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THE SPECIAL TERMS AND CONDITIONS OF COMBINED, PARALLEL, SUPPLEMENTAL AND PRIVATE COLLECTIVE VOLUNTARY HEALTH INSURANCE FOR OUTPATIENT AND INPATIENT TREATMENT

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INTRODUCTORY PROVISIONS
Article 1

(1) These Special terms and conditions of combined parallel, supplemental and private individual health insurance (hereinafter: the Special terms and conditions) and General terms and conditions of voluntary health insurance (hereinafter: the General terms and conditions), constitute integral parts of the contract on combined parallel, supplemental and private health insurance (hereinafter: the Insurance contract) that the Policyholder voluntarily concludes with Insurance provider Triglav osiguranje a.d.o. (hereinafter: Insurer).

(2) Expressions in these Special Terms and Conditions have the following meanings:

1. Insurance provider (hereinafter referred to as: Insurer) - Triglav osiguranje a.d.o., which, in accordance with the law, organizes and implements voluntary health insurance;
2. Policyholder - is a legal or natural entity, as well as other legal entity that concludes Voluntary Health Insurance contract with the Provider of Insurance in the name and for the account of the Insured, or on his own behalf and for the account of the Insured, and who has undertaken to pay insurance premiums from his own assets or at the expense of the Insured;
3. Offering party - is an entity that, in writing, submits an insurance proposal to the Insurer for the conclusion of a contract on voluntary health insurance;
4. Insured person is a natural entity who concludes a Voluntary Health Insurance Contract or for whom, on the basis of his / her consent, a Voluntary Health Insurance Contract is concluded with the insurance provider and who benefits by the rights set forth in the Voluntary Health Insurance Contract, as well as a family member of the insured;
5. Family members - are spouses or partners, children (born in a marriage, out of wedlock and / or adopted or stepchildren and children taken to support) of the Insured persons who are legally dependent persons until the age of 18, or until the age of 26 in case they are in regular studies, and who have a residence registered at the same address;
6. Newly insured person - a person who is included in voluntary health insurance during the term of the insurance contract;
7. Insurance coverage - implies an agreed basic insurance coverage, and also a supplementary insurance coverage if separate contracts are signed and additional premiums are paid;
8. Insurance sum - is the maximum amount expressed in Euros (EUR) up to which the Insurer is liable to reimburse the insurance costs incurred in connection with the healthcare provided to the insured. The insurance sum is reduced during the term of the insurance for the amount of each paid fee for the purpose of the realized costs for each insured person at the specific risk.
   The deduction from the previous paragraph is realized by deducting the paid fee (in RSD) from the available insured sum, converted into EUR at the middle exchange rate of the National Bank of Serbia on the day of calculation.
   The amount of the contracted insurance sum may only be changed when the insurance is renewed.
9. Limit – is the maximum amount of the obligation of the Insurance provider per single medically justifiable treatment within the scope of the contracted insurance coverage for each insured person during the insurance term, as stated in the policy, i.e. insurance contract, and which is in accordance with these Special terms and conditions;
10. Country of Residence – is the country where the insured person has registered residence at the time when the insurance contract is concluded, that is, a person who, in accordance with applicable provisions of law, has been issued a permit for permanent or temporary residence, be it a person of domestic or foreign nationality, who lives or performs his/her employment duties in the country of residence. The country of residence, as stipulated by these Special terms and conditions, shall solely be the Republic of Serbia;
11. Licensed physician – is any individual holding a degree from a recognized faculty of medical professions, and is licensed and authorised to practise medicine in the Republic of Serbia in accordance with applicable provisions and the relevant legal system, unless a licensed physician is the Insured itself, Policyholder itself, or their spouse;
12. Medically justified treatment - medical service, medical - technical aids, implants, medical supplies or medicine that is justified if:
    1. it is appropriate and necessary for the diagnosis or treatment of acute-phase illness or injury covered by the insurance policy and defined by these Special Terms and Conditions;
    2. it is necessary for the purpose of healing, improvement of health condition and / or prevention of deterioration of the health of the insured person;
    3. in extent, duration or intensity, it does not exceed the level of protection required to ensure safe, adequate and appropriate treatment;
    4. it is prescribed by an authorized physician;
    5. it takes place during the term of the insurance coverage;
    6. it is in accordance with the widely accepted professional standards of medical practice in the Republic of Serbia (conventional medicine procedures);
    7. it is not primarily intended for the personal comfort or comfort of a patient, family, physician or other provider of health services;
    8. it is not part of the patient's education or professional training nor is it connected to it;
    9. it is not experimental or in the research phase;
13. An emergency medical case is a disease or injury that without immediate medical assistance can lead to the life threats of the insured person, that is, irreparable and serious damage to his/her health or to death. Emergency medical assistance includes medical assistance provided within 12 hours from the moment of taking in the insured person in order to avoid the expected occurrence of an emergency medical condition;
14. Accident – is any occurrence that is sudden and independent of the will of the insured person which, acting mainly from the outside and abruptly onto the body of the insured person, results in health damage that requires medical care;
15. Pre-existing health condition – means any health condition that is a consequence of any previously diagnosed disease or which had required inpatient treatment, treatment or medication before the insurance contract came into effect, that is, before the insurance inception, and of which the Insured is aware at the moment of concluding the insurance contract. The pre-existing health condition particularly means any chronic disease, injury, illness or condition that may be expected to last for a longer period of time with no reasonably foreseeable end date, and which may be characterized by remissions which require permanent or temporary care, as needed;
16. Surgical procedure – means any invasive medical procedure, performed manually or with instruments, during the surgery that is undertaken for the purpose of diagnosing a disease or treating the insured person suffering from a disease;
17. Healthcare institution - is a legal entity that performs a healthcare activity and has been granted a license by the Ministry competent for health (hereinafter: Ministry) for performing healthcare activity in accordance with the law regulating health care;
18. Private practice - is another form of health service in which certain healthcare activities are performed and which has obtained the permission of the Ministry for performing certain healthcare activities in accordance with the law regulating health care and the regulations adopted for the implementation of that law;
19. Other healthcare providers - are other legal or natural persons performing certain activities in the field of healthcare, that is, providing medical and technical assistance, having a permission for the performance of those tasks granted by the competent authority, in accordance with the law;
20. The network of healthcare institutions - health institutions, private practice and other providers of health services, who have a valid agreement with the Insurer on providing health services, in which the insured person uses the services stipulated by the policy and in the manner provided for by these conditions;
    The network of healthcare institutions is published on the Insurer's website.
21. Participation - Obligatory participation of the Insured in the costs of contracted health services.

GENERAL PROVISIONS
Insurance contract
Article 2

(1) An insurance contract is concluded with a fixed or unspecified duration of at least 12 (twelve) months, except in the cases:
   1. when the status of a mandatory Insured is shorter in accordance with the regulations governing compulsory and voluntary health insurance, and the Policyholder is required to notify the Insurer when the Insured person ceases to be mandatory insured,
   2. when private voluntary health insurance is contracted.

(2) An insurance contract may be contracted with the following duration:
   1. short-term:
   2. Equal ("=") 12 (twelve) months in a parallel and additional voluntary health insurance;
   3. Less or equal ("≤") 12 (twelve) months with private voluntary health insurance;
      a. long-term - with indefinite duration;
      b. perennial - with a certain duration.

(3) In the case of long-term and perennial insurance contracts, the Insurer shall, before the expiration of the insurance year, provide the calculation policy for the next year of insurance.

(4) By the insurance contract, the Policyholder undertakes to pay the premium to the Insurer, and the Insurer undertakes to reimburse the costs of treatment, or the costs of a medically justified treatment of the contracted insurance coverage when the insured event occurs, as stipulated by these Special Terms and Conditions.

(5) The reimbursement of the cost of treatment provided by the Insurer may not be higher than the maximum contracted amount of insurance indicated on the policy during the contractual period of insurance, i.e. maximum up to the limit defined by the policy, for individual treatments within the insurance coverage.

(6) Under these Special Terms and Conditions, an insurance contract may be concluded to cover the cost of treatment and medical services such as:
   1. basic insurance coverage
   2. supplementary insurance coverage

(7) The insured person shall, in accordance with the contracted insurance coverage, use contracted medical treatment in the territory of the Republic of Serbia, in the institution that is, in accordance with these Conditions, considered a provider of health services, as defined by the insurance contract.

(8) Insurance coverage is valid for the territory of the Republic of Serbia.

(9) Notwithstanding paragraphs (5) and (6) of this Article, the Insurer may extend the insurance coverage to: Slovenia, Croatia, Bosnia and Herzegovina, Montenegro and Macedonia, whereby the Policyholder is required to pay an additional premium (hereinafter: regional coverage).

(10) The insurance coverage referred to in paragraph (7) of this Article refers only to the possibility of using the scope of health services defined by the basic coverage, except for covering for pregnancy and childbirth, if defined in the basic coverage.

(11) In the case of contracting the coverage referred to in paragraph (7) of this Article, the Insurer reserves the right to exclude certain health services from the basic and supplementary coverage in the insurance contract.

Article 3

(1) The insurance contract shall be concluded on the basis of a written proposal made on the Form of the Insurer.

(2) The proposal is an integral part of the contract on voluntary health insurance and both parties are required to sign it.

(3) An integral part of the collective insurance contract is also a list of persons covered by insurance.

(4) With a collective insurance contract, each insured person can include members of his/her family in insurance and bear the premiums for family members.

(5) The identity of the connected family members can be included in the list of insured persons of the existing collective insurance policy, or there may be a separate policy which would cover only the family members of the insured. In the event of issuing a separate policy, the Insurance Policyholder may also be a natural person - an insured who includes members of his / her family in insurance.

(6) In the case of a collective insurance contract, the policy for family members shall be issued for the same period of insurance as the collective policy.

OBTAINING THE STATUS OF THE INSURED
Article 4.

(1) According to these Special Conditions for Collective Insurance, a group of persons of at least twenty (20) who are employed, or who are beneficiaries of services, or who are family members of the Policyholder, can be accepted for insurance.

(2) The contractual insurance coverage provided for by these Special Conditions shall also apply to the members of the Insured's family, if their identity is indicated in the policy, the insurance contract, or the list of insured persons, and if they have been paid a premium for.
(3) Upon the entry into force of an insurance contract, it is possible to include a new person in insurance coverage only if the person involved is:
1. a new person who entered into employment, who became the beneficiary of the services of the Policyholder, or became a member of the Policyholder – in which case the Insurer is provided with a certified confirmation of the Policyholder, i.e. an employer that this person entered into employment, or became a member of the Insurance Policyholder or a beneficiary of the services of the Policyholder after the commencement of the insurance contract, or that, if the Insured is employed by the Policyholder, the contracted working conditions have been changed for this person, that is, the agreed contractual terms of membership with the Policyholder have changed or the contractual terms for the beneficiary's services have been amended;
2. a member of the family of a new person in accordance with point 1) of paragraph (3) of Article 4.
3. a spouse or a partner of the insured - with the submission of a marriage certificate proving that the spouse acquired this status after the commencement of the insurance contract, or, in the case of partnership, by submitting documentation proving the registration of the place of residence which is the same as the one of the Insured;
4. a new-born child of the Insured, by submitting the issued birth certificate to the Insurer, which proves that the child is born after the beginning of the insurance contract or by submitting the Decision on adoption received from the Centre for Social Issues, as evidence that the adopted child acquired this status after the beginning of the insurance contract;
(4) In the cases defined in paragraph (3) of this Article, the Policyholder shall, within thirty (30) days from the date of the change, submit to the Insurer the related specified documentation.
(5) The exclusion of a certain insured person from insurance prior to the expiration of the contracted insurance period is possible in the cases defined in Article 5, (7) and (8) of these Special Terms and Conditions, whereby the Policyholder is required to notify the Insurer on termination of insurance for a certain insured person and to submit to the Insurer a confirmation that there has been an eventuality defined in Article 5, (7) and (8) of these Special Terms and Conditions as well as to submit the Voluntary Health Insurance Certificate (hereinafter: the document) for the insured person.
(6) In the event of the exclusion of the insured person prior to the expiration of the contractual period of insurance, the Insurer shall be entitled to a premium only up to the day the insurance was active for that person, unless otherwise agreed, in accordance with the General Conditions.
(7) In case of misuse of the Certificate that is not timely returned to the Insurer after the exclusion of a certain insured person from the insurance, the expenses incurred in the insured event shall be borne by the insured person, or the Policyholder.
(8) In any event, for the inclusion or the exclusion of a person in the insurance contract, after the commencement of the insurance, the Insurer reserves the right to request additional documentation that proves the existence of the basis for the commencement or the suspension of insurance.

COMMENCEMENT AND EXPIRY OF THE INSURER'S OBLIGATION

Article 5

(1) The obligation of the Insurer commences at the expiry of 24th hour on the date indicated in the Policy as the commencement date, provided that the premium or a premium instalment has been paid, unless otherwise agreed.
(2) If the first stipulated premium has not been paid by the date indicated in the policy as the commencement date, the Insurer's liability commences at the expiry of 24th hour on the date when the first stipulated premium is paid in its entirety.
(3) If the waiting period has been stipulated, the Insurer's liability commences at the expiry of 24th hour on the date after the expiry of the waiting period provided the premium has been paid, unless otherwise agreed.
(4) The liability of the Insurer ceases as of the expiry of 24th hour of the date specified in the policy as the insurance expiry date, or in other events stipulated by these Special and General terms and conditions.
(5) The Insurer shall not compensate for the expenses incurred due to a medical therapy or treatment that occurs after the expiry of the Insurer's liability, regardless of whether the treatment is initiated during the insurance contract term.
(6) The insurance ceases to apply for any insured person, regardless of the contracted insurance period, in cases of:
1. the death of the Insured shall occur, except for insured family members, until the expiration of the existing policy, if the premium is paid for the remaining period of insurance;
2. loss of the status of the insured person in compulsory health insurance;
3. the insured person acquires the status of a mandatory health insured person - in a private voluntary health insurance;
4. the insured person ceases employment or membership at the Policyholder, or ceases to be the beneficiary of the services of the Policyholder, which was the basis for acquiring the property of the insured person in the collective insurance;
5. other cases defined by the General Terms and Conditions.
(7) In any case, with collective insurance, the termination of insurance of the Insured shall also terminate the insurance of the members of the family of the insured, regardless of the reason for the termination of the insurance of the Insured, except in the case defined in the preceding paragraph, item 1 of this Article.

WAITING PERIOD (WITHDRAWAL PERIOD)

Article 6

(1) A withdrawal period (hereinafter: the waiting period) is the period during which the liability of the Insurer is excluded if an insured event occurs, regardless of the fact that the insurance contract is in effect.
(2) The waiting period starts from the commencement of the insurance contract, or the commencement of insurance for a newly-insured person, provided that by that date the first due contracted premium is paid, unless otherwise agreed.
(3) If due premium has not been paid by the commencement of the insurance contract, the waiting period starts at the expiry of 24th hour of the date when the first contracted premium is paid.
(4) The general waiting period is 2 (two) months, except in cases of insurance coverage for pregnant women and childbirth for which the withdrawal period is 9 (nine) months
(5) The waiting period shall not apply to persons with insurance in continuity, i.e. does not apply to persons who have acquired the status of an insured person by the previous policy and for which the withdrawal period has already elapsed during the period of the previous policy.
(6) The waiting period shall not apply if an accident (incident) occurs, as well as in surgical procedures resulting from an accident.
(7) The waiting period shall not apply to illness or injury which, without immediate medical assistance, can lead to the life threat of the insured person.
(8) When renewing the insurance, if for a particular insured person the waiting period did not fully expire during the previous policy period, the remaining time of the previous waiting period will be transferred to the next period of insurance under the new policy.

OBLIGATION OF THE POLICYHOLDER

Article 7

(1) During the insurance contract period, the Policyholder is obliged to report to the Insurer any new circumstances that arise related to the insured person, such as the change in status of the person insured under compulsory health insurance, change of address, profession or marital status, and to submit information about any other important change that affects the information given when concluding the insurance contract or given at the first inclusion into insurance of such insured person.
(2) The Policyholder is obliged to inform all the persons insured under the Special terms and conditions with the contents thereof.

INSURED EVENT

Article 8

(1) An insured event represents a future uncertain event when, due to a disrupted health condition (a disease or injury) the insured person undergoes a medically justifiable treatment, which is subject-matter of the insurance contract and the costs of which are to be paid to a medical institution, a private practice, other provider of healthcare services or to the insured person.
(2) A medical condition disorder as stipulated in paragraph (1) of this Article must be established by an authorized physician as a sudden and unexpected illness or injury that was first incurred during the contracted duration of the insurance, unless the prior health condition causing the health disorder is stated in the questionnaire when concluding an insurance contract, and the insurer has performed a risk assessment (increased risk) in accordance with Article 5 of these Special Terms and Conditions and if the coverage of those diseases and conditions and their consequences are not excluded from the proposal or the policy.
(3) The insured event is also the treatment expenses of an emergency dental care treatment incurred as a result of an accident. The emergency dental care treatment is a treatment necessary to restore or replace sound natural teeth damaged in the accident. Sound teeth are the teeth with no cracks, or teeth which were not subject to dental services of treating dental diseases (crowns, fillings, etc.) before the insured event. Teeth damage from chewing food does not entitle one to the emergency dental care treatment. The emergency dental care treatment can be provided either as inpatient or outpatient treatment.
(4) The expenses of medically justifiable treatment, or treatment pertaining to supplemental insurance coverage shall also be deemed to be an insured event only if contracted separately and additional premium has been paid for expenses of:
1) General health check-up,
2) Ophthalmology services,
3) Dental care services,
4) Physical therapy,
5) Prescription and ordered medicines.
(5) The insured event commences with the beginning of medical therapy, or treatment, and ends at the moment when, from the medical standpoint, there is no more need for the treatment, because the health condition is restored or stabilized, and its further improvement or worsening is not certain.
(6) In any case, the insured event terminates on the day of expiry of the insurance contract.

COMPENSATION FOR TREATMENT EXPENSES

Article 9

(1) When the insured event occurs, the insurer will reimburse the reasonable and usual expenses incurred in connection with the treatment of the insured person who is obliged to pay it, or who paid it to the provider of health services in the manner defined in Article 21 of these Special Terms and Conditions, up to the maximum amount of the insured sum specified in the policy, or for certain health services up to a limit provided for in this Special Terms and Conditions, by an insurance contract, i.e. by the policy.
(2) All the expenses related to the treatment and medical services exceeding the contracted insured sum, or exceeding the available amount of defined limits are borne by the Insured itself.
(3) The reasonable and usual expenses stipulated in Paragraph (1) of this Article are considered to be the medical therapy expenses that are not higher than the general level of expenses in similar institutions in the Republic of Serbia for the same or similar medical therapy – treatment, services or help to persons of the same gender and similar age, for a similar disease or injury.
(4) Reasonable and normal costs are determined as average prices for the same or similar medical treatment in accordance with paragraph (3) of this Article, in five (5) institutions from the Network of Providers of Health Services of the Insurer, valid at the moment of occurrence of the insured event.
(5) All amounts exceeding the reasonable and normal costs shall be borne by the Insured.
(6) Treatment or medical treatment shall mean any medical or surgical procedure which, according to generally recognized rules of the medical profession, is considered appropriate for alleviating the symptoms of the disease, improving the health or preventing deterioration or the treatment of the disease in order to restore health or cure the disease.
(7) Treatment, or medical services, may be provided as a hospital and / or outpatient service.
(8) The maximum contracted amount of insurance, as well as the maximum amount of compensation, i.e. the limits for individual coverage, are stated in the policy and insurance contract.

BASIC INSURANCE COVERAGE

OUTPATIENT TREATMENT

Article 10

(1) Outpatient treatment shall mean the costs of medical treatment, that is, the treatment received by the insured person in the healthcare institution as a provider of health services, in the manner defined in Article 21 of these Special Terms and Conditions, which is officially recognized as a place where such treatment can be implemented and it restricts medical services to scientifically recognized methods that have been clinically tested and accepted in the Republic of Serbia, provided that the insured person did not spend 24 continuous hours at that institution (staying overnight or taking a bed).
(2) Out-patient services include the following insurance coverage:
1. The price of an appointment with an authorized physician from the selected healthcare institution in which the person is provided for out-of-hospital treatment, which includes a check-up of a general practitioner and / or a specialist of any specialty according to the medical indication and according to the request of an authorized physician;
2. Ambulatory surgery of up to 100 (hundred) euros
3. Costs of home visits by an authorized physician are reimbursed only in urgent cases according to the assessment of an authorized physician and a medical indication, with the mandatory approval of the Medical Contact Centre of the insurer;
4. Compensation for diagnostic methods - procedures, laboratory tests, tests and analyses according to the medical indication and only at the recommendation of an authorized physician (not older than 6 months), which are necessary for maintaining good health, improving health or preventing deterioration of health of the Insured. The diagnostic methods required by an authorized physician, in accordance with the medical indication and diagnosis, include:
    1. laboratory tests, all necessary laboratory diagnostics,
    2. radiological tests, such as: RTG screening, ultra-sound screening, roentgenography, roentgenoscopy, CT and MR,
    3. endoscopic procedures,
    4. biopsies,
    5. ergometry,
    6. spirometry,
    7. EEG, EMG, EMNG, ECG, Holter ECG,
    8. Other medical diagnostic procedures;
5. Compensation for expenses of ambulance transportation, in a vehicle owned by private practice, only in emergency medical cases, and provided that the transportation has been ordered by an authorized physician, excluding the obligation of the insurer to organize an emergency medical transport;
6. Compensation for ordering or administering of therapy, which represents compensation for the work of the competent medical practitioner and medical technicians for the implementation of the therapy with medicines for which the marketing authorization has been issued in the territory of the Republic of Serbia in accordance with the law;
7. Compensation for medical-technical devices - temporary and permanent medical equipment and prosthetics, only if prescribed by an authorized physician that can be contracted to the maximum limit defined in the policy, with the exclusion of myoelectric and aesthetic dentures;
8. Compensation for homeopathy and acupuncture, when provided by authorized doctors and when it is a treatment for a disease covered in accordance with these Special Terms and Conditions, up to the maximum sum given in the policy.

9. Compensation for psychiatric services and mental health services for crisis interventions of up to 100 euros per insured person during the insurance year, in the following cases:
   - physical abuse;
   - rape;
   - death of a family member;
   - malignancy.

(3) If particularly stipulated within the policy, out-of-hospital treatments may include the following coverage:
   1. Cost reimbursement in cases where diagnostic procedures, laboratory tests, tests and analyses are carried out in order to determine infertility, up to the limit specified in the policy;
   2. Compensation for speech therapist and speech exercises, up to the maximum limit specified in the policy;
   3. The fee for the examination of an authorized psychiatrist and psychotherapy fee up to the maximum limit stated in the policy.

(4) When using outpatient treatment services, the Insured is entitled to compensation for expenses of up to the total contracted insured sum and defined limits, contracted in the policy or the insurance contract for this coverage in the course of the insurance year.

INPATIENT TREATMENT

Article 11

(1) The inpatient treatment includes compensation for expenses of a medical therapy, or treatment in an institution that is according to law considered a hospital, as a healthcare provider, registered in accordance with the provisions of law and established in accordance with the legal system of the country wherein the insurance coverage applies, where the insured person is under continuous supervision by medical staff, that has sufficient quantity of diagnostic, laboratory, surgical and therapeutic equipment. In inpatient treatment, medical services have to be scientifically acknowledged methods that are clinically tested and recognised in the country wherein the insurance coverage applies, in accordance with the policy, while the insured person occupies a bed in the institution for the purpose of treatment that lasts more than 24 consecutive hours.

(2) The inpatient treatment does not include placing the insured person in residential type institutions such as:
   1) Day-care hospitals,
   2) Addiction quitting institutions,
   3) Mental hospitals,
   4) Residential health institutions specialized in rehabilitation (spas),
   5) Hydro-clinics,
   6) Sanatoriums,
   7) Nursing homes,
   8) Retirement homes or geriatric institutions,
   9) Health resorts, centres for rest, weight loss and recovery.

(3) Inpatient treatment services include solely:
   1) Compensation for expenses of hospital accommodation and medically allowed food which is recommended by a licensed physician in the course of inpatient treatment. As for the accommodation and food expenses, if the hospital wherein the insured person is being treated has the capacity and the possibility to provide the following to the insured person, the Insurer will compensate the expenses for:
      1. Accommodation in a room (so-called suite accommodation) that includes one or two beds per room, air conditioning, TV, phone, bathroom and toilet within the suite, a qualified medical technician providing additional care, as well as the medically allowed food recommended by a licensed physician during the inpatient treatment.
      2. Accommodation in a room with three or four beds per room with air conditioning, bathroom and toilet within the room, a qualified medical technician providing additional care, as well as the medically allowed food recommended by a licensed physician during the inpatient treatment.
   2. Compensation for authorized medical practitioners of all specialties within a healthcare institution, that is, a hospital in which a person is hospitalized, which implies an examination by a specialist of any specialty, according to a medical indication;
   3. Compensation for diagnostic methods - procedures, laboratory tests, tests and analyses according to the medical indication and only at the recommendation of an authorized physician, which are necessary for maintaining good health, improving health or preventing deterioration of health of the Insured. The diagnostic methods required by an authorized physician, in accordance with the medical indication and diagnosis, include:
      1. laboratory tests, all necessary laboratory diagnostics,
      2. radiological tests, such as: RTG screening, ultra-sound screening, roentgenography, roentgenoscopy CT and MR,
      3. endoscopic procedures,
      4. biopsies,
      5. ergometry,
      6. spirometry,
      7. EEG, EMG, EMNG, ECG, Holter ECG,
      8. Other medical diagnostic procedures;
   4. The fee for the administration of therapy, which represents compensation for the work of an authorized physician and qualified medical technicians, the costs of using medical or technical equipment, the costs of administering medicines and radiological materials, and other material costs of the following types of therapies: medicaments, injection, infusion, physical and rehabilitation, speech therapies, chemotherapy and radiotherapy;
   5. Compensation for procedures that include: procedures in local anaesthesia, procedures in general endotracheal anaesthesia and laparoscopic procedures;
   6. Remuneration for medicines and sanitary material prescribed for use during hospital treatment, with exclusion of compensation for medicinal and mineral water, medical wines, nutrients and strengthening agents, restorative agents, cosmetics, personal care products and medicinal products and preparations that are, according to national register of medicines, unregistered;
   7. Compensation for costs of medical-technical devices, maximum up to the limit defined in the policy;
   8. Compensation for surgery costs, which includes a fee for the engagement of a surgeon, anaesthesiologists, assisting doctors and assistants (qualified medical technicians and other health professionals), including pre-operative preparation costs incurred from the moment of hospital admission to a surgery, intensive care and post-treatment (post-operative care until discharge from the hospital), maximum to the amount of insurance contracted by the policy. The cost of surgery includes implants prescribed by an authorized physician, maximum up to a limit of 3,000 EURO per year per insured person;

(4) For the use of hospital treatment services, the Insured shall be entitled to reimbursement of the maximum contracted amount of insurance, and the defined limits, agreed by the policy, i.e. an insurance contract for this coverage during the insurance year.

PREGNANCY HEALTHCARE AND DELIVERY

Article 12

(1) If an insurance coverage for the health care of a pregnant woman is contracted, the insured person is entitled to reimbursement of the costs of medical treatment justified by the outpatient or hospital treatment, up to the limit defined by the policy.

(2) The obligation of the Insurer regarding the health care of pregnant women shall begin after the end of the waiting period of nine (9) months from the beginning of validity of the insurance contract.

(3) Pregnancy is deemed occurred before the insurance inception date if the licensed gynaecologist of the insured person determines the delivery date to be before the period of nine (9) months expires, counting from the date of the first inclusion into the insurance of the insured person, or counting from the date when the due premium is paid in case it has not been paid by the insurance contract inception date.

(4) Paragraphs (2) and (3) of this Article shall not apply if the insured person contracted coverage of pregnancy healthcare under the previous policy with the same Insurer and provided there has been no lapse of insurance.

(5) In any case, if during the insurance period new persons are included as a spouse, or a partner or a member of the family of the insured, there is no obligation of the Insurer to provide for the health care of pregnant women and childbirth if the pregnancy started before the insurance began.

(6) The maximum annual coverage for health care costs for pregnant women and childbirth includes the following medically justifiable treatments, i.e. reimbursements:
   1. for examinations, swabs, laboratory analyses such as complete blood analysis, basic biochemistry, urine analysis, according to the recommendation of an authorized physician - pregnancy supervising gynaecologist;
   2. costs for ultrasound examination of the fetus;
   3. Additional ultrasound (so-called expert ultrasound);
   4. additional ultrasound in case of high-risk pregnancy or complications, and based on a reasoned and documented opinion on medical necessity provided by an authorized gynaecologist;
   5. for biochemical screening for chromosomal aberrations, according to the medical indication;
   6. for invasive prenatal diagnosis in terms of amniocentesis of biopsy of chorionic villus, cardiocentesis, and the like, if it is indicated by a competent gynaecologist;
   7. For prenatal vitamins up to 100 EUR per year, provided that they have been prescribed by an authorized gynaecologist;
   8. for the total cost of delivery, maximum up to the amount defined by the policy (for epidural anaesthesia, apartment accommodation, father's attendance at childbirth, doctor's fees, medical technicians, anaesthesiologists, caesarean section only if it is medically indicated).
   9. Nursing care provided by a qualified medical technicians (midwives) immediately after the expiration of the home care to which the insured person has the right as a mandatory insured, and at longest until the new-born is one month old, at the recommendation of an authorized doctor to maximum cost of up to 100 euros.

(7) In case of a separate policy, the following coverage may also be included:
   1. for home care provided by midwives immediately after the expiration of the period of home care to which the insured person has the right as a mandatory insured person, and no later than when a new-born is one month old, according to the recommendation of an authorized physician, to the maximum limit specified in the policy;
   2. for the health care of new-born babies in the first month of life, up to the maximum limit specified in the policy;
   3. for prenatal vitamins up to the amount of 100 Euro per year, provided that they are prescribed by an authorized gynaecologist.

(8) The liability of the Insurer is excluded for education and preparations of a pregnant woman to go through the labour.

SUPPLEMENTAL INSURANCE COVERAGE

Article 13

(1) If an additional premium is paid, supplementary insurance coverage of costs of health services and medicines may also be contracted.
   If more than one person is provided with a policy, supplementary insurance coverage may be contracted only on condition that all insured persons are covered by supplementary insurance coverage.
   Possible supplementary insurance coverage is:
   1. general health check-up,
   2. ophthalmological services,
   3. dental services,
   4. Prescription drugs and orders,
   5. Physical therapy,

(2) Limits by supplementary coverage are defined in the policy.

(3) Supplementary insurance coverage may be contracted only on condition that it includes all the insured persons.

(4) The exclusions defined in Articles 19 and 20 under these Special terms and conditions apply to all types of supplemental coverage.

GENERAL HEALTH CHECK-UP

Article 14

(1) A general health check-up means one general health check-up annually per insured person in the course of the insurance year, and includes the following:
   1. For insured persons older than 18 years:
      1. Laboratory analysis:
         i. Qualitative examination of urine with sediment
         ii. Complete blood count (Er, Le, Hb, Hct, Le formula), Se Glucose in blood
         iii. AST
         iv. ALT
         v. Urea, Creatinine, Triglycerides
         vi. Cholesterol - total HDL cholesterol and LDL cholesterol;
      2. Gynaecological examination, colposcopy, vaginal secretion, Papanicolaou test, ultrasound examination of breasts (for women),
      3. Overview of urological and ultrasound of the prostate, (for men over 40 years) or ultrasound of the testis (for men up to 40 years),
      4. Examination of an internal doctor with an EKG;
      5 Ultrasound examinations of the abdomen.
   2. Infants (up to one year old):
      1. blood test
      2. urine
      3. hips ultrasound
      4. anthropometric measurements
      5. paediatric examination
   3. Children aged one to 18 years:
      1. blood test
      2. urine
      3. clinical examination of paediatricians
      4. anthropometric measurements
      5. swabs of the throat and nose
      6. examination of ophthalmologist, otorhinolaryngologist or orthopaedic specialist

OPHTHALMOLOGY SERVICES

Article 15

(1) Ophthalmology services include an examination by an ophthalmology specialist to measure visual acuity, and the following ophthalmology services in the course of the insurance year:
   1. Supply of a spectacle frame,
   2. Supply of dioptric glasses or contact lenses

(2) When using ophthalmological services, the insured person shall be entitled, during a single insurance year, to compensation for expenses up to the limit for ophthalmology services defined in the policy.

(3) The Insurer's liability is excluded in the following cases:
   1. radial keratotomy or any other surgical procedure (including laser correction of sight);
   2. sunglasses and / or related accessories for glasses.

DENTAL CARE SERVICES

Article 16

(1) Dental care services include:
   1) A preventive treatment – includes routine examinations, dental care instructions, fluoride treatment.
   2) A basic restorative treatment – includes amalgam and composite fillings, compomer restoration and extractions.
   3) A greater restorative treatment – includes root canal filling, crowns, fillings, and bridges (including the expenses of laboratory and anaesthesia), wisdom teeth extraction, periodontal plaque removal and root cleansing, oral surgical procedures.
   4) An orthodontic treatment – analysis models (including panoral X-rays), casts, and mobile wire apparatus (braces). The orthodontic treatment is allowed only with a written approval by the Insurer and only for the insured persons of up to 30 years of age.

(2) When using dental care service, the insured person is entitled, in the course of a single insurance year, to compensation for expenses up to the limit for dental services defined in the policy.
(3) The Insurer's liability is excluded in the following cases:
1. cosmetic treatment;
2. artificial teeth;
3. any ceramic restorations on dental implants;
4. dental implants;
5. fixed braces;
6. multi-surface fillings (onlay);
7. facets and all related costs.

PRESCRIPTION AND ORDERED MEDICINES

Article 17

(1) Prescription drugs include medicines prescribed by an authorized physician, based on a medical indication. The maximum amount of compensation, i.e. the limit for the cost of prescribed prescription drugs is defined in the policy, but it is only permitted to prescribe medication at maximum therapeutic doses for the next sixty (60) days.
(2) Medication orders include medicines prescribed by an authorized physician while the Insured is in hospital treatment.
(3) The medicinal product is considered a product that has been granted a marketing authorization in the Republic of Serbia and a product that has not been granted a marketing authorization in the Republic of Serbia, which is imported on the basis of the approval of the Agency for Medicinal Products and Medical Devices of Serbia, in accordance with the law regulating the field of drugs.

PHYSICAL THERAPY

Article 18

(1) Physical therapy, according to the medical indication, and if conducted either as outpatient or inpatient treatment includes:
1. Kinesiotherapy,
2. Electrotherapy,
3. Laser therapy,
4. Magnetotherapy,
5. Ultrasound therapy,
6. Thermal therapy.
(2) Therapeutic treatments in the field of physical medicine can only be provided by qualified therapists. Only in case the person is immobile, the physical therapy can be carried out in the home environment, with the prior mandatory approval of the Insurer.
(3) For using physical therapy, the insured person is entitled, in the course of a single insurance year, to compensation for expenses up to the limit for physical therapy defined in the policy.

GENERAL EXCLUSIONS OF THE INSURER'S OBLIGATION

Article 19

(1) The obligation of the Insurer to compensate the costs of preventive programs of vaccinations, immunoprophylaxis and chemoprophylaxis which are obligatory under the program of immunization of the population against certain types of infectious diseases in the Republic of Serbia has been excluded.
(2) The Insurer's obligation to reimburse the costs of treatment arising as a consequence or in connection with:
1. Reproductive treatment:
   1. to prevent conception for men and women (contraception and its consequences);
   2. vasectomy and sterilization;
   3. Sexual dysfunction;
   4. abortion and its consequences - if it has been carried out for psychological or social reasons, except for abortion in emergency medical cases, or for medical reasons such as: structural or chromosomal damage to the fetus, health conditions endangering the mother's life, spontaneous abortion and medically indicated abortus;
   5. treatment of infertility, all treatments for preparation for artificial insemination and drugs and any form of artificial insemination;
   6. after sterilization, restoration;
   7. Gender reassignment surgery;
   8. Viagra treatment or treatment with its generic replacement;
2. Surgical procedures for organ and tissue transplantation, regardless of whether the Insured is a recipient or a donor.
3. Surgical procedures by personal desire, including implants and corrective medical - technical aids:
   1. for aesthetic purposes, whether or not due to psychological reasons, including dental aesthetic treatments, as well as consequences of it, except for implants in total mastectomy;
   2. surgical procedures and processes of personal preference, treatment and / or surgical procedures that are not medically necessary;
   3. removal of moles by personal desire;
   4. circumcision - if it is not medically indicated;
   5. procurement of hearing aids;
   6. using the emergency services of the health service provider for cases that are not a medical emergency;
   7. ambient therapy for rest and / or observation;
   8. therapeutic procedures for rehab for any type of addiction;
   9. Hospital services or treatments in all long-term care facilities, hydro-clinics, stationary health care facilities specializing in rehabilitation (spa), sanatoria or old people's homes (geriatric institutions) that are not considered hospitals;
   10. all costs of cryopreservation and implantation or reimplantation of living cells;
   11. purchases of orthopaedic shoes, orthopaedic cartridges or other foot support such as: support for soles and orthotic devices and materials, all aids arising from the diagnosis of weak, overstretched, unstable or flat feet or suspended soles and tarsalgia or metatarsalgia;
   12. any expenses related to foot injuries such as blisters, corns and hyperkeratosis, or bunions;
   13. treatment of weight loss or weight loss program, gastric balloon installation, nutrition advice, diet related training;
   14. rejuvenation treatments;
   15. all types of massage not prescribed by an authorized physician as part of physical therapy (e.g. relaxation massages and other types of massage for aesthetic purposes);
   16. Therapeutic exercises, except for kinesitherapy, regardless of whether they were prescribed by an authorized physician;
   17. Long-term rehabilitation therapy (lasting for longer than a month), regardless of whether it is prescribed by a licensed physician;
   18. Compensation for treatments provided by persons who are not licensed to provide health care services;
   19. Services, preparations, and products which are not prescribed by a licensed physician and are not intended for treatment of the insured person;
   20. Healthcare services which are not approved by a licensed physician of the insured person, except for emergency medical treatment when the insured person's licensed physician is fully informed about the treatment and can support the compensation claim;
   21. Experimental medical treatment that includes:
       1. A treatment which is not scientifically or medically acknowledged;
       2. Sleep studies and other treatments related to respiratory arrest during sleep;
   22. Other expenses that include:
       1. Any expenses exceeding the standard and usual expenses, as stipulated in these Special terms and conditions;
       2. Any expenses of additional insurance coverage which is not contracted and for which no additional premiums have been paid;
       3. Expenses of purchasing personal care items during the hospital stay;
       4. costs of prescription drugs such as vitamins, dietary supplements, medical preparations used for mucous membranes of natural openings, medicinal herbs, cold medicines, drugs in experimental and research phases, medicinal and mineral water, medical wines, nutritional products and immune enhancers, local antiseptic agents, restorative agents, cosmetics, personal care products and non-regenerated drugs, products;
       5. the costs of an innovative, or original prescription drug, when there is a generic substitution, unless the doctor has indicated that the specified medicinal product is necessary;
       6. costs incurred because the hospital has practically become or could be treated as a home or permanent residence of the insured person;
       7. all non-medical expenses;
       8. Expenses associated with medical treatment incurred after the policy expiry date, which are result of accidents, illnesses or pregnancy during the insurance year, unless the policy is renewed, or if the expenses incurred are in connection with a medically justifiable treatment of people with continuous insurance, excluding prescribed drugs in therapeutic dosage in the amount allowed for sixty (60) days, which are prescribed during the insurance year and provided that this coverage has been contracted for;
       9. Instructions for use and maintenance of durable medical equipment;
       10. Adaptation of vehicles, bathrooms or a residing facility to one's personal needs;
       11. Expenses for any medical-technical aids that are issued without order;
       12. Medical-technical aids from within the group of other auxiliary aids and sanitary devices for use in outpatient conditions and for permanent purposes, such as: insulin pumps, motor wheelchair or bed, hospital bed with a harness, extra wheels, RT Crane, anti-decubitus mattresses, belts, items to increase comfort (such as phone holders and tables that are placed over the bed), items used to change the air quality or temperature (such as air-conditioners, humidifiers, dehumidifiers and air purifiers), disposable supplies, stationary bicycles, sun or heat lamps, heating pads, bidets, toilet seats, bath seats, sauna, elevator, Jacuzzi, work-out equipment and similar items;
   23. Treatment of a malocclusion or temporomandibular disease
   24. Hospital treatment in a health institution, hospital, ward or similar stationary mental health institution.

Article 20

(1), Any liability of the Insurer is excluded:
1. If the insured event occurs before the first inclusion into the insurance and it is still lasting at the time of concluding the insurance contract under which the insured person acquires the status of the insured or if the insured event lasts past the expiration of the insurance contract;
2. When the insured event requires inpatient treatment, and is a consequence of a person's pre-existing health condition present before the first inclusion in the insurance;
3. Regarding any supplemental coverage defined in Article 14 of these terms and conditions, unless additional premium has been contracted and paid;
4. The Insurer shall not compensate for the expenses of transportation to an institution in the Network of healthcare institutions;
5. The Insurer shall not compensate for expenses incurred due to the medical therapy or treatment that is initiated before the commencement of the insurance;

(2) Any liability of the Insurer is excluded if the insured event occurs also:
1. As a result of wilful and ultimate negligence act of the insured person, including traffic accidents, as well;
2. As a result of the participation of the insured person in any criminal act;
3. When being under the influence of alcohol, narcotics and opiates;
4. As a result of wilful acts of the insured person, such as: suicide, attempted suicide or mental illness (unaccountability) of the insured person, deliberate self-harm, the treatment of alcoholism, drug addiction or narcotic (hallucinogenic) products abuse;
5. Due to the insured person practicing risky and dangerous activities or sports, such as: hunting, acrobatics, diving, sailing, caving, climbing, manipulation of pyrotechnic products, fireworks, ammunition and explosives, parachuting, ski-jumping, bob sledging, acrobatic skiing, bungee jumping, car and motorcycle races, karting and the like;
6. As a result of war, invasion, acts of foreign enemies, hostilities, terrorist act, civil war, act of sabotage, terrorism or vandalism, riot, revolution, insurrection, military or other types of coupes, and active participation of insured persons in unrests or riots of any kind;
7. As a result of natural catastrophes (e.g. volcanic eruptions, earthquakes, and alike), severe weather conditions, epidemics and pandemics;
8. As a result of ionizing radiation or radioactive contamination from other radioactive waste caused by burning nuclear fuel, i.e. radioactive, toxic, explosive or other hazardous properties of explosive nuclear assembly or components thereof;

(3) f any compensation claim should be found false on any grounds or based on false information and misrepresentation, the Insurer shall not be liable;
(4) The Insurer is not liable to compensate for treatment expenses incurred by the insured persons who suffer from and are treated for the following pre-existing conditions:
1) Chronic diabetes with complications,
2) Alzheimer's disease,
3) Aneurysm of cerebral arteries and large arteries of systemic circulation,
4) Angina pectoris,
5) Condition after cardio-vascular insult (infarction) with functional disorders,
6) Cirrhosis of the liver,
7) Brain tumours with neural disturbance,
8) Moderate and severe chronic renal failure,
9) Malignant disease in all organs,
10) Multiple sclerosis,
11) Motor neuron disease,
12) Paralysis / paraplegia,
13) Parkinson's disease,
14) Chronic lung disease,
15) Muscular dystrophy,
16) Pre-senile dementia,
17) Rheumatoid arthritis,
18) Mental disorders,
19) Epilepsy,
20) AIDS, acquired constriction ring syndrome related to AIDS (ARCS) and any diseases caused by HIV and/or related to it.

EXERCISING THE RIGHTS UNDER THE INSURANCE AND NOTIFYING ON THE OCCURRENCE OF THE INSURED EVENT

Article 21

(1) In case that an insured event should occur, the Insured is required, prior to any use of medical services, to place a call to Medical Contact Centre, which arranges the type, date and time of examination or other medical services on behalf of the insured person within healthcare institutions from within the Network of healthcare institutions.
(2) If the insured uses the services of health institutions outside the Network of Health Institutions, he pays the costs of medical treatment himself, and the request for refund is submitted to the Insurer.
(3) For basic risks covered by insurance, the mandatory participation of insured persons in all realized expenses for services at health institutions outside the Network shall be 30%.
(4) In case of reimbursement of costs, the Insured shall provide the following:
1. A claim notification form
2. A medical report with the stated diagnosis
3. A prescription for medicines/supplies by a licensed physician
4. The original receipt for medical services

5. A copy of the document on Voluntary Health Insurance
6. A copy of ID Card
7. A current account number.

(5) Claims may only be submitted for the treatment that was actually received during the insurance period, and the expenses will be compensated for only if incurred before the expiry of the insurance period.

(6) In the process of settling a compensation claim, should it be necessary, the Insurer is entitled to require the Insured to provide the persons authorized by the Insurer with the excerpt from the medical records and the information at the disposal of third parties on the current and pre-existing health condition of the Insured (the excerpt from medical records for a particular insured event, reports of specialist medical offices, copies or extracts from medical history in hospitals and the like, in accordance with the law governing healthcare protection and the law governing records in healthcare).

(7) At the request of the Insurer, the Policyholder is obliged to allow the Insurer to access all records kept by the Policyholder, in order to establish the relevant circumstances related to the insured event, in accordance with law.

(8) If the expenses arising from the exercising of rights under the insurance are less than the specified maximum limit for particular coverage or contracted sum insured envisaged by the policy, i.e. contract, the insured person is not entitled to a difference in payment in the event of insurance expiry.

(9) The reimbursement of expenses for the provided health services in accordance with these Special Terms and Conditions, based on the insurance contract that was valid at the time of occurrence of the insured event, is paid by the Insurer to the insured or institution from the Network of health institutions or to a person who proves that he has paid the costs of medical treatment within 14 (fourteen) days from the date when the Insurer receives the completed documentation and establishes the existence of an obligation.

TRANSITIONAL AND FINAL PROVISIONS

Article 22

(1) These Special terms and conditions can be changed following the procedure and the method by which they are adopted.

(2) The amended terms and conditions apply only to newly-concluded insurance contracts, i.e. policies.

(3) Regarding the effective insurance contracts, the General and Special terms and conditions under which these contracts are concluded shall apply until the end of the insurance year, unless the change in the terms and conditions occurs due to changes in legal regulations, which is beyond the control of the Insurer.

(4) If the Insurer amends the Special terms and conditions, it is obliged to inform the Policyholder in writing thereof, i.e. to inform the Insured with whom it has concluded a long-lasting insurance contract.

(5) The Insurer is obligated to publish the updated version of these Special terms and conditions on its website.

Article 23

(1) Receivables from the Insurance contract expire under the provisions of the Law on Obligations.

Article 24

(1) To all the relationships between the Insurer and Policyholder that are not governed by these Special terms and conditions, the provisions of General terms and conditions shall apply, and if the provisions of General terms and conditions are contrary to the provisions of Special terms and conditions, the Special terms and conditions shall prevail.

Article 25

(1) These Special Terms and Conditions shall enter into force on the day of their adoption, and they shall start to be applied upon receiving the positive opinion of the Ministry of health.