SPECIAL TERMS AND CONDITIONS FOR GROUP VOLUNTARY HEALTH INSURANCE

I 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 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 institution, which does not require stationary treatment;

- Inpatient treatment – medically justified healthcare service rendered by the healthcare service providers during the treatment in an outpatient clinic or in the course of stationary hospitalization (where the Insured occupies hospital bed for the purpose of treatment).
The hospital treatment in an outpatient clinic shall be carried out in a special unit of a healthcare institution designated for surgical interventions, therapeutic procedures and observations that do not require stationary treatment.
Inpatient treatment shall be considered the accommodation of the Insured in the institutions of inpatient type such as: institutions for addiction treatment, psychiatric hospitals, spas, and hydro-clinics (except in the case of extended rehabilitation therapy), sanatoriums, nursing homes, retirement homes or homes for the aged, treatment centers, resorts offering therapeutic baths, rest, weight loss and recovery;

- Domiciliary care - home care provided immediately after inpatient treatment by qualified medical staff, based on a written report and instructions of the authorized 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 the coverage of pregnancy and childbirth (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 authorized 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;
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 –the date when the person has acquired the capacity of an insured person: under these Special Terms and Conditions, for continuous coverage, or under another Insurance Terms and Conditions of the same kind concluded with the same or, exceptionally, with another insurer;

- 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;

- The share paid by the insured in covering the costs of a healthcare service (co-payment) refers to the portion of the cost of a specific healthcare service that is borne by the insured and is his obligation to pay personally, based on the concluded insurance contract;

- 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 must be insured under equal conditions provided for in the insurance cover, 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) The insurer reserves the right to request additional documents for family members of the insured, 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 these 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 or medical condition, 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 or medical condition must be diagnosed by the authorized doctor of appropriate specialty. Diagnostic procedures, laboratory tests, examinations, and analyses are performed only based on the medical indication of an authorized doctor of the appropriate specialty.

(3) The insurance cover may be agreed as standard insurance cover, whereas selected additional 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:
- Costs of pregnancy and childbirth,
- Prescription drugs,
- Ophthalmological services,
- Dental services,
- Preventive healthcare (general check-up),
- Medical rehabilitation in outpatient treatment.

(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 authorized doctor (general practitioner or a specialist doctor);
- Home visits of the authorized doctor in emergency cases;
- Examination of a dietician performed upon the recommendation of the authorized 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;
- 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;
- Outpatient interventions, including:
  - Outpatient surgical interventions on the skin and subcutaneous tissue during local anesthesia and other ambulatory therapies:
    - removal of benign and malignant lesions (melanocytic nevus, lipoma, fibroma, hemangioma, basal cell carcinoma, squamous cell carcinoma, malignant melanoma, seborrheic keratosis, viral warts);
    - incision and drainage of inflammatory lesions (abscess, furuncle, carbuncle, subcutaneous cysts);
    - immobilization after injury or accident;
    - plaster cast immobilization;
    - extraction of a foreign body, parasite or tick;
    - surgical treatment of minor wounds (washing, edge treatment and suturing);
    - treatment of wounds and burns;
    - dressing, removing stitches;
    - joint puncture.
  - indications for removal of benign and malignant lesions and for incision and drainage of inflammatory lesions of the skin and subcutaneous tissue shall be made by a dermatologist.
  - removal of melanocytic nevus, lipoma, fibroma, subcutaneous cysts and viral warts is limited to the medically justified cases when in addition to the request for prior approval of the treatment, it is necessary to submit to the Insurer medical documents evidencing medical justification;
    - Prescription drugs (injection, inhalation, infusion) - medication therapy with registered drugs in the course of outpatient treatment which includes ambulatory drug application at a healthcare service provider's premises by injection, infusion or inhalation and with coverage of drug expense, therapy administration, medical supplies, medical consumables and infusion, i.e., inhalation solution. Coverage includes the use of drugs registered for use in human medicine according to the effective National Drug Register of the Republic of Serbia.
    - 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 authorized doctor, provided that the treatment conducted by the authorized 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;
- Methods of complementary medicine (homeopathy, quantum medicine and acupuncture), if provided by medical staff licensed by the Serbian Ministry of Health for practicing the methods of complementary medicine and hired, according to the law, by the healthcare service providers approved to expand their activities to a particular method of complementary medicine and if applied for treatment of health conditions covered in accordance with these Conditions and the Insurance Contract;
- Medical and technical aids within outpatient treatment, only if prescribed by the authorized doctor, as follows: prostheses (including prostheses for upper and lower limbs, as well as ocular prostheses), orthoses, walking aids (crutches, assistive canes, walkers), orthopedic shoes, and orthopedic insoles once a year, corsets, sanitary assistive devices, therapeutic contact lenses in the event of injuries to the cornea, typhlo-technical aids, hearing aids, and voice amplifiers and speech aids, compression stockings for veins, maternity belt if coverage for pregnancy and childbirth expenses is contracted;

- Treatment in the emergency room includes the costs of treatment of a serious injury or illness of the insured, which in the absence of emergency medical intervention may lead to permanent health impairment or death. Emergency medical intervention includes emergency medical assistance provided to the Insured in the first 12 hours of his/her admission to the emergency room.

2. Inpatient treatment

- Hospital accommodation, medical care and nutrition by the indication of the authorized doctor during the inpatient treatment in healthcare institutions of secondary and tertiary level;
- Examinations and services performed by the authorized 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;
- Prescription drugs - medication therapy with registered drugs in the course of inpatient treatment which includes all methods of drug application at a healthcare service provider's premises with coverage of drug expense, medical supplies, medical consumables and infusion or inhalation solution. Coverage includes the use of drugs registered for use in human medicine according to the effective National Drug Register of the Republic of Serbia;
- Medical rehabilitation which includes the application of physical therapy, work therapy, occupational therapy, speech therapy and special education therapy carried out in the course of inpatient treatment by the authorized therapists;
- Spa therapy (extended rehabilitation therapy) carried out according to the indication of the authorized doctor of appropriate specialty as a form of extended rehabilitation conducted after the treatment started in hospital or institutions of secondary and tertiary level, 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 which include the costs incurred in the course of day hospital treatment i.e., from the admission to hospital treatment to the discharge from hospital, such as the costs of preoperative preparation, the costs of performance of surgical intervention, intensive care and subsequent treatment and postoperative care.

Surgical interventions include traditional open surgery, microsurgery, minimally invasive surgical therapeutic techniques (laparoscopy, endoscopy, thoracoscopy, hysteroscopy, arthroscopy, angioplasty, etc.), laser surgery, vascular surgery, surgery of the vascular structures of the anal area, etc.;
The cover includes emergency interventions by a maxillofacial/oral surgeon to alleviate the consequences of an accident;
- Medical and technical aids;
- Treatment in emergency room - includes the costs of treatment of a serious injury or illness of the insured, which in the absence of emergency medical intervention may lead to permanent health impairment or death. Emergency medical intervention includes emergency medical assistance provided to the Insured in the first 12 hours of his admission to the emergency department;
- 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 authorized doctor.

2) Additional cover:

1. Costs of pregnancy and childbirth

- Examinations, including the first follow-up examination after the childbirth within 60 days from the childbirth at the latest, swabs, laboratory analyses following the indication of the authorized doctor (gynecologist) who is monitoring the pregnancy;
- Prenatal vitamins and medication therapy prescribed by an authorized gynecologist;
- Additional ultrasound for high-risk pregnancy;
- Regular fetal ultrasound examinations;
- Expert fetal ultrasound;
- Prenatal diagnostic testing
  - biochemical screening, that is, non-invasive prenatal diagnosis from the blood of the mother for chromosome aberrations and fetal 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, anesthesiologists, delivery room, medications, epidural anesthesia, additional diagnostic testing, etc. Expenses for caesarean delivery are covered only if caesarean delivery is medically indicated;
- Accommodation in a birthing suite;
- Cardiotocography (CTG);
- Presence of a support person 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;
- Pregnancy complications - coverage includes the costs of inpatient treatment of medical conditions that may lead to pregnancy complications, the costs of inpatient treatment of pregnancy complications and childbirth, as well as the costs of outpatient or inpatient treatment in the event of abortion for medical or ethical reasons and complications thereof.

2. Prescription drugs

The coverage of expenses for prescription drugs shall include the costs incurred for the drugs prescribed by the authorized doctor of relevant specialty following medical indication. The insurer shall cover the costs of prescription drugs only if prescribed in therapy doses for a maximum of 60 (sixty) days.

The cover shall include the costs of drugs administered at the premises of the healthcare service provider in the course of outpatient or inpatient treatment.

The Insurer shall accept the costs of drugs registered for use in human medicine according to the effective National Drug Register of the Republic of Serbia, as well as the drugs which are not registered in the Republic of Serbia, and which are imported based on the approval of the Medicines and Medical Devices Agency.

Coverage of expenses for prescription drugs also includes the costs of acquiring medications made at a pharmacy based on a doctor's prescription for a specific patient, as personalized therapy.

3. Medical rehabilitation in outpatient treatment

Physical therapy (in outpatient treatment) shall include the application of physical therapy, work therapy, occupational therapy, speech therapy and special education therapy. Medical rehabilitation shall be carried out by the authorized therapists (physical therapists, work/occupational therapists, speech therapists, special education therapists);

Physical therapy shall include kinesitherapy, electrotherapy, laser therapy, magnetotherapy, sonotherapy, thermotherapy and spinal decompression.

Physical therapy shall be limited to the diseases and injuries diagnosed for the first time after the first entry into insurance: degenerative joint diseases (spondylosis, gonarthrosis, coxarthrosis), spinal disc herniation, inflammatory rheumatism (rheumatoid arthritis, polyarthritis, Bechterew disease), nervous system diseases (Bell's palsy, carpal tunnel syndrome, tarsal tunnel syndrome, Parkinson's disease, multiple sclerosis, conditions after a stroke or brain injury), conditions after injuries (bone fractures, spinal cord injuries, contusion and distortional joint injuries, joint dislocations, strains and ruptures of tendons, ligaments and muscles), conditions after joint surgeries.

According to the recommendation of the authorized 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).

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

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

Special education therapy includes motor dysfunctions and disorders, prevention and treatment of behavioral disorders, visual and hearing dysfunctions and disorders, and sensorimotor developmental dysfunctions and disorders.

4. Ophthalmological services

The cover of ophthalmological services during one insurance year provides for:

- One examination for diopter determination,
- Provision of one eyeglass frame,
- Provision of eyeglasses/lenses.

The provision of eyeglasses/lenses shall be recognized only for the diopters in the range higher than ±0.99. The purchase is also possible if the specified diopter is determined in only one eye.
The purchase of contact lenses is possible in quantities that correspond to medical needs, the type of lenses and insurance period, according to the doctor's assessment.

5. Dental services

The cover of dental services may include the following:

- **Preventive treatment** – includes routine examinations and dental instructions once a year and fissure sealing for individuals under 18 years of age.
- **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 anesthesia costs)
- **Periodontal scaling –** allowed once in the insurance period
- **Periodontal pocket reduction**
- **Oral surgical interventions** – dental extractions (routine, complicated and surgical).

The cover shall include the costs of anesthesia 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 main general check-up shall be covered for one general check-up during the insurance year.
The policyholder can arrange for one additional general check-up during the insurance year, with the selected scope of healthcare services. Additional general check-up can be arranged only if the main general check-up has been contracted.
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 count (Er, Le, Hb, Hct, Le formula), Se, blood glucose, AST, ALT, urea, creatinine, triglycerides, cholesterol (total cholesterol, HDL cholesterol, LDL cholesterol);
- Examination by an internal medicine doctor with ECG,
- Ultrasound examination of upper abdomen;
- Ophthalmological examination of eyes and eyesight;
- Examination by urologist and ultrasound and PSA - for men older than 40;
- Gynecological examination with colposcopy, gynecological 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 count (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 or otorhinolaryngologist or physiatrist (selected at own discretion);
- Examination by a pediatrician.

3. For children up to one year of age:

- Laboratory analyses: Qualitative urinalysis with sediment, complete blood count (Er, Le, Hb, Hct, Le formula), glucose ;
- Anthropometric measurements – body height, weight, body mass index, waist circumference and body composition;
- Hip ultrasound;
- Examination by a pediatrician.

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 (main and additional general check-up). The services of a general check-up are used fully, within the agreed scope. Exceptionally, at the request of the Insured, the Insurer may allow the use of a separate examination/diagnostic procedure within the agreed scope of a general check-up. After the use of even one separate service, the agreed cover of Preventive Healthcare (general check-up) shall be considered fully used up.

(2) During the agreed insurance period and according to the agreed level of coverage under these 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. Healthcare service providers are classified into Network 1 (N1), Network 2 (N2), and Network 3 (N3), based on service standards, cost-efficiency, and other relevant criteria that determine the level of co-payment. The list of institutions within the network and the current classification are subject to change at any time. Within the insurance cover, the Insurer shall provide necessary information of the Insured in connection with the insurance cover and organize the provision of a healthcare service via the Medical Call Centre available throughout the year 00-24h. According to the concluded Insurance Contract, the Insured shall choose the healthcare institution within the network of healthcare service providers of the Insurer or outside such network (provided that the treatment outside the network has been agreed). Healthcare institution shall be responsible for the quality of provided healthcare services.

(3) Upon the payment of the appropriate insurance premium, the policyholder shall select the desired standard of a healthcare service:

- service level of the network of clinics – Classic, Super, VIP, according to the valid list of healthcare service providers of the insurer,
- treatment outside the insurer's network of healthcare service providers is subject to a co-payment corresponding to the rates applicable to Network 2 providers, along with the agreed-upon service level for the clinic network,
- Examination by a professor - healthcare services provided by a professor with a doctorate in medical sciences,

If the service of examination by a professor is not contracted, the Insurer will refund the costs of the provided healthcare services up to the average amount of the examination by a specialist doctor in a given healthcare institution and/or in the contracted network of healthcare institutions if such a healthcare institution does not provide for an examination by a specialist doctor. In the case of an examination by a professor in an institution outside the network of health institutions, the Insurer will reimburse the costs of the provided healthcare services up to the average amount of an examination by a specialist doctor in the N1 network of clinics.

(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. A medical report or a referral issued by a competent doctor of a healthcare institution, on the basis of which additional healthcare services are scheduled, shall not be older than 6 months, unless its validity is otherwise defined in the referral.

(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 these Special Conditions, and the expenses for purchasing medications based on a prescription/medical report no older than 6 months from the date of issue, 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, (with the co-payment specified for Network 2 of healthcare service providers), or
- has paid, for any reason, the service to the healthcare service provider with which the insurer has concluded a business cooperation agreement.

Insurance is concluded with a co-payment for certain healthcare services, as specified in the policy, unless otherwise agreed and an additional insurance premium is paid.

Co-payment shall not apply to preventive healthcare services and the costs of prescription drugs.

Depending on the agreed service level for the network of clinics – Classic, Super, VIP, for the services used outside of network, the appropriate copayment shall be applied, which shall be summed up with the amounts of other envisaged copayments.

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 refund, 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 for supplementary cover for preventive healthcare, which requires payment of the full annual premium. 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. In case of misuse of the Insurance Document, the costs of utilized healthcare services after the insurance termination shall be borne by the insured and/or the policyholder.

(6) For the agreed cover extension by taking out additional coverage for pregnancy and childbirth, – the waiting period shall be 4 (four months). The liability of the insurer shall start running from the twenty fourth hour of the waiting period expiry date.

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

(8) If the pregnancy occurs before the inception of the Insurance Contract or within the waiting period, the Insurer shall not be obliged to cover the expenses for pregnancy and childbirth. The provisions of this paragraph shall also be applied to the persons declared for insurance during the term of insurance contract.

(9) 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.

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); all forms of coronary (ischemic) heart disease; condition after coronary stent implantation; stroke; transient ischemic attack; ventricular tachycardia; ventricular fibrillation); bradycardia with implanted pacemaker; aortocoronary bypass; cardiac insufficiency; heart valve disease; severe elevation of blood pressure requiring inpatient treatment; aplastic anemia; all blood coagulation disorders; congenital heart defects; pemphigus; myasthenia gravis; systemic lupus erythematosus; multiple sclerosis; sclerodermia; motor neuron 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 tumor; 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 medical rehabilitation in outpatient treatment. 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 catastrophes 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, and only for children younger than 18.
16) in experimental medical research or healthcare services which are not scientifically or medically recognized, such as sleep studies and obstructive sleep 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 or miscarriage caused for medical or ethical reasons,
- all infertility treatment methods,
- sterilization 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) for prenatal classes and preparation for childbirth.
19) for dental services (within the additional cover) of cosmetic dentistry procedure, teeth whitening, teeth jewelry placement (zirconium), for fixed braces, mobile braces – orthodontic treatment, full mouth and partial braces for upper and lower jaw, for implants, splints, retention splints and retainers, as well as others not included in this additional cover.
20) for costs of preventive examinations before vaccination and compulsory preventive vaccination, immunoprophylaxis and chemoprophylaxis that are compulsory according to the program 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 immunization against: rabies, tetanus in injured persons, hepatitis B in newborns, HBsAg-positive carrier mothers, persons who had an accident with infectious materials, and pregnant women with liver damage if they have been exposed to infection.
21) for relaxation massages in physical outpatient and inpatient therapy, therapy with acoustic waves (Shockwave), High Intensity Laser (HIL), T-care therapy, endermologie (LPG), INDIBA therapy, ozone and plasma therapy.
22) for weight loss treatments or program of weight reduction by gastric balloon surgery.
23) for PRP- platelet-rich plasma therapy.
24) 3 Tesla MR (3T) magnet scan.
25) for costs of cryopreservation and implantation and re-implantation of living cells.
26) for rejuvenation treatment, regardless of whether prescribed by an authorized doctor or not.
27) for Autonomic Nervous System Testing, syncope.
28) for costs in connection with the treatment of astigmatism and strabismus, myopia, hypermetropia and presbyopia, including surgical procedure of radial certotomy.
29) for surgical procedures of organ and tissue transplantation, regardless of whether the insured is a recipient or a donor.
30) for temporomandibular joint disorders, examinations and treatments of occlusal disturbances.
31) for removal of moles, growths and other dermatological changes at one's own discretion.
32) for circumcision (foreskin removal) if not medically indicated.
33) for treatment of fungal nail infections of hands and feet, as well as examinations and treatment of ingrown toenails and cuticles.
34) for costs in connection with the concrete feet injuries such as: callus, foot corns, hyperkeratosis and bunions.
35) for illnesses or injuries occurred during professional and amateur pursuit of sports and professional and amateur sports competitions.
36) for illnesses or injuries occurred as a result of involvement in a fight (except in cases of self-defense).
37) for all medical services which are not prescribed and/or performed by the authorized doctor.
38) performed treatments, that is, healthcare services, medications, medical supplies, medical and technical aids and implants not indicated by the doctor of an appropriate specialty.
39) for use of emergency service of a healthcare service provider in cases which do not represent a medical emergency.
40) in the event when the insured has refused to follow the instructions obtained from a medical team.
41) for procurement of medications not prescribed by the authorized doctor.
42) 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.
43) for reimbursement of medical expenses which are reimbursable under any other agreement or right.
44) in the event of Document misuse, when the costs incurred following the insured event shall be borne by the insured,
45) other costs:
- exceeding reasonable and customary expenses within the meaning of these Special 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 immunization against: rabies, tetanus in injured persons, hepatitis B in newborns, HBsAg-positive carrier mothers, persons who had an accident with infectious materials, and pregnant women with liver damage if they have been exposed to infection, advanced therapy medicines, extemporaneous drug formulations and stock preparations used for treatment of cold, medications in experimental and research phase, therapy waters and mineral waters, medicinal wines, nutritives and immunizers, invigorants and the like, if prescribed by an authorized doctor,
- for all medical devices, except for medical and technical aids if agreed in accordance with these Conditions,
- for mucous membrane hygiene agents, topical antiseptics, preparations for problematic skin treatment, dietary and vitamin supplements except for prenatal vitamins if the additional coverage of pregnancy and childbirth 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 the indication of the attending physician,

- following devices: additional wheels, room crane, items for increasing comfort (such as telephone holders and over the bed trays), items used to change the quality of air or temperature (such as air conditioners, humidifiers, seasoners and air purifiers), insulin pumps, exercise bikes, sunlamps or heat lamps, heating pads, bidets, saunas, elevators, Jacuzzi, training equipment and similar products,
- for frames and glasses for sunglass and/or related accessories,
- for consumer goods,
- for transport, except for emergency patient transport or medically justified transport,
- examination by a general practitioner or a specialist doctor for the purpose of issuing the certificate for the kindergarten, recreational classes, driving license, travelling abroad, visa, and other administrative purposes,
- preventive examinations, screening tests and diagnostic procedures and medical interventions indicated by age, positive family history or upon personal request of the insured, regardless of medical indication,

46) for any other expenses not referred to in Article 5 of these 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 Call Centre of the insurer and provide necessary identification details (number of insurance document or first and last name, date of birth, name of the policyholder and the sum per policy, as well as the type of illness or injury) in order to exercise the rights arising from the concluded Insurance Contract, and accept the treatment at the healthcare service provider's included in the network of healthcare service providers of the insurer, unless the treatment is agreed outside the Network,
- enable to the authorized 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 and 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, authorize 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, authorize 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 these 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 medical documents with the doctor's report containing the diagnosis of illness or injury or description of a medical condition, and receipts for medical services, drugs and other services performed according to the agreed insurance cover (original bills must be submitted when the Insurer finds that necessary), which evidence the relevant facts in connection with the occurrence of the insured event, as well as the contact telephone. The delivered medical documents and all receipts must contain the date of issue.

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

(4) If 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 stated on the bill by the agreed co-payment percentage. If the amount so obtained is lower than the limit /sublimit, the limit shall be exhausted for the said amount i.e., the compensation shall be granted in the refund process. If the obtained amount is higher than the agreed limit/sublimit, the compensation shall be equal to the limit/sublimit amount i.e., to the remaining unexhausted limit/sublimit amount if such limit has already been the subject of exhaustion.

(5) The insurer shall not be liable for the expenses incurred during the use of a healthcare service of treating the illnesses, injuries or medical condition excluded as a pre-existing medical condition, or for the illnesses, injuries or medical condition 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 authorized 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 authorized 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) Upon coming into force of these Special Terms and Conditions, the Special Terms and Conditions for Group Voluntary Health Insurance shall cease to be effective ("Company Journal" no. 14/20).

(2) These Special Conditions shall be published on the official website of the insurer. The Special Conditions shall come into force and become effective on the date of their publishing on the Company Journal.

THE SPECIAL TERMS AND CONDITIONS HEREOF SHALL BE APPLIED AS OF 18TH JANUARY 2025.