SPECIAL TERMS AND CONDITIONS
FOR GROUP VOLUNTARY HEALTH INSURANCE

INTRODUCTORY PROVISIONS

Article 1

(1) General Terms and Conditions for Voluntary Health Insurance (hereinafter: "General Conditions") and Special Terms and Conditions for Group Voluntary Health Insurance (hereinafter: „Special Conditions") of Dunav Insurance Company a.d.o. (hereinafter: "Insurer") constitute an integral part of the concluded Contract for combined parallel and private group voluntary health insurance.

(2) Particular terms in these Special Conditions shall have the following meaning:

- Sum insured /Sublimit – maximum amount of money or the number of services or days, which represents maximum liability of the Insurer within a particular insurance cover and/or medically justified treatment indicated in the Insurance Contract for each and every insured person during the insurance year;

- Outpatient treatment – medically justified treatment received by the insured at the healthcare service provider's, provided that in such institution the insured has not spent 24 consecutive hours (stayed overnight or slept in a hospital bed);

- Inpatient treatment – medically justified treatment provided by the healthcare service providers of secondary and tertiary level during the hospitalization of the insured, where the insured occupies hospital bed for the purpose of treatment which lasts longer than 24 hours. Inpatient treatment shall not be considered the accommodation of the insured in institutions of inpatient type such as: institutions for addiction treatment and rehabilitation, mental hospitals, spas, hydro clinics, sanatoriums, nursing homes, retirement homes or homes for the aged, resorts offering therapeutic baths, rest, weight loss and recovery centres;

- Domiciliary care - home care provided immediately after inpatient treatment by qualified medical staff, based on a written report and instructions of the authorised doctor confirming the necessity of providing such healthcare service at home of the insured person;

- Reasonable and customary expenses – expenses that do not exceed the rates agreed for the level of services provided by the network of clinics – Classic, Super, VIP - or for the same or similar medical treatment by healthcare service providers included in the insurer's Network of healthcare service providers, that are valid at the moment of the occurrence of the insured event, that is, when the expenses of medical treatment abroad are specially agreed, the expenses that do not exceed the general level of customary expenses in similar medical institutions at the place where they have been incurred. All amounts exceeding the reasonable and customary expenses shall be borne by the insured person;

- Medically justified healthcare service – healthcare service, medical and technical aids, implants, medical supplies or medically justified drug if:
1. appropriate and necessary for diagnosis or treatment of an illness or injury of the insured person in accordance with the insurance contract (policy);
2. necessary for healthcare of expectant mothers (provided that such coverage is agreed);
3. necessary to prevent the onset of a disease and for the early detection thereof by the general check-up (provided that such coverage is agreed);
4. prescribed by the authorised doctor if there is a clear medical indication for the administration of a particular medical treatment;
5. it has occurred during the validity of the insurance contract;
6. in accordance with broadly accepted professional standards of medical practice pursuant to the policy and these Special Conditions;
7. not primarily intended for personal comfort and convenience of a patient, family, doctor or other healthcare service provider;
8. not a part of education or professional training of a patient and not connected therewith;
9. not experimental or in a research phase;
10. agreed in accordance with these Special Conditions and defined in the policy or Insurance Certificate;
11. its scope, duration or intensity, according to the professional assessment of a doctor, does not exceed the level of protection which is necessary to provide a safe and adequate treatment in accordance with the Guidelines for Good Clinical Practice (conducted procedures must be related to the disease symptoms and must be justified with the current clinical manifestation);

- First entry into insurance – in relation to the continuous coverage, the date when the person has acquired the capacity of an insured person for the first time according to these Special Conditions;

- Continuous coverage – repeated conclusion of the insurance contract for a person who has already been insured under the previous policy by the same or, exceptionally, by the other insurer, without any lapses between the two policies or with the lapse that is not longer than 3 (three) months;

- Pre-existing medical condition – means any medical condition which is a consequence of any chronic or recurrent disease or injury occurred prior to the first entry into insurance and which after the inception of insurance cover requires continuous or occasional medical care and treatment, including medication therapy and inpatient treatment. Pre-existing medical condition may be established based on the medical documents obtained from the insured person or a healthcare service provider, when using medically justified treatments covered by insurance or when performing an additional medical examination upon a request of the insurer;

- Copayment – participation of the insured in the payment of the agreed rate of healthcare service stipulated by these Special Conditions, unless agreed otherwise;

Accident - any sudden event, independent of the Insured's will, which, due to an external and sudden impact on the insured person's body, results in his or her death, total or partial disability, temporary incapacity for work or health impairment requiring medical assistance.

II GENERAL PROVISIONS

Acquiring Capacity of an Insured Person

Article 2

(1) In accordance with these Special Conditions, the capacity of an insured person shall have a person who is employed or a person who is, on other grounds, a member of the group, or a person who uses the services of the policyholder and is indicated in the insurance policy or in the list enclosed to the policy and for whom the agreed insurance premium has been paid.

(2) In accordance with these Special Conditions, the capacity of an insured person may be acquired by a person who has the capacity of an insured person under mandatory health insurance, and by a person who is not covered by the mandatory health insurance.

(3) If specially agreed, the insured person may also be a family member or a spouse or a common law partner of the insured as well as a biological and adopted child of the insured up to 26 years of age, provided that they have been reported to the insurer.

(4) All members of the group and their family members indicated in the same insurance contract must be insured under equal conditions, except when it comes to the insurance of a specific group of personnel members who are related by particular characteristics and insured together with the rest of the personnel members by the issue of a special policy for such group, under the special conditions.

(5) For family members of the insureds, special policies may be issued, in which case the policyholder is a natural person, that is, the insured who includes his or her family members into insurance.

(6) The insurer reserves the right to request additional documents evidencing the capacity of the insured and of the family members.

Conclusion of Insurance Contract

Article 3

(1) The Policyholder undertakes, under the Insurance Contract, to pay the insurance premium to the insurer, and the insurer undertakes to compensate reasonable and customary expenses for a medically justified treatment, incurred on the territory which falls under the agreed scope of cover, not exceeding the amount of the sums insured and individual sublimits stipulated in the Insurance Contract. All amounts which exceed the reasonable and customary expenses shall be borne by the insured person.

(2) According to these Special Conditions, minimum of 10 (ten) group members may be insured by one policyholder, provided that the group members appropriately participate in the total number of members.

Insurance Cover and Insured Event

Article 4

(1) In accordance with the insurance cover defined in the Special Conditions, the insured event shall be a future event, which is uncertain and independent from the will of the insured, when due to the illness or injury, a healthcare institution, private practice, or other healthcare service provider has provided the insured with medically justified healthcare service which is the subject matter of the Insurance Contract, and which requires the settlement of expenses, as well as of the expenses of preventive healthcare services, provided that such expenses have been agreed.

(2) Disease or injury must be diagnosed by the authorised doctor of appropriate speciality.

(3) The insurance cover may be agreed as standard insurance cover, whereas selected supplementary covers may be specially agreed, provided that the additional insurance premium has been paid.

(4) Standard cover shall be compulsory, and it shall include:
- Outpatient treatment,
- Inpatient treatment.

Exceptionally, with the consent of the insurer, it may be agreed that a part of the standard cover contains either outpatient or inpatient treatment, only. If both standard covers have been agreed (outpatient and inpatient treatment), then the agreed sum insured for both covers shall be a single sum.

(5) Individual sublimits for the agreed level of individual sub-covers within the standard cover shall be contained in the agreed sum insured and shall not increase the maximum liability of the insurer defined in the agreed sum insured. The agreed sum insured and individual sublimits indicated in the Insurance Contract for the standard cover shall represent the upper limit of the insurer's liability per insured person, for the entire agreed insurance period.

(6) Additional covers may not be agreed independently but only if the standard cover has been agreed, in which case, it shall be possible to effect one or more additional covers.

Additional covers include:
- Healthcare of expectant mothers,
- Costs of prescription drugs,
- Ophthalmological services,
- Dental services,
- Insurance of preventive healthcare (general check-up),
- Services of a physical therapist and speech therapist.

(7) The sums insured for additional covers shall be independent from the sum insured for a standard cover and shall increase the maximum liability of the insurer by the agreed amount. The individual sublimits shall be included in the sums insured agreed for additional covers and shall not increase the maximum liability of the insurer under additional covers. The agreed sum insured and individual sublimits for additional covers indicated in the Insurance Contract shall represent the upper limit of the insurer's liability per insured person for the entire agreed insurance period.

(8) The sums insured for a standard cover and additional covers and sublimits shall be indicated in the insurance proposal/policy in Euros and shall be exhaustive, that is, they shall be reduced by the costs of the provided healthcare services calculated in Euros at the mean exchange rate of the National Bank of Serbia ruling as at the date of the claim settlement.

(9) If the costs incurred upon the occurrence of the insured event are lower than the indicated sums insured/maximum sublimits stipulated in the Insurance Contract, the insured shall not have the right to receive the payment of the difference.

(10) The selected insurance covers and the sums insured shall be mutually agreed by the contracting parties and defined in the insurance policy and appendices thereto.

(11) Upon the request of the policyholder, the insurer may accept to select the scope of healthcare services, specified exclusions of the insurer's liabilities, and the level of limits, in accordance with the business act of the insurer.

Liabilities of the Insurer

Article 5

(1) The insurer shall indemnify medically justified, reasonable and customary treatment expenses incurred on the grounds of one or more medical treatments under the selected covers for insurance of healthcare services defined in the insurance policy and appendices thereto, within the offered:

1) Standard cover:

1. Outpatient treatment

- Examinations of the authorised doctor (general practitioner or a specialist doctor);
- Home visits of the authorised doctor in emergency cases;
- Examination of a dietician performed upon the recommendation of the authorised doctor of appropriate specialty, which is limited solely to the following diseases diagnosed for the first time after the first entry into insurance: diabetes mellitus, metabolic syndrome, cancer, arthritis;
- Laboratory tests, examinations and analyses (except for genetic testing);
- Diagnostic procedures, tests and analyses, according to the medical indications and recommendation of the authorised specialist doctor;
- Diagnostic procedures, laboratory tests, examinations and analyses necessary for infertility tests;
- Emergency patient transport or medically justified transport which includes the transport by ambulance due to illness or life-threatening injuries of the insured to the healthcare service provider, and non-emergency transport by ambulance which is, however, justified and medically necessary;
- Day hospital and ambulatory surgical interventions involving surgical intervention and ambulatory therapies at the healthcare service provider's where the insured person stays shorter than 24 hours, in accordance with the insurance policy;
- Materials and therapy administration service – injection, infusion and occupational therapy including the drug expense, as follows: therapy with drugs registered in accordance with the National Drug Register, injection therapy, inhalation and infusion therapy (in which case the inhalation or infusion solution is also covered), early rehabilitation and occupational therapy for enabling a person for independent living and work;
- Emergency dental aid due to accident, for the restoration or replacement of healthy teeth damaged in an accident;
- Chemotherapy and radiation therapy (for the diseases occurring for the first time during the insurance period). If standard insurance cover has been agreed for outpatient and inpatient treatment, the sublimit for chemo therapy and radiation therapy services shall be unique for inpatient and outpatient treatment (sublimits for outpatient and inpatient treatment shall not be summed up);
- Domiciliary care provided by medical staff immediately after inpatient treatment, according to the recommendation of the authorised doctor, provided that the treatment conducted by the authorised doctor is underway and that the insured person is temporarily or permanently unable to move (bedridden);
- Services of a psychiatrist or psychologist, that is, any healthcare services relating to mental health and issues, including psychotherapy, provided that they are medically necessary. These services shall include the compensation for the consultations of psychiatrists, psychologists or, as necessary, the doctors of other specialties relating to the issues of mental health;
- Homeopathy and acupuncture if provided by medical staff and if they represent a treatment for a disease covered in accordance with these Conditions and the Insurance Contract;
- Medical and technical aids within outpatient treatment, only if prescribed by the authorised doctor, as follows: prostheses (including visual), orthoses, walking aids (crutches, assistive canes, walkers), corsets, sanitary assistive devices, therapeutic contact lenses in the event of injuries to the cornea, tiphlotechnical aids, hearing aids, and voice amplifiers and speech aids;
- Treatments in the emergency room.

2. Inpatient treatment

- Hospital accommodation, medical care and nutrition recommended by the authorised doctor during the inpatient treatment in healthcare institutions of secondary and tertiary level;
- Compensation for the costs of examination performed by the authorised doctor and staff;
- Diagnostic procedures;
- Laboratory examinations, tests and analyses (except for genetic testing);
- Emergency dental aid due to accident for restoration or replacement of healthy teeth damaged in an accident;
- Therapy (with registered drugs, injection therapy, infusion);
- Therapies (physical therapy, early and prolonged rehabilitation therapy, speech therapy);
- Spa therapy (extended rehabilitation therapy) carried out according to the recommendation of the authorised doctor of appropriate speciality, which is limited solely to the diseases and conditions first diagnosed after the first entry into insurance;
- Chemotherapy and radiation therapy (for the diseases occurred for the first time during the insurance period). If standard insurance cover for outpatient and inpatient treatment has been agreed, there shall be a single sublimit for inpatient and outpatient services of chemo therapy and radiation therapy (sublimits for inpatient and outpatient treatment shall not be summed up);
- Surgical interventions (local anaesthesia, general endotracheal anaesthesia, laparoscopic interventions) which include all costs of surgical intervention and costs of preoperative preparation, from the admission to hospital treatment, performance of surgical intervention, intensive care and subsequent treatment (postoperative care) to the discharge from hospital. Surgical interventions also involve emergency interventions performed by a maxillofacial/oral surgeon for the purpose of healing the consequences of an accident;
- Medications and medical supplies;
- Medical and technical aids;
- Treatments in emergency room;
- Emergency patient transport or medically justified transport to the healthcare service provider, which includes the transport by ambulance due to illness or life-threatening injuries of the insured, and non-emergency transport by ambulance which is, however, justified and medically necessary;
- Implants in surgery with clear medical indications prescribed by the authorised doctor.

2) Additional cover:

1. Healthcare of expectant mothers

- Examinations, swabs, laboratory analyses (FBC, basic biochemical tests, urine analyses) following the recommendation of the authorised doctor (gynaecologist) who is monitoring the pregnancy;

- Prenatal vitamins prescribed by an authorised gynaecologist;
- Additional ultrasound for high-risk pregnancy;
- Regular foetal ultrasound examinations;
- Expert foetal ultrasound;
- Prenatal diagnostic testing
  - biochemical screening, that is, non-invasive prenatal diagnosis from the blood of the mother for chromosome aberrations and foetal DNA analysis, according to medical indication,
  - invasive diagnostic testing (amniocentesis, chorionic villus biopsy, cordocentesis);
- Childbirth which includes the costs incurred for the doctor, medical technicians, anaesthesiologists, birthing room, medication, additional diagnostic testing, etc. Expenses for caesarean delivery are covered only if caesarean delivery is medically indicated;
- Accommodation in a suite;
- Epidural anaesthesia prescribed by the doctor;
- Father's presence at childbirth;
- Treatment costs of a newborn during the first month of his/her life – per one child;
- Domiciliary care in the first month of an infant's life, per child, provided by medical staff (midwives), maximum up to the first month of a newborn's life;
- Routine check-up in the first 24 months of a child's life (examination by a paediatrician) without vaccines, per one child, until the expiry of the effective insurance policy.

2. Prescription drugs

The coverage of expenses for prescription drugs shall include the costs incurred for the drugs included in the National Drug Register effective in the Republic of Serbia or in the agreed territory of coverage and shall be issued based on the prescription of an authorised doctor, with medical indication. The cover shall include the costs of prescription drugs prescribed within the therapy administered in outpatient and inpatient treatment.

The insurance shall also cover the drugs registered in the Republic of Serbia or in the agreed territory of coverage, which may be issued over-the-counter and which are prescribed by the authorised doctor for the treatment of the insured, only if indicated in the medical documents and if medically justified and necessary according to the opinion of the insurer.

The insurer shall cover the costs of prescription drugs only if prescribed in therapy doses for a maximum of subsequent 60 days.

3. Physical therapist and speech therapist (outpatient treatment)

Physical therapy (in outpatient treatment) shall include: kinesitherapy, electrotherapy, laser therapy, magnetotherapy, sonotherapy and thermotherapy. Therapeutic treatments in the area of physical medicine may be provided only by qualified therapists.

Physical therapy shall be limited solely to the following diseases and injuries diagnosed for the first time after the first entry into insurance: fractures, dislocations and partial joint dislocations, strains and ruptures of tendons and ligaments, spinal cord injuries, conditions after joint replacement surgery, Carpal tunnel syndrome, stroke, Parkinson's disease, muscular dystrophy, osteoarthritis.

According to the recommendation of the authorised doctor who previously treated the insured person, physical therapy may be administered at home only if the insured person is bedridden, provided that the prior approval of the insurer has been obtained, and in the event that lower limbs of the insured person are fractured or if he or she has spinal injury or cardiovascular insult (heart attack).

Speech therapist (in outpatient treatment) shall include the service provided by a speech pathologist in the event of speech disorder.

4. Ophthalmological services

The cover of ophthalmological services during one insurance year provides for:
- Examination by an ophthalmologist for dioptre determination,
- Provision of eyeglass frames,
- Provision of eyeglasses/lenses.

The provision of eyeglasses/lenses shall not be recognised for the dioptres in the range ±0.99.

5. Dental services

The cover of dental services may include the following:
- **Preventive treatment** – includes routine examinations and dental instructions once a year,
- **Standard restorative treatment** – includes amalgam and composite fillings, compomer restorations,
- **Major restorative treatment** – includes root canal filling, dental crowns and fillings, dental bridges (including laboratory and anaesthesia costs),
- **Periodontal scaling** – allowed once a year. Periodontal pocket reduction maximum up to five (5) teeth,
- **Oral surgical interventions** – dental extractions (routine, complicated and surgical).

The cover shall include the costs of anaesthesia and dental x-ray.

6. Preventive healthcare (general check-up)

Preventive healthcare shall include the set of healthcare services (general check-up) of the agreed scope and content, which are provided preventively at the premises of the healthcare service provider with which the insurer has agreed the provision of such service, for the purpose of checking the health of the insured person. The expenses of a general check-up shall be covered for one general check-up during the insurance year.

Main general check-up, depending on the selected and agreed scope of healthcare services, may include:

1. For persons older than 18:
- Laboratory analyses: Qualitative urinalysis with sediment, complete blood picture (Er, Le, Hb, Hct, Le formula), Se, blood glucose, AST, ALT, urea, creatinine, triglycerides, cholesterol (total cholesterol, HDL cholesterol, LDL cholesterol);
- Clinical examination by an internal medicine doctor or a cardiologist with ECG (heart US as medically indicated by the authorised doctor), ultrasound examination of upper abdomen;
- Targeted ophthalmological examination of eyes and eyesight according to the Rules on preventive measures for a safe work when using display screen equipment;
- Spirometry - pulmonary function test;
- Examination by urologist and prostate ultrasound - also PSA for men older than 40;

- Gynaecological examination with colposcopy, gynaecological US, Papanicolaou, vaginal swab and breast US - for women;
- Final examination and closing.

2. For persons older than one year of age up to 18 years of age:
- Laboratory analyses: Qualitative urinalysis with sediment, complete blood picture (Er, Le, Hb, Hct, Le formula), Se;
- Nose and throat swab;
- Anthropometric measurements – body height, weight, body mass index, waist circumference and body composition;
- Examination by an ophthalmologist, otorinolaringologist or specialist orthopaedic surgeon;
- Clinical examination by a paediatrician.

3. For children up to one year of age:
- Laboratory analyses: Qualitative urinalysis with sediment, complete blood picture (Er, Le, Hb, Hct, Le formula), Se;
- Anthropometric measurements – body height, weight, body mass index, waist circumference and body composition;
- Hip ultrasound;
- Clinical examination by a paediatrician.

The policyholder may select a different scope of healthcare services of general check-up, in which case the policyholder and the insurer shall jointly agree on the schedule for implementation of preventive healthcare.

(2) During the agreed insurance period and according to the agreed level of coverage under Special conditions, the Insurer shall enable the insured to use healthcare services rendered by the healthcare service provider chosen from the network of healthcare institutions with which the insurer has concluded a business cooperation agreement.

(3) Upon the payment of the appropriate insurance premium, the policyholder shall select the desired standard of a healthcare service:
- whether the examination will be performed by an authorised doctor or by a professor holding a Doctorate of Medicine,
- whether the examination may also be performed by a healthcare service provider not included in the insurer's Network of healthcare service providers,
- service level of the network of clinics – Classic, Super, VIP, according to the List of healthcare service providers of the insurer.

(4) The insurer shall be obliged to update and make available on its website the list of all healthcare service providers included in the insurer's Network of the healthcare service providers.

(5) Following the call of the insured, the insurer's Call Centre shall verify the scope and amount of coverage and shall schedule an appointment for a specific healthcare service.

(6) The Insurer shall reimburse to the Insured medically justified, reasonable and customary costs of provided healthcare services, according to contracted amount of cover, pursuant to the Special Conditions, after he has received the request for reimbursement, provided that the Insured:
- has used and paid healthcare services provided by a healthcare service provider with which the insurer has not concluded a business cooperation agreement, or
- has paid, for any reason, the service to the healthcare service provider with which the insurer has concluded a business cooperation agreement.

(7) When using a particular healthcare service stipulated in the Additional Covers, the insured shall make a compulsory copayment as follows:
- services of an ophthalmologist, 20% of the agreed service price,
- services of a dentist, 20% of the agreed service price,
- services of a physical therapist and speech therapist, 20% of the agreed service price.

The stipulated copayment may be excluded (copayment buyout) if specially agreed, and provided that the additional premium has been paid.

In a standard cover, the policyholder may agree the copayment for the use of services of a healthcare service provider, with the reduction of insurance premium.

Depending on the agreed service level for the network of clinics – Classic, Super, VIP, the appropriate copayment shall be applied, which shall be summed up with the amounts of other envisaged copayments, unless such copayments have been bought out.

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

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

Territorial Scope

Article 6

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

(2) Exceptionally from paragraph 1 of the Article hereof, the insurer may extend insurance cover to include the territory of other countries solely for the group members who live and work abroad, in which case the policyholder shall be obliged to pay an additional insurance premium depending on the agreed territorial scope of insurance, whereas the insurer shall reserve the right to correct the scope of insurance cover.

Insurance Period

Article 7

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

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

(3) By way of exception from provisions of paragraph 2 of the Article hereof:
- for persons included in insurance during the term of Insurance Contract, the insurance shall begin upon the lapse of 24:00 hours on the date when the insurer has received a written application from the policyholder, or thereafter, if it is explicitly stated in the application. Insurance of such persons shall terminate at 24:00 hours on the date indicated in the policy as the date of insurance expiry;
- for insureds excluded from insurance during the term of the Insurance Contract, the insurance shall terminate at 24:00 hours on the date when the insurer has received a written cancellation

by the policyholder, or thereafter if so indicated in the notice of cancellation. Upon the termination of insurance for the insured, the insurance of his or her family members shall also terminate if they are covered by a single policy.

(4) In the event of changes during the insurance period (inclusion/exclusion of insured persons) the insurer shall be entitled to the premium only for the used/related insurance period, except in cases of short-term insurances (with the duration shorter than one year), where in the event that a new group member is included, full premium is calculated for the agreed insurance period.

(5) In the event that the insurance terminates prior to the agreed expiry thereof, the policyholder or the insured shall be obliged to deliver/return to the insurer the Document evidencing insurance.

(6) For the agreed cover extension by taking out additional coverage – healthcare of expectant mothers – the waiting period shall be 4 (four months), that is, if pregnancy occurs before or during the waiting period, the insurer shall not be obliged to cover healthcare expenses for expectant mothers and childbirth, except within the coverage of treatment expenses of 24-months-old babies. Provisions of the paragraph hereof shall also apply to persons declared as insured during the term of the Insurance Contract. The liability of the insurer shall start running from the twenty fourth hour of the waiting period expiry date.

(7) The policyholder may specially agree the exclusion of the provision on the waiting period, provided that a special consent of the insurer has been obtained and that the increased insurance premium has been paid.

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

Premium Payment

Article 8

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

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

1) Exclusion of Insurer's Liability

Article 9

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

For additional covers, the insurer shall reimburse the costs incurred for pre-existing conditions, save for the services of a physical therapist. The costs for prescription drugs shall be covered for pre-existing conditions, provided that such pre-existing condition is the subject matter of the insurance cover.

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

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

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

16) in experimental medical research or healthcare services which are not scientifically or medically recognized, such as sleep studies and obstructive sleep apnea treatments,
17) costs of birth control (contraception), infertility treatment, artificial insemination and treatment of sexual dysfunction, as follows:

- all contraceptive methods for women and men and consequences thereof (mechanical, hormonal and surgical contraception, that is, sterilization by vasectomy or tubal ligation),
- pregnancy termination at the personal request of the insured person and consequences thereof, except in medically justified cases such as the disease which threatens the life of the mother, pregnancy caused by rape or incest, structural and chromosomal abnormalities of foetus, disease of the mother during the first pregnancy trimester which damages the foetus (rubella), treating the mother with medications that damage the foetus (tetracyclines, cytostatics), spontaneous abortion,
- all infertility treatment methods,
- sterilisation reversals (tubal litigation reversal, vasectomy reversal),
- preparation for artificial insemination and medications, as well as any artificial insemination procedure,
- treatment of sexual dysfunction,
- treatment with Viagra or a generic alternative,
- sex reassignment, including psychotherapy and hormonal therapy, sex and breast reconstruction surgery,

18) prenatal classes and preparation for childbirth,
19) dental services (within the additional cover) of cosmetic dentistry procedure, teeth whitening, teeth jewellery placement (zirconium) and fixed braces,
20) costs of compulsory preventive vaccination, immunoprophylaxis and chemoprophylaxis that are compulsory according to the programme of compulsory and recommended immunization of population against certain contagious diseases in the Republic of Serbia, except for the costs of post-exposure active and passive immunisation against: rabies, tetanus in injured persons, hepatitis B in newborns, HBeAg-positive carrier mothers, persons who had an accident with infectious materials, and pregnant women with liver damage if they have been exposed to infection,
21) relaxation massages in physical outpatient and inpatient therapy, therapy with acoustic waves (Shockwave), High Intensity Laser (HIL), T-care therapy, endermologie (LPG), ozone and plasma therapy,
22) weight loss treatments or programme of weight reduction by gastric balloon surgery,
23) PRP- platelet-rich plasma therapy,
24) costs of cryopreservation and implantation and re-implantation of living cells,
25) rejuvenation treatment, regardless of whether prescribed by an authorised doctor or not,
26) Autonomic Nervous System Testing, syncope,
27) costs in connection with the treatment of astigmatism and strabismus, myopia, hypermetropia and presbyopia, including surgical procedure of radical certotomy,
28) surgical procedures of organ and tissue transplantation, regardless of whether the insured is a recipient or a donor,
29) temporomandibular joint disorders, examinations and treatments of occlusal disturbances,
30) mole removal at one's own discretion,
31) circumcision (foreskin removal) if not medically indicated,
32) treatment of fungal nail infections of hands and feet, as well as examinations and treatment of ingrown toenails and cuticles,
33) costs in connection with the concrete feet injuries such as: callus, foot corns, hyperkeratoses and bunions,
34) illnesses or injuries occurred during professional and amateur pursuit of sports and professional and amateur sports competitions,
35) illnesses or injuries occurred as a result of involvement in a fight (except in cases of self-defence),
36) all medical services which are not prescribed and/or performed by the authorised doctor,
37) performed treatments, that is, healthcare services, medications, medical supplies, medical and technical aids and implants not indicated by the doctor of an appropriate speciality,
38) use of emergency service of a healthcare service provider in cases which do not represent a medical emergency,
39) in the event when the insured has refused to follow the instructions obtained from a medical team,
40) procurement of medications not prescribed by the authorised doctor,
41) if the insured refuses to relieve the doctor and the medical team, that have diagnosed his/her disease, from patient confidentiality obligation and thus makes impossible for the insurer to obtain necessary information,
42) reimbursement of medical expenses which are reimbursable under any other agreement or right,
43) in the event of Document misuse, in which case the costs incurred following the insured event shall be borne by the insured,
44) other costs, involving expenses:

- exceeding reasonable and customary expenses within the meaning of these Special Conditions,
- for the purchase of personal care products and all cosmetic preparations,
- for taking and preserving stem cells and all other related expenses,
- for herbal medications, traditional medications and traditional herbal medications, as well as biologic medications, except for the expenses of post-exposure active and passive immunisation against: rabies, tetanus in injured persons, hepatitis B in newborns, HBeAg-positive carrier mothers, persons who had an accident with infectious materials, and pregnant women with liver damage if they have been exposed to infection, advanced therapy medicines, extemporaneous drug formulations and stock preparations used for treatment of cold, medications in experimental and research phase, therapy waters and mineral waters, medicinal wines, nutritives and immunizers, invigorants and the like, if prescribed by an authorised doctor,
- for all medical devices, except for medical and technical aids if agreed in accordance with these Conditions, compression stockings for varicose veins, maternity belly bands if the healthcare coverage of expectant mothers has been agreed,
- for mucous membrane hygiene agents, topical antiseptics, preparations for problematic skin treatment, dietary and vitamin supplements except for prenatal vitamins if the healthcare coverage of expectant mothers has been agreed,
- for original prescription drug (under patent protection) when there is a generic alternative, except when the doctor has indicated that the specified drug is necessary,
- expenses incurred because the hospital has actually become or could be perceived as home or permanent residence of the insured person,
- all expenses that are not medically related,
- adjustment of a vehicle, bathroom or accommodation facility to personal needs,
- all medical and technical aids issued without medical indication or recommendation of the attending physician,
- following devices: motor wheelchair and hospital bed, hospital bed with trapeze, additional wheels, room crane,

anti-decubitus mattresses, items for increasing comfort (such as telephone holders and over the bed trays), items used to change the quality of air or temperature (such as air conditioners, humidifiers, seasoners and air purifiers), insulin pumps, exercise bikes, sunlamps or heat lamps, heating pads, bidets, toilet seats, bath seats, saunas, elevators, diakuzzis, training equipment and similar products,

- for sunglass frames and glasses and/or related accessories,
- for consumer goods,
- for transport, except for emergency patient transport or medically justified transport,
- examination by a general practitioner or a specialist doctor for the purpose of issuing the certificate for the kindergarten, recreational classes, driving licence, travelling abroad, visa, and other administrative purposes,
- preventive examinations, screening tests and diagnostic procedures indicated by age, positive family history or upon personal request of the insured, regardless of medical indication,

45) for any other expenses not referred to in Article 5 of the Special Conditions.

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

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

Obligations of the Insured

Article 10

(1) The insured or the policyholder shall:

- report to the insurer any circumstances which are known or could not have stayed unknown to him and which are relevant for the risk assessment,
- during the term of the Insurance Contract, report to the insurer any relevant circumstances affecting the information provided upon the conclusion of the Insurance Contract,
- pay the agreed insurance premium.

(2) Upon the occurrence of the insured event, the insured shall be obliged to:

- call the Medical Contact Centre of the insurer and provide necessary identification details (number of insurance document or first and last name, date of birth, name of the policyholder and the sum per policy, as well as the type of illness or injury) in order to exercise the rights arising from the concluded Insurance Contract, and accept the treatment at the healthcare service provider's included in the network of healthcare service providers of the insruer, unless the treatment is agreed outside the Network,
- enable to the authorised person the perusal of policy or the Insurance Document at the healthcare service provider's premises,
- independently pay the costs of healthcare services incurred at the healthcare service provider with which the insurer has concluded the Business Cooperation Agreement,
- if he has paid the costs of healthcare services independently, within one month from the date of treatment completion, file the request for the reimbursement of costs, provide to the insurer any necessary information and documents evidencing the occurred insurance event, for the purpose of establishing the existence and scope of liability. Otherwise, the insurer shall not be obliged to bear the increased costs,
- in connection with the insured event, authorise doctors and healthcare service providers that, at the request of the insurer, they may provide all necessary information in connection with his treatment,
- in connection with the insured event, authorise doctors and healthcare service providers where he seeks his treatment that, at the request of the insurer, they may provide all necessary information in connection with his pre-existing medical condition,
- as necessary, undergo the examination by a doctor assigned by the insurer, in order to establish the circumstances relevant for the grounds and amount of liability arising under the Insurance Contract,
- at the invitation of the healthcare service provider or insurer, pay the amount exceeding the amount of the agreed sum insured.

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

Settlement of Liability

Article 11

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

(2) In the event of reimbursement for the purpose of exercising the right to compensation, the insured shall deliver to the insurer the request for the compensation of treatment costs, complete original medical documents with the doctor's report containing the diagnosis of illness or injury, and original bills which evidence the relevant facts in connection with the occurrence of the insured event, as well as the contact telephone. All bills must contain the date of issue.

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

(4) If copayment has been agreed, the insured shall pay such portion to the healthcare service provider and in the event of reimbursement, the insurer shall reduce the compensation by the amount of the agreed copayment.

(5) The insurer shall not be liable for the expenses incurred during the use of a healthcare service of treating the illnesses or injuries excluded as a pre-existing medical condition, or for the illnesses and injuries of pre-existing medical condition that have not been previously agreed and for which there is an option of special contracting and inclusion in insurance in accordance with

these Special Conditions, and for the amount of the expenses so incurred he shall have the right of recourse against the insured.

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

III FINAL PROVISIONS

Article 12

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

Article 13

(1) Anything not regulated by these conditions shall be subject to the provisions of the General Conditions, unless contrary to these Special Conditions.

Article 14

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

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

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

Article 15

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

Article 16

(1) These Special Conditions shall be published on the official website of the insurer. The Special Conditions shall come into force on the date of their adoption.

THIS ISSUE OF TERMS AND CONDITIONS SHALL APPLY AS OF 26.12.2018.