
(2) These Special Terms and Conditions shall apply as of July 1, 2021. As of the effective date of these Special Terms and Conditions, the Special Terms and Conditions dated April 1, 2020 shall cease to apply.