GENERAL TERMS AND CONDITIONS
OF VOLUNTARY HEALTH INSURANCE

OU-DZO-1/21

INTRODUCTORY PROVISIONS

Article 1

(1) These General Terms and Conditions of Voluntary Health Insurance (hereinafter: General Terms and Conditions) constitute an integral part of the Agreement on Voluntary Health Insurance (hereinafter: the Insurance Agreement) that the Policyholder voluntarily concludes with Sava neživotno osiguranje a.d.o. Belgrade, as the Insurer.

(2) These General Terms and Conditions govern the conditions and the manner of organization of voluntary health insurance, the types of voluntary health insurance, the rights and obligations of the Insurer, the Policyholder and the Insured, the duration of voluntary health insurance, the conditions for the conclusion and termination of Voluntary Health Insurance Agreement and other conditions of significance for voluntary health insurance, in accordance with the law that regulates insurance and the law that regulates voluntary health insurance.

DEFINITIONS

Article 2

(1) Certain expressions in these General Terms and Conditions shall have the following meaning:

1. **Voluntary Health Insurance Provider** (hereinafter: the **Insurer)** - "Sava neživotno osiguranje" a.d.o. Belgrade, that organizes and implements the voluntary health insurance in accordance with the law;
2. **Voluntary Health Insurance Policyholder** (hereinafter: the **Policyholder**) - a legal or natural entity, as well as other legal entity that, in the name of and for the account of the Insured, that is, in its own name and for the account of the Insured, concludes the Agreement on Voluntary Health Insurance with the Insurer, and who undertakes to pay the insurance premium from its own funds or from the funds of the Insured.
3. **The person insured under the voluntary health insurance** (hereinafter: the **Insured)** - a natural entity who concluded the Agreement on Voluntary Health Insurance or, on whose behalf the Agreement on Voluntary Health Insurance is concluded with the Insurer, and who uses the rights set forth in the Agreement on Voluntary Health Insurance, as well as a family member of the Insured if included in the Agreement on Voluntary Health Insurance;
4. **Family members -** are spouses or common-law partners and children of the Insured, biological and/or adopted, who are seen by the law as supported persons until the full age of 18 or up to the full age of 26 if they are attending a regular school. The age limitations do not apply to children not capable of living independently, due to such a degree of physical and/or mental damage preventing them to execute common motor and/or bodily functions.
5. **Collective insurance** - voluntary health insurance contracted by the Policyholder for a group of the Insured for whom the Policyholder has an interest in concluding an Insurance Agreement;
6. **Voluntary health insurance offer** (hereinafter: the **Offer**) is a proposal for the conclusion of a Voluntary Health Insurance Agreement given by the Insurer to the person wishing to concluded an Insurance Agreement;
7. **Cover note -** a document that temporarily replaces the policy and contains the essential insurance agreement elements;
8. **Voluntary health insurance policy** (hereinafter: the **policy**)- a proof of the conclusion of a Voluntary Health Insurance Agreement with the Insurer;
9. **A document on voluntary health insurance** (hereinafter: the **document)** - the document which is issued by the Insurer to the Insured, on the basis of which the Insured proves the status of the Insured person under the voluntary health insurance and exercises the rights from voluntary health insurance;
10. **Voluntary health insurance premium** (hereinafter: the premium) is the amount of money paid by the Insured under the voluntary health insurance, i.e. the Policyholder, to the Insurer, based on the concluded Agreement on Voluntary Health Insurance;
11. **The first inclusion in the insurance** - the first inclusion in the insurance implies the inclusion under the policy for continuous insurance. If the insurance is not continuous, the first inclusion shall imply the commencement of insurance after an interruption;
12. **Continuous insurance** - re-execution of the policy for the person who was previously insured under the voluntary health insurance policy with the same or a different Insurer, with the same coverage, without interruptions or with interruptions in accordance with the decision of the Insurer;
13. **Sum insured** - is the amount of money representing the maximum annual obligation of the Insurer based on the concluded Agreement on Voluntary Health Insurance;
14. **Insured event** - a future event, which is uncertain and independent of the will of the Policyholder, i.e. the Insured, which initiates an obligation for the Insurer;
15. **Financial compensation** - the compensations which the Insurer provides to the Insured in the case of agreed costs of treatment, loss of income and/or salary or other earnings due to temporary inability to work, compensation for costs of transport-related to the treatment, as well as other kinds of financial compensations in relation with exercising the rights from Voluntary Health Insurance Agreement;
16. **Healthcare services** - services provided at the healthcare service provider in accordance with the law regulating healthcare protection, which cover the measures of prevention and early detection of diseases, examinations and treatment in case of illness and injury or in relation to family planning, medical rehabilitation, including the methods and procedures, alternative and

complementary, i.e. traditional medicine, which are safe, of good quality and efficient;

17. **Healthcare institution** - is a legal person who engages in healthcare activities and who has a permit issued by the Ministry in charge of healthcare activities (hereinafter: the Ministry) for the performance of healthcare activities in accordance with the law regulating health protection and the regulations adopted for the implementation of the said law;
18. **Healthcare service provider** – a common name for the healthcare institutions, private practices and other healthcare service providers, who got a permit from the Ministry in charge of healthcare activities, to perform certain healthcare activities in accordance with the law regulating health protection and regulations adopted for the implementation of the said law. The healthcare service providers are also legal entities, entrepreneurs and counseling centers registered to provide speech therapy services or consultations with psychologists and psychotherapists, as well as the optician's shops if such services are covered by the insurance policy;
19. **Other healthcare service providers** - other legal or natural persons who conduct certain jobs from health activity, i.e. provide medical and technical aids and who have obtained the permit from the competent authority for the performance of such jobs in accordance with the law;
20. **Private practice** - another form of healthcare services were certain jobs from healthcare domain are conducted and which has obtained the permit from the Ministry for the performance of certain jobs from healthcare activity in accordance with the law governing health protection and the regulations adopted for the implementation of the said law;
21. **Network of healthcare institutions** - are healthcare institutions, private practice and other healthcare service providers, which have a valid contract with the Insurer on the provision of healthcare services during the term of the Insurance Agreement, where the insured person uses the services contracted under the policy and in the manner prescribed by these terms and conditions;
22. **Previous health condition** - implies any health condition that is a consequence of any congenital, chronic or reoccurring disease or injury occurring before the effective date of the Insurance Agreement, i.e. before the first inclusion in the insurance, of which the Insured was aware at the moment of conclusion of the Insurance agreement. A previous health condition shall, in particular, include chronic disease, injury, illness or condition for which it may be expected to last for a longer period of time without a reasonably foreseen date of cessation and which may be characterized by remissions that require constant or occasional care and treatment, as required;
23. **Accident -** is any sudden event independent from the will of the Insured which, acting predominantly from the outside and abruptly on the body of the Insured, results in the impairment of his/her health requiring medical attention;
24. **Waiting period** (hereinafter: Waiting period) - is a contracted period of time at the commencement of the insurance term, during which the Policyholder is under the obligation to pay the insurance premium, and the Insurer is not under the obligation to pay the insurance claim regardless of the occurrence of the insured event;
25. **Co-payment** – participation in the costs of the contracted medically-justified treatment the Insured must pay, if so agreed under the policy, i.e. foreseen by the Terms and Conditions of Insurance;
26. **Special Terms and Conditions of Voluntary Health Insurance** (hereinafter: the Special Terms and Conditions) - are the terms and conditions of the Insurer that regulate the rights and obligations of the parties regarding a specific type or combination of types of voluntary health insurance, and which constitute an integral part of the Insurance Agreement and must be handed over to the Policyholder.

TYPES OF INSURANCE

Article 3

(1) The types of voluntary health insurance offered by the Insurer are the following:
   1. Supplemental health insurance is the insurance that covers the costs of healthcare protection incurred when the Insured supplements the rights from compulsory health insurance in terms of content, scope and standards, in accordance with the General and Special Terms and Conditions of the Insurer;
   2. Supplemental health insurance is the insurance that covers the co-payment of the costs of healthcare protection, i.e. the costs of healthcare services, medicines, medical devices, i.e. pecuniary compensation that are not covered by the rights under compulsory health insurance, in accordance with the General Terms and Conditions of the Insurer;
   3. Private health insurance is the insurance of persons not covered by compulsory health insurance or not included in the compulsory health insurance, to cover the costs of the type, contents, scope and standard of rights that are contracted with the Insurer;
   4. Combination of the previously mentioned types of insurances.

(2) The voluntary health insurance also includes the insurance in case of use of healthcare protection of the Insured during his/her stay abroad, if so contracted.

ACQUIRING THE STATUS OF THE INSURED

Article 4

(1) The voluntary health insurance may be used to insure all the persons who express their clear intention, i.e. for whom the Policyholder expresses its clear intention to conclude an Agreement on Voluntary Health Insurance with the Insurer, regardless of their age, health condition, gender and exposure to risk insured against, in accordance with the law regulating voluntary health insurance, these General Terms and Conditions and Special Terms and Conditions of the Insurer for certain types of voluntary health insurance.

(2) The status of the Insured under the voluntary health insurance may be acquired by any person who is a domestic or foreign citizen, who has a registered place of residence or approval for temporary stay or permanent residence in the Republic of Serbia;

(3) The status of the Insured under voluntary and supplementary health insurance may be acquired by a person who has the status of the Insured person in the compulsory health insurance system in accordance with the law.

(4) For other types of insurance, the status of the person in the compulsory health insurance system is not taken into consideration for the conclusion of an Insurance agreement.

(5) The status of the Insured may also be acquired by the family members of the Insured, in accordance with the Special Terms and Conditions, under the condition that

voluntary health insurance has been contracted for them and if the agree premium has been paid for them.

CONCLUSION OF THE INSURANCE AGREEMENT

Article 5

(1) A Voluntary Health Insurance Agreement is concluded based on a prior offer given by the Insurer to the person wishing to conclude a Voluntary Health Insurance Agreement.

(2) If the Policyholder and the Insured under the voluntary health insurance are not the same person, the written consent of the Insured is required for contracting voluntary health insurance, if the payment of the premium is borne by the insured under the voluntary health insurance.

(3) The Policyholder shall be obliged to submit a proof of such consent at the request of the Insurer.

(4) If the Insured is a minor, the Insurance agreement is to be signed by a parent or a guardian.

(5) The Special Terms and Conditions of insurance may envisage situations where the contractual obligation related to insurance is created with the payment of the premium.

OFFER

Article 6

(1) The offer contains all the essential information about the parties, i.e. the persons insured under the voluntary health insurance, the insurance commencement date, waiting period, insurance end date, amount and deadlines for insurance premium payment, maximum agreed sums for insured risks and other elements of importance for conclusion of the insurance agreement.

(2) The essential information about the parties, i.e. the insured persons under the voluntary health insurance referred to in paragraph 1 of this Article include the following:

1) for a natural person:
   1. name and surname, and date of birth of the Insured under the voluntary health insurance,
   2. Unique citizen number, i.e. the identification number for foreign citizens,
   3. address of residence, i.e. domicile in the Republic of Serbia (street and number, city and municipality),
   4. contact data (phone number or e-mail address);
2) for a legal person:
   1. name, i.e. business name,
   2. TIN and registration number,
   3. registered address (street and number, city and municipality),
   4. contact data (phone number or e-mail address).

(3) In the case of collective insurance, the Policyholder may submit a single offer containing the data on each individual person to be covered by collective insurance, which contains the data on each individual person covered by collective insurance, as follows:

1) name and surname, and date of birth of the Insured under the voluntary health insurance;
2) Unique citizen number, i.e. the identification number for foreign citizens;
3) address of residence, i.e. domicile in the Republic of Serbia (street and number, city and municipality);
4) contact data (phone number or e-mail address).

(4) The offer also contains other essential information, such as the information about the previous health condition of the Insured needed by the Insurer to assess the insurance risk.

(5) During the conclusion of the Insurance agreement, the Policyholder, i.e. the Insured shall be obliged to report to the Insurer all the circumstances of significance for the risk assessment and known to the Insured, i.e. which could not have remained unknown.

(6) During the contracting procedure, the Insured shall be obliged to fill in a Health condition questionnaire (hereinafter: the Questionnaire) at the request of the Insurer, which is an integral part of the offer, or to undergo a medical examination, as well as to submit the medical reports and other necessary documents with the aim of assessing the risk, except in the event of collective insurance when the Questionnaire is not obligatory.

(7) The costs of the medical examination in the sense of the previous paragraph of this Article shall be borne by the Insured.

(8) The data from the Questionnaire cannot be used as a reason for the rejection of admission into voluntary health insurance.

(9) If in the period from the submission of the offer to the conclusion of the Insurance agreement there is an increase in the risk to the health of the Insured for individual health insurance, the Insured shall be obliged to inform the Insurer immediately after learning this fact.
The increased dangers to the health of the Insured shall include all the diseases, i.e. illnesses, changes of occupation, injuries of the Insured, playing sports or traveling to critical areas, tropical regions or participating in expeditions, as well as other changes that increase the danger to the health of the Insured.

(10) The offer for the conclusion of the Insurance agreement is binding for the Insurer for 8 (eight) days from the date of receipt of the offer by the Insurer, unless a shorter period is agreed, and for 30 (thirty) days if a medical examination is required.

(11) Depending on the Insured's risk assessment, the Insurer is entitled to the right to offer amended insurance terms and conditions, i.e. to increase the premium or amend the amount or scope of coverage.

(12) Should the offeror fail to accept the amended terms and conditions in cases defined in the previous paragraph of this Article within 8 days from the date of receipt of the registered letter containing the insurance offer with amended terms of the Insurer, upon the expiry of this period the Agreement is to be deemed terminated, i.e. it shall be interpreted that the offeror has abandoned the insurance offer.

POLICY, COVERED RISKS AND DOCUMENTS

Article 7

(1) The Insurer issues a policy as proof of Insurance agreement conclusion; the policy is drafted in two counterparts, one for the Policyholder, i.e. the Insured, and the other for the Insurer.
In the event the Agreement has been concluded based on the payment of the insurance premium, the Insurer shall submit a confirmation.

(2) Exceptionally to the provisions of the previous paragraph of this Article, the Insurer may issue a cover note.

(3) In case of a Collective Insurance Agreement, the Insurer shall issue one insurance policy that covers all the persons found in the list prepared by the Policyholder, i.e. in the excerpt from HR records, which represents an integral part of the Insurance agreement, i.e. the insurance policy.

(4) In the event that the Insurance agreement is also concluded for family members of the Insured, the Insurer may issue one insurance policy that includes the members of his/her family who are covered by insurance, where the Policyholder is the person who is insured under a collective policy.

(5) The policy, i.e. the cover note, contains the following:

1) name and surname of the Insured covered by the voluntary health insurance or the Policyholder, i.e. the name of the Policyholder;
2) date of birth of the Insured covered by the voluntary health insurance insurance;

3) place of residence, i.e. domicile and the residential address of the Insured covered by the voluntary health insurance or the Policyholder, i.e. the registered address of the Policyholder;
4) Unique citizen number, i.e. the identification number for foreign citizens, or TIN and registration number of the Policyholder;
5) name and address of the Insurer;
6) insurance coverage;
7) sum insured and the insurance risk;
8) the amount of premium, the premium payment manner and terms;
9) reference to the tariff based on which the premium was calculated;
10) policy, i.e. cover note number;
11) number of the offer to conclude a Voluntary Health Insurance Agreement;
12) date of insurance commencement, waiting period and validity period of the insurance, i.e. policy or cover note;
13) signature of the authorized person of the Insurer;
14) signature of the Insured under the voluntary health insurance;
15) place and date of issuing of the policy, i.e. the cover note;
16) other information in accordance with the law.

(6) The General and Special Terms and Conditions of Voluntary Health Insurance represent an integral part of the Voluntary Health Insurance Agreement.

(7) Based on the insurance policy, the Insurer shall be obliged to issue a document to each individual Insured, as at the date of issuing of the policy but no later than within 60 days, containing the following data:
1) business name of the Insurer;
2) name and surname, and date of birth of the Insured under the voluntary health insurance;
3) Unique citizen number of the Insured under the voluntary health insurance, i.e. registration number for foreign citizens;
4) amount of coverage;
5) policy number;
6) validity of the document.

(8) The purpose of this document is for the Insured to prove the status of the Insured and to exercise his/her rights under voluntary health insurance, which may exceptionally be done based on the policy or cover note in the following cases:
- until the issuing of the document
- when the rights under the voluntary health insurance are exercised directly with the Insurer
- when the Insurance agreement is concluded for a period of 90 days or less

(9) The document is valid if presented together with a personal identification document.

(10) The Insured shall be obliged to inform the Insurer in writing and without delay about the loss, theft or damaging of the document, in which case the Insurer shall be obliged to issue a copy of the document.

TERM OF THE INSURANCE AGREEMENT

Article 8

(1) The Insurance Agreement cannot be concluded for a period shorter than 12 months.

(2) Notwithstanding paragraph 1 of this Article, the voluntary health insurance may last shorter, as follows:
1. during the stay of the Insured abroad, i.e. to cover the costs of healthcare provided abroad;
2. in the case when the capacity of the Insured in the system of compulsory health insurance lasts for a shorter period in accordance with the law;
3. during a temporary stay of the Insured, who is a foreign citizen or a stateless person, in the Republic of Serbia;
4. for persons who have acquired the basis for insurance under collective agreements during the agreed insurance period;
5. if the issuance of the insurance policy is preceded by the conclusion of the list of coverage.

(3) The insurance coverage begins upon the expiration of 24:00th hour on the day stated in the policy as the commencement of insurance, if the Policyholder has paid the premium by then, but not before the expiration of 24:00th hour on the day when the premium was paid, i.e. the first installment of the premium.

(4) The insurance coverage ceases to be effective upon the expiry of 24:00th hour on the day specified in the insurance policy as the insurance end date.

(5) If the waiting period is agreed, the Insurer's obligation shall begin on the twenty-fourth hour of the day which is specified as the expiration date of the waiting period, provided that the insurance premium has been paid.

(6) The insurance coverage also ceases before the contracted deadline in the following cases:
1. death of Insured – on the day of death;
2. exclusion of the Insured from insurance by the Policyholder in case of collective insurance;
3. termination of the Agreement in accordance with Article 14 of the General Terms and Conditions.

(7) In any case, the termination of the insurance coverage for the Insured results in the termination of insurance for the members of his/her family, regardless of the reason for the loss of the status of the Insured person.

WAITING PERIOD

Article 9

(1) The Insurance agreement may also regulate the waiting period, i.e. the period during which the Insurer is under no obligation to pay the insurance claim in case of the insured event.

(2) The waiting period is calculated from the commencement of insurance specified in the policy, under the condition that the first agreed matured premium has been paid on such date.

(3) If the matured premium has not been paid until the commencement of insurance, the waiting period is calculated from the expiry of 24:00 hour on the day when the first agreed premium is paid.

(4) The waiting period shall not apply to Agreement renewal, unless the Insurance agreement provides otherwise.
The provisions of this paragraph shall apply only to the Insured who have acquired the status of the Insured under the prior policy, i.e. the Insurance agreement, i.e. for which the waiting period has already expired
during the term of the previous policy. If the waiting period has not expired fully during the term of the previous policy, the remaining period until the total waiting period shall be transferred to the following insurance period under the new policy.

(5) The Insured may stipulate a waiting period for certain insurance coverage, in accordance with the Special Terms and Conditions.

PREMIUM AND CONSEQUENCES OF FAILURE TO PAY THE PREMIUM

Article 10

(1) The insurance agreement, i.e. the insurance policy stipulate the amount and mode of payment of the insurance premium.

(2) The amount of insurance premium is determined by the Insurer in accordance with the premium tariff and the regulations that regulate the voluntary health insurance.

(3) The Insurer cannot increase the amount of insurance premium during the term of Voluntary Health Insurance Agreement.

(4) Exceptionally from paragraph (3) of this Article, the insurance premium may change in the following cases:

1. in case of Agreements concluded for a period of several years, after the expiry of a 12-month period from the date of concluding the Insurance agreement, i.e. every 12 months until the expiry of the term of the Insurance agreement;
2. in the event that, when concluding the Agreement on voluntary health insurance, the Policyholder withheld circumstances of significance for the risk assessment.

(5) The Policyholder shall be obliged to pay the insurance premium to the Insurer in due time, upon maturity and within the deadlines stipulated by the Insurance agreement, i.e. the policy.

(6) If it is agreed that the annual premium is paid in semi-annual, quarterly or monthly instalments, the Insurer shall be entitled to an insurance premium for the entire year of the insurance.
Exceptionally, in case of termination of insurance due to the death of the Insured, the Insurer is entitled to the premium until the date of Insured's death.

(7) The Insurer is entitled to the right to calculate a legal default interest to the Policyholder for each day of exceeding the deadline for payment of the matured insurance premium.

(8) The first agreed insurance premium i.e. the first premium instalment shall be payable until the day of the insurance agreement commencement.
Each subsequent instalment of the insurance premium becomes due on the last day of the current period of insurance premium payment, for the following period.

(9) The payment of the premium instalments in arrears always relates to the first unpaid premium instalment.

(10) It shall be deemed that the insurance premium is paid on the day when the payment is registered in the Insurer's account.

(11) The Insurer shall be obliged to accept the paid insurance premium from any person who has legal interest that the insurance premium is paid.

(12) If the Policyholder fails to pay the agreed premium, i.e. the premium instalment which became due, the obligation of the Insurer concerning the compensation of costs, i.e. a part of the costs of provision of healthcare services covered by the insurance agreement, i.e. the policy shall cease to be effective upon the expiry of 30 days from the day when the Policyholder received the written notice on matured and unpaid premiums.

(13) After the expiry of the deadline set forth in paragraph (10) of this Article, the Insurer may terminate the Insurance agreement without a notice period and may initiate a procedure before the competent court to collect the premiums that became due, together with the accrued interest.

RIGHTS AND OBLIGATIONS OF THE INSURER

Article 11

(1) The Insurer shall ensure the same scope, content and standard of rights and obligations for all Insured persons under the voluntary health insurance within a specific type of voluntary health insurance the Insurer organizes and implements.

(2) The Insurer shall be obliged to ensure the exercise of the Insured's rights under the Voluntary Health Insurance Agreement, as well as the exercise of the rights under these General Terms and Conditions, the Special Terms and Conditions and the Insurance agreement.

(3) According to the Insurance agreement, i.e. the policy, these General Terms and Conditions and Special Terms and Conditions, the Insurer shall be obliged to compensate the Insured/ healthcare service provider for the expenses or part of the expenses incurred by exercising the rights from the voluntary health insurance, within 14 days from the day when complete documentation has been received on the grounds of which the existence and scope of obligation can be determined beyond dispute.

(4) The Insurer shall be obliged to notify the Policyholder about the changes of the general or special terms and conditions of voluntary health insurance within the deadline from paragraph 3 of this Article, and to provide an explanation, unless the conditions are more favourable for the Policyholder.

(5) The Insurer shall be obliged to provide the Policyholder, i.e. the Insured, in a timely manner, with all the information, as well as the necessary documents, i.e. excerpts from the documents kept by the Insurer, which relate to the implementation of voluntary health insurance, and which are important for exercising the rights under the Agreement, as well as the information with which the Insured may exercise his/her rights from voluntary health insurance before the health care providers, except for information that is a business secret. This information is given to the Insured free of charge.

(6) The sum insured specified in the policy is the upper limit of Insurer's obligation under the Insurance agreement.

(7) The Insurer is entitled to request from the Insured, the Policyholder or any other legal or natural person to provide additional explanation or additional documents in order to establish important circumstances relevant for the reported insured event.

(8) The Insurer is entitled to refer the Insured to a control medical examination or additional medical evaluation, by which necessary circumstances relevant for the reported insured event would be established. The costs of such examination are borne by the Insurer.

(9) At the moment of renewal of the insurance, the Insurer is entitled to the right, based on the history of claims or additional information obtained from the Insured, to propose a renewal of the Insurance agreement with the change of premium or limitation of Insurer's obligations, regardless of the continuous insurance.

(10) In case of increase of the amount of insurance premium, in accordance with this Law and these Terms and Conditions, the Insurer shall be obliged to notify the Policyholder in writing about the increase of the amount of premium at least 30 days prior to the expiry of the current insurance year, and to provide an explanation.

EXCLUSION OF THE OBLIGATIONS OF THE INSURER

Article 12

(1) The obligations of the Insurer are excluded in the following cases:
1. If the Insured gave incorrect and untrue data, i.e. has withheld important circumstances of significance for the conclusion of the insurance agreement;
2. If neither the Policyholder i.e. the Insured have paid the matured insurance premium until the agreed deadline nor some other person who has a legal interest for the premium to be paid does it instead;
3. In the case of insurance policy, i.e. document abuse;
4. If the scope of agreed health services and expenses has been exceeded;
5. If the insurance claim is based on false data and false documents;
6. In other cases, in accordance with the Special terms and conditions of the Insurer

(2) The Insurer shall not be obliged to reimburse the costs incurred as a consequence of:
1. intentional actions or gross negligence of the Insured;
2. natural disaster or Act of God (earthquake, flood, storm, landslide, etc.);
3. large-scale epidemic and pandemic which implies the occurrence of more severe forms of infectious diseases, even resulting in death, unless agreed otherwise;
4. if the insured event has occurred as a consequence of technical-technological disaster that may jeopardize life and health of a large number of people on a large-scale (accidents in power, oil and gas plants,
accidents while handling radioactive and nuclear

materials, severe soil, water and air pollution and alike);

5. War or armed actions other than the participation of the Insured person in such actions by occupation or drafting by the competent government authorities;
6. events that can be directly attributed to invasion, armed conflict, civil war, uprising, terrorism, rebellion or revolution, vandalism, physical altercation (except for proven self-defence) or criminal act;
7. Suicide in attempt or suicide, intentional self-inflicted injuries or mental illness (incompetence) of the Insured for any reason;
8. Intentional initiation of the insured event by the Policyholder, the Insured or the beneficiary;
9. the Insured has deliberately exposed himself/herself to life-threatening danger (except in the attempt to save someone's life, but not for participation in search parties);
10. Injury or illness occurring as a result of alcohol consumption (blood alcohol level over 0.3‰ , i.e. 6.48 mmol/l) or substance abuse (alcohol, drugs, medicines etc.);
11. Preparation, attempt or execution of a premeditated criminal act, and escape after such act;
12. Engaging in risky sports and activities (professionally, amateur or recreational), such as: hunting, kart racing, acrobatics (rollerblading, skiing, etc.), parkour, street board, mountaineering, pyrotechnics, ammunition and explosives handling, ski jumping, bobsledding, acrobatic skiing, automobile, aviation, motorcycle and nautical races, as well as other speed competitions, parachuting, kite flying, paragliding, bungee jumping, rafting, inline skating and similar activities that carry an increased risk of endangering life and health, especially those performed with mandatory protective or special equipment.

RIGHTS AND OBLIGATIONS OF THE POLICYHOLDER AND THE INSURED

Article 13

(1) The rights under the Insurance agreement are exercised by the Insured based on the insurance document (or policy), which must be shown to the healthcare service provider in the event of insurance covering the compensation of treatment costs.

(2) The right to the compensation of treatment costs or other financial compensation is exercised by the Insured in accordance with the conditions of the Insurance agreement valid as at the date of occurrence of the insured event.

(3) The Insured shall be obliged:

1. to show the ID document and document to the authorised person of the service provider at the institution from the Network prior to the use of the services;
2. to notify the Insurer about the loss of the document at shortest possible notice;
3. not to lend the document to other persons and to always provide truthful information while exercising the insurance rights and to always act in accordance with the law;
4. to return the document to the Insurer in case of loss of the status of the Insured person prior to the expiry of the Insurance agreement in case of collective insurance.

(4) The Insured (or if the Insured is a minor, his/her parent) is under the obligation to be familiar with the coverages contracted for him/her and not to accept a service at the expense of the insurance if such service is not covered by the policy.

(5) The Policyholder shall be obliged to pay the insurance premium regularly by maturity date.

(6) If the Policyholder and the Insured are not the same person, the Policyholder shall be obliged to fully inform the Insured about the insurance conditions, i.e. to inform the Insured about the rights to compensation arising from the contracted voluntary health insurance.

(7) The Policyholder, i.e. the Insured shall be obliged to provide the Insurer with all the documents necessary for the establishment of the grounds, scope and amount of Insurer's obligation.

(8) The Insurer shall be obliged to undergo a medical examination at the request and expense of the Insurer, in order to determine the necessary facts in relation to the reported insured event.

(9) The Insured shall be obliged to authorize the physicians and healthcare service providers to provide all the necessary information regarding his/her treatment, as well as all the necessary information regarding his/her previous health condition in connection with the insured event that has occurred.

(10) The Policyholder, i.e. the Insured, shall be obliged to inform the Insurer as soon as possible about all the changes in the data concerning the insured persons, such as the change of residential address, change of surname, occupation, marital status, termination of employment, etc.

(11) The rights under the Insurance agreement cannot be inherited or transferred to other persons.
The financial compensations that have matured for collection, which have remained unpaid due to the death of the Insured, may be inherited in accordance with the law.

TERMINATION AND CANCELLATION OF THE INSURANCE AGREEMENT

Article 14

(1) The Insurer cannot terminate the Insurance agreement prior to the expiry of the term of contract, except in following situations:

1. if the Policyholder, i.e. the Insured has filed an incorrect application or withheld any circumstances of such nature that Insurer would not have concluded the Agreement under the same conditions if the real state of affairs had been known;
2. failure to pay the agreed insurance premium;
3. the Insured covered by voluntary health insurance is no longer an insured under the compulsory health insurance during the term of contract on supplementary, i.e. additional voluntary health insurance;
4. in other cases provided by the Special Terms and Conditions and the Law.

(2) In case of termination of the Agreement referred to in paragraph (1), item 1 of this Article, the Insurer is entitled to the full amount of matured premium.

(3) The Policyholder may not terminate the policy unilaterally, except in cases defined by the law.

(4) Each contracting party may cancel an Insurance agreement with an indefinite duration, unless the Agreement has terminated on some other basis.

(5) The cancellation is made in writing, no later than three months before the end of the current year of insurance.

(6) If the insurance is concluded for a period longer than five years, either party may terminate the contract upon the expiry of this period, with a six-month notice period, by sending a written termination notice to the other party.

INSURED'S COMPLAINT

Article 15

(1) An Insured who believes that his/her rights under the insurance agreement have been violated by the decision of the Insurer regarding a claim, may submit a complaint to the Insurer within 30 (thirty) days from the date of receipt of the Insurer's decision.

(2) The Insurer shall be obliged to make a decision on the complaint and notify the Insured thereabout within 15 days from the receipt of the Insured's complaint.

DETAILS ABOUT THE INSURED PERSONS

Article 16

(1) By signing the policy, the Policyholder and the Insured authorize the Insurer to collect, verify, process, store, transfer and use the personal data necessary for the conclusion and implementation of the Insurance agreement in accordance with the law governing the protection of personal data.

(2) Insurer shall be obliged to keep the data from paragraph (1) of this Article as a business secret in accordance with the Law.

(3) On the occasion of conclusion of the Insurance agreement, the Insurer shall not seek genetic information, i.e. the results of the genetic testing for the Insured or for his/her relatives, regardless of the line and the degree of kinship.

THE RIGHT TO RECOURSE

Article 17

(1) The rights of the Insured towards the third party shall be transferred to Insurer in the height of the obligation paid by Insurer without obtaining any special consent from the Insured.

(2) In order to exercise the right to recourse, in the sense of the paragraph (1) of this Article, the Insured shall be obliged to provide the Insurer with all the proof sought by the Insurer relating to the insurance claim. Costs of obtaining this evidence shall be borne by the Insurer.

(3) If the Policyholder or the Insured receive compensation from the third party responsible for damage, the Insurer shall be entitled to deduct such amount from the compensation to be paid to the Insured on the grounds of policy.

TRANSITIONAL AND FINAL PROVISIONS

Article 18

(1) The claims under the Insurance agreement shall expire according to the provisions of the Law on Contracts and Torts.

(2) Any issues not regulated by these General Terms and Conditions shall be regulated by the provisions of the Law on Contracts and Torts and other applicable regulations in the Republic of Serbia.

(3) The General Terms and Conditions or Special Terms and Conditions may be amended by applying the same procedure and in the same manner in which they have been passed.

(4) The Insurer shall be obliged to publish the updated general and special terms and conditions at its official website, as well as to make them available in written form at all Insurer's points of sale or in any other adequate manner.

(5) For the ongoing Insurance agreements, until the expiry of insurance year, the General or Special Terms and Conditions shall apply based on which such Agreements have been concluded, except if the conditions were changed due to legislation changes to which Insurer had no influence.

(6) The contracting parties shall resolve all disputable issues amicably; otherwise, they agree to the competence of the court according to the registered address of the Insurer.

Article 19

(1) These General Terms and Conditions come into effect on the eighth day from the date of their publishing on the Company's notice-board and shall apply starting from 15.08.2021.

(2) With the effective date of these General Terms and Conditions, the General Terms and Conditions of insurance for surgical interventions OU-HI-01/19 (ref. no. 02-369) and the General Terms and Conditions of Insurance for serious illnesses OU-TB-01/19 (ref. no. 02-370) shall cease to produce effect, as adopted by the Board of Directors of the Company on 21.02.2020.

Implementation commencement date: 15th August 2021