SAVA OSIGURANJE

PU-DZOVBB-1/21

SPECIAL TERMS AND CONDITIONS OF VOLUNTARY HEALTH INSURANCE FOR OUTPATIENT AND INPATIENT CARE

INTRODUCTORY PROVISIONS

Article 1

(1) These Special Terms and Conditions of Voluntary Health Insurance for Outpatient and Inpatient Care (hereinafter: Special Terms and Conditions) and the General Terms and Conditions of Voluntary Health Insurance (hereinafter: the General Terms and Conditions) represent an integral part of the Agreement on voluntary health insurance concluded between the Policyholder and the insurance provider Sava neživotno osiguranje, a.d.o. Belgrade (hereinafter: the Insurer).

(2) The following terms used in these Special Terms and Conditions shall have the following meanings:

1. **Insurance coverage** - costs of healthcare service provided, medicines and medical devices covered by these Special Terms and Conditions;
2. **New insured** - a person added to the voluntary health insurance during the term of the Insurance agreement;
3. **Limit** - is the maximum amount that represents the obligation of the Insurer for individual medically justified treatment within the contracted insurance coverage for each insured person during the insurance year, which is specified in the policy, i.e. the Insurance agreement, and which is in accordance with these Special Terms and Conditions;
4. **Reasonable and usual costs** - those costs of medical treatment that do not exceed the general level of costs in similar institutions in the Republic of Serbia, when it comes to the same or similar medical treatment - treatment, services or assistance to persons of the same sex and similar age for a similar illness or injury;
5. **Co-payment** - participation of the Insured in the part of the costs of the agreed medically justified treatment. The co-payment is expressed either as a fixed amount or as a percentage of the cost incurred by the use of rights from insurance;
6. **Authorized physician** - a person with a degree in medicine, dentistry or other appropriate faculty, who has a license and is authorized to practice medicine in the Republic of Serbia in accordance with applicable regulations and the legal system;
7. **Medically justified treatment** - health service, medical-technical aid, implant, medical supply or medicine is medically justified if:
   - it is appropriate and necessary for the diagnosis or treatment and control of the Insured's illness or injury, if they correspond to the clinical needs of the Insured in terms of scope, doses and duration and in accordance with the agreed insurance policy,
   - it is necessary for health protection of pregnant women or prevention or early detection of disease during medical examination, if such coverage is contracted,
   - it is contracted in accordance with these Special Terms and Conditions and defined in the insurance policy,
   - it is prescribed by authorised physician
   - in terms of scope, duration and intensity does not exceed the level of protection required to ensure safe, adequate and appropriate treatment according to guidelines to good clinical practice (procedures performed must be related to the symptoms of the disease and their performance must be justified by the current clinical situation),
   - it occurred within the duration of the insurance contract,
   - it complies with the widely-accepted professional standards of the medical practice in the residential country of the Insured,
   - it is not primarily intended for personal comfort of the patient, family, physician or other health service provider,
   - it is neither a part of education or professional training of the patient nor in relation to the same,
   - it is not experimental or in an investigation phase;
8. **Treatment** - medically justified treatment which, according to the generally accepted rules of the medical profession, is considered appropriate for relieving the symptoms of illness or injury, re-establishing health or preventing deterioration of health, and which is contracted under the insurance policy;
9. **Emergency medical condition** is a disease or injury which, without immediate medical assistance, can lead to the danger of the insured person's life, i.e. irreparable and serious damage to his health or death. Emergency medical care also implies the medical care that is provided within 12 hours from the moment of admission of the Insured, in order to avoid the expected occurrence of an emergency medical condition;
10. **Hospital** - a healthcare institution performing stationary healthcare activity, as well as specialist-consulting activity at the secondary and tertiary level of healthcare;
11. **Medicine** - a product that contains a substance or a combination of substances manufactured and intended for treatment or prevention of diseases in people, making a diagnosis, improvement or change of physiological functions, as well as for achievement of other medically justified objectives and which was granted a marketing authorization in accordance with the Law governing the field of medicines;
12. **Medical-technical aids** - medical aids used for functional and aesthetic replacement of the lost parts of the body, i.e. for enabling support, prevention of occurrence of deformities and correction of the existing deformities and facilitation of performance of the basic vital functions;
13. **Implants** - medical devices implanted into a human organism by surgical intervention;
14. **Complementary medicine** - traditional methods and procedures of prevention, diagnostic, treatment and rehabilitation, which have a beneficial effect on human health or health condition and which, in accordance with current medical doctrine, are not covered by methods and procedures of conventional medicine, and which are performed exclusively at health

institutions or private practice established as a general or specialist practice of a doctor of medicine, dentist, polyclinic, healthcare clinic or rehabilitation clinic and provided exclusively by a healthcare worker who is licensed to perform the methods and procedures of alternative and complementary medicine.

15. **Sava Call centre** - the call centre of the Insurer through which the Insured get assistance in the realization of the insurance in the manner foreseen by these Special Terms and Conditions.

INSURANCE CONTRACT

Article 2

(1) In accordance with these Special Terms and Conditions, the Insurer provides additional, supplementary and private health insurance, as well as a combination of the previously mentioned types of insurances in accordance with the law.

(2) Under the Insurance agreement, the Policyholder undertakes to pay the premium to the Insurer, and the Insurer undertakes to reimburse the costs of treatment, i.e. medically justified treatment or pay other financial compensation in accordance with the Insurance agreement.

(3) Pursuant to these Special Terms and Conditions, the following can be contracted:

1. Collective insurance, a group of at least 10 persons, if the Policyholder is a legal person or other person that contracts insurance for its employees, service users, students or other persons with whom it is in a contractual relationship.
   The contracted insurance coverage, with the approval from the Policyholder, may also include the family members of the Insured.
   The integral part of the concluded Insurance contract is a list of the insured persons.
2. The individual insurance, if the Policyholder is a natural person and contracts the insurance only for himself/herself, for himself/herself and for family members or only for the family members, if the Insured is simultaneously insured under another collective insurance policy in accordance with these Special Terms and Conditions.

(4) Reimbursement of medical expenses provided by the Insurer may not exceed the maximum contracted sum insured specified in the policy during the contracted insurance period, i.e. up to the limit defined by these Special Terms and Conditions and the insurance policy for individual treatments within the insurance coverage.

(5) According to these Special Terms and Conditions, the Insurance agreement may cover the costs of treatment and medical services as:

1) basic insurance coverage, with
2) additional insurance coverage.

(6) The insured person is obliged, in accordance with the contracted insurance coverage, to use the contracted medically justified treatments on the territory and in the manner defined by the Insurance agreement.

(7) The insurance coverage is valid for 24 hours a day, on the territory specified in the insurance policy.

QUESTIONNAIRE ON HEALTH CONDITION OF THE INSURED

Article 3

(1) The questionnaire on health condition is mandatory for individual voluntary health insurance.

(2) During the first inclusion into the collective insurance, i.e. the conclusion of the Insurance agreement, the Insurer is entitled to the right to ask the Insured to fill in the questionnaire during the conclusion of the Insurance agreement.
In such a case, the questionnaire represents an integral part of the Agreement.

(3) The Insured is not obliged to fill the questionnaire for insurance renewal or in the event that the policyholder re-concludes the insurance agreement with the same insurance coverage for such person for the following insurance year.

(4) The Insured is under the obligation to give truthful answers to the questions in the questionnaire form and to report any other circumstance known to the Insured which is relevant for risk assessment.

CHANGES IN THE LIST OF INSURED PERSONS DURING THE TERM OF INSURANCE

Article 4

(1) After the effective date of the insurance agreement, a new person may be added to the insurance coverage only if the new person included in the insurance is:

1) in case of collective insurance - in the capacity of a newly-employed person who became a user of the services of the Policyholder, i.e. became a member of the Policyholder, after the commencement of the Insurance agreement, i.e. that such person's contractual working conditions have been changed, if the Insured working for the Policyholder, i.e. the changed contractual conditions for the members of the Policyholder, i.e. changed contractual conditions for the user of services of the Policyholder;
2) in the capacity of a spouse or extramarital partner of the Insured who acquired such capacity after the effective date of the Insurance agreement;
3) in the capacity of a new-born child of the Insured, for a child born after the commencement of the Insurance agreement or a decision on adoption from the Centre for Social Work, as proof that the adopted child acquired this capacity after the commencement of the Insurance agreement.

(2) In cases defined by paragraph (1) of this Article, the Policyholder shall be obliged to report the inclusion of a new person to the Insurer within 30 (thirty) days from the day of such inclusion.

(3) In case of inclusion of a person in the insurance after the commencement of the contracted insurance period, the Insurer is entitled to a proportional part
of the premium from the day of inclusion of such person until the expiration of the contracted insurance period, for basic coverage, while for supplementary coverage the Insurer is entitled to an annual insurance premium, unless otherwise agreed.

(4) Exclusion of a certain insured person from insurance before the expiration of the contracted insurance period is possible in cases defined by the General Terms and Conditions, whereby the Policyholder is obliged to notify the Insurer of the termination of insurance
for a specific insured person within 7 days from the occurrence of such change, and to submit to the Insurer a confirmation that some of the cases defined in Article 14, paragraph (1) of the General Terms and Conditions have occurred, as well as to submit a Voluntary Health Insurance document for such insured person.

(5) In case of exclusion of a person from the insurance before the expiration of the agreed insurance period, the Insurer is entitled to the premium only until the day by which the insurance was in effect for such person, for basic coverage, and in case of supplementary coverage to the full premium, unless otherwise agreed.

(6) In case of misuse of the Voluntary Health Insurance Document which is not returned to the Insurer in a timely manner after the exclusion of a certain insured person from the insurance, the costs incurred due to the insured event shall be borne by the insured, i.e. the Policyholder.

(7) In any case of exclusion or inclusion of a person in the Insurance agreement after the commencement of such agreement, the Insurer reserves the right to request additional documents proving the existence of grounds for termination or commencement of insurance.

PROPOSAL FOR INSURANCE UNDER CHANGED CONDITIONS

Article 5

(1) The Insurer has the right to accept a person for insurance under changed conditions, if it is determined on the basis of the Questionnaire on health condition that there are reasons for which such person represents an increased risk.

(2) If the Insurer, based on the data from the Questionnaire on health condition, determines that the person represents an increased risk for acceptance into insurance, the Insurer may request additional medical examinations and tests for the person concerned to ensure adequate risk assessment.

(3) If the Insurer deems it necessary for the Insured to perform a medical examination in order to assess the acceptance for insurance, the Insured shall be obliged to perform the following medical examinations and analyses at its own expense and to obtain the following:

1. opinion of a general practitioner or internist on the determined general health condition of the person (Insured) with a detailed case history, ECG and spirometry;
2. reports of specialist physicians on examinations by organs and systems with diagnoses (for women - gynaecological examination with breast ultrasound, for men - urological examination);
3. laboratory analyses (complete blood count, sedimentation, cholesterol, triglycerides, liver enzymes, pancreatic enzyme, glucose, bilirubin, urea and creatinine, general urine examination);
4. ophthalmologic examination report (fundus and intraocular pressure);
5. abdominal ultrasound.

(4) The Insurer also has the right to expand the content of the necessary medical examination, according to the assessment of the Insurer's physician.

(5) In the event that after having received the offer the Insurer requires additional data in accordance with paragraphs 2 and 3 of this Article, namely, if a medical examination has to be carried out, the offer shall be deemed as received when the Insurer receives the additional data i.e. the required medical reports upon performed medical examination.

(6) If the offeror, at the written request of the Insurer, fails to submit the requested data within 8 (eight) days, counting from the day of receipt of the written request of the Insurer for the submission of the requested data, or within 30 (thirty) days in case of the request for medical examination, it shall be deemed that the offeror has withdrew his offer.

(7) The standard risk is a person who at the time of submitting the Questionnaire and/or medical examination does not have any subjective physical or psychological problems (diseases) or has a disease with insignificant risk in the opinion of the Insurer, or diseases that do not involve recurrence or consequential diseases.

(8) The increased risk is a person who does not have major subjective physical or psychological problems and performs all life and work activities with occasional or regular treatment, or a person who has one or more previous diseases that have been diagnosed and which required outpatient or inpatient treatment, or therapy before the commencement of the insurance.

(9) The degree of increased risk in accordance with paragraph (2) of this Article shall be determined by the censor and/or the risk taker of the Insurer on the basis of data from the Questionnaire and/or the results of the medical examination.

(10) If the Insurer determines that a person represents an increased risk, the Insurer shall, within eight (8) days of receiving the Questionnaire and/or the performed medical examination, send to the Policyholder a written offer for insurance with changed conditions and inform the Insured at the same time.

(11) If the risk assessment procedure shows that the person in question represents an increased risk, the Insurer may propose insurance with changed conditions to the Policyholder, as follows:
- limitation, i.e. exclusion of certain insurance coverages;
- increase of insurance premium;
- implementation of specific waiting times.

(12) If the Policyholder does not accept the proposed change of conditions in writing within fourteen (14) days from the receipt of the Insurer's proposal, it shall be deemed that the Policyholder has given up on the insurance for the person that poses an increased risk.

(13) The Insurer may propose insurance under the changed conditions even after the conclusion of the agreement, if the Insured has at the moment
of conclusion of the Insurance agreement suffered from an illness that was not reported when submitting the offer, in one of the following ways:

a) after a medical or other examination, or when using the services covered by the contract of voluntary health insurance,
b) based on communication with the SAVA Call centre and subsequently submitted medical documents.

(14) If the Insured does not accept the changed offer, the Insurer has the right to unilaterally terminate the insurance agreement.

(15) In case of termination of the Contract from the previous paragraph of this Article, the Insurer shall be entitled to the entire amount of the due premium.

SUM INSURED

Article 6

(1) The contracted sum insured is expressed in euros, and represents the maximum amount up to which the Insurer is obliged to reimburse the costs covered by the insurance, which are incurred in connection with the health services provided to the Insured.

(2) The contracted sum insured, i.e. any limitations (limits) of individual insurance coverages, is specified in the Insurance Policy.

(3) The sum insured and limits are reduced during the term of insurance by any amount paid as compensation for incurred costs for any insured person per actual risk.

(4) The reduction from the previous paragraph is realized by deducting the paid compensation (in RSD) from the available sum insured and the limit, converted into EUR according to the median exchange rate of the National Bank of Serbia on the day of claim calculation.

(5) The amount of the contracted sum insured and the limit can be changed only during the renewal of the insurance.

WAITING PERIOD

Article 7

(1) The waiting period is agreed in the insurance policy.

(2) The waiting period is calculated from the agreed insurance commencement date for each insured person.

(3) The waiting period does not apply to persons insured under continuous insurance.

(4) In any case, if the waiting period for the Insured has not expired during the term of the previous policy, the remaining waiting period shall be transferred to the following insurance period under the new policy.

(5) In the event that after the expiration of the policy, a policy is concluded with a new coverage to which the waiting period applies, for the services

used under the new coverage, a waiting period commences from the date of commencement of insurance for the Insured under the new policy.

All medically justified treatments done after the expiry of the waiting period in connection with the treatment of diseases diagnosed during the waiting period are covered by insurance in accordance with these Special Terms and Conditions.

INSURED EVENT

Article 8

(1) The insured event represents a future uncertain event in which the Insured has undergone a medically justified treatment due to a health disorder (illness or injury), which is the subject of the Insurance agreement and the costs of which need to be compensated to the healthcare institution, private practice, other healthcare service provider or the insured, depending on the contracted insurance coverage under the policy.

(2) The health condition deterioration in the sense of paragraph (1) of this Article must be determined by an authorized physician.

(3) Provided that the insured event occurs in view of these Special Terms and Conditions, the Insurer shall be obliged to compensate the reasonable and common expenses up to the agreed amount of coverage, which occur during the term of the insurance agreement.

(4) Only if a premium has been separately agreed and paid, the insured event also includes the costs of medically justified treatment, i.e. the treatment for supplementary insurance coverage that can be contracted as coverage of costs of:
   1) Hospital treatment;
   2) Health protection of pregnant women and new-borns;
   3) medical examination;
   4) Ophthalmology services;
   5) dental services;
   6) prescription medicines and orders;
   7) physical and speech therapy;
   8) complementary medicine;
   9) special coverage in case of tumours;
   10) second medical opinion.

(5) The insured event begins with the beginning of the medical treatment or therapy, and ends when, from the medical standpoint, there is no longer the need for treatment because the patient was cured or his/her health was stabilized so that the further health improvements or deteriorations are not to be expected.

(6) The insured event in any case ends with the day of expiration of the Insurance agreement.

REIMBURSEMENT OF TREATMENT COSTS

Article 9

(1) When an insured event occurs, the Insurer shall reimburse reasonable and usual costs incurred in connection with the treatment of the Insured, to the healthcare service provider, up to the amount of the sum insured specified in the policy, i.e. for certain healthcare services up to the limit for such service, as specified in the Insurance agreement, i.e. the policy.

(2) All the costs relating to the treatment or medical services, which exceed the amount of the sum insured, i.e. exceed the available amount of the set limits, shall be borne solely by the Insured.

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

(4) Treatment or medical treatment shall include any medical or surgical procedure which, according to the generally recognized rules of the medical profession, is considered appropriate for relieving the symptoms of the disease, improving health or prevention of deterioration, i.e. for the treatment of the disease in order to restore health, i.e. cure the disease.

(5) Treatment or medical treatment may be provided as inpatient and/or outpatient treatment.

CO-PAYMENT

Article 10

(1) The contract on voluntary health insurance can be contracted with the general co-payment, which implies the participation of the Insured in each medically justified treatment, for basic and supplementary coverage if they are contracted.

(2) If a mandatory co-payment has been agreed for certain coverages or health services and/or health institutions, such co-payment is also specified in the insurance policy.

(3) If two or more co-payments are applied to a certain service, each subsequent one is added.

(4) If the Insured uses a service whose price is higher than reasonable and common costs, the Insurer shall reimburse the amount of reasonable and common costs less the amount of co-payment.

AUTHORIZATION

Article 11

(1) The authorization of medical treatment implies the procedure of approving the costs of health services before their use, for the cases referred to in paragraphs (2) and (3) of this Article, except in the case of emergency medical care.

(2) The request for authorization shall be submitted on the Insurer's form by the Insured or the healthcare institution at least 14 days earlier in the following cases:
   1) non-urgent hospital treatment,
   2) non-urgent surgery,
   3) for all medical treatments exceeding EUR 300,
   4) for childbirth,
   5) for prenatal diagnostics,
   6) for procurement of permanent medical-technical aids.

(3) The policy may also define other cases for which authorization is necessary.

(4) The authorization may be requested by the Insured or an authorized person of the healthcare provider in which the medically justified treatment will be performed, whereby the Insured must be acquainted with the request for authorization and the response of the Insurer to such request.

(5) Along with the request for authorization, all the relevant documents are to be submitted to the Insurer (medical documents, proforma invoices and all other documents that the Insurer additionally requests).

(6) The written approval of the Insurer should specify whether the proposed medically justified treatment is in accordance with the conditions and with the contracted coverage or if it is an exclusion in such specific case.

(7) In case of non-compliance with the provisions of this Article, the Insurer has the right to reduce the insurance indemnity and limit its obligation to reasonable and common costs.

(8) The services relating to an emergency medical conditions when the life of the Insured is endangered are not subject to authorization.

INSURANCE COVERAGE (RISKS COVERED BY THE INSURANCE)

Article 12

(1) The insurance policy is used to contract the basic package of coverage for outpatient treatment, as defined by Article 13 of these Special Terms and Conditions, where the following supplementary coverage may be contracted:
1. inpatient treatment,
2. Health protection of pregnant women and new-borns,
3. medical examination,
4. Ophthalmology services,
5. dental services,
6. prescription medicines and orders,
7. physical and speech therapy,
8. complementary medicine services;
9. special coverage in case of tumours;
10. second medical opinion.

(2) The selected insurance coverage (coverage package) is determined by the agreement between the Insurer and the Policyholder.

(3) The agreed package of insurance coverage with a precisely determined scope and content of healthcare services (Coverage table) represents an integral part of the insurance policy.

(4) At the request of the Policyholder, the Insurer may agree to provide a choice of the scope of health services, specified exclusions of the Insurer's obligations, as well as the amount of the limit.

OUTPATIENT TREATMENT

Article 13

(1) The outpatient treatment includes the costs of medical treatment, i.e. the treatment that the Insured received at the health institution as a provider of health services, which is officially recognized as a place where such treatment can be carried out.
In outpatient treatment, the medical services must include scientifically recognized methods that have been clinically tested and accepted in the Republic of Serbia, and the insured person must not spend more than 24 hours at the institution (stayed overnight, i.e. occupied a hospital bed).

(2) As part of outpatient treatment, the following coverage can be contracted, i.e. the following health services:

1) **Examinations and diagnostics**

Examinations – examinations by general practitioners and physicians of all specialties except examinations by neuropsychiatrists, psychiatrists and specialists in physical medicine, unless otherwise agreed. The examinations include the first and control examinations.
The examinations by professors can be covered only if they are specially contracted in case of more serious damage to health, i.e. disease which has resulted in complications.

Diagnostics - includes the following diagnostic procedures, if they are contracted in accordance with the Insurance agreement and solely at the recommendation of an authorized physician (given during the insurance period, i.e. during the previous continuous insurance policy) in accordance with the medical indications and diagnosis:

1. **Laboratory** - haematological, biochemical, hormonal examinations, tumour markers, serological and microbiological diagnostics, including molecular diagnostics (PCR microbiology) and pathohistology, panels of inhalation, nutritional and other allergens.
The coverage for laboratory diagnostics does not include the following:
   - genetic testing (cytogenetics, molecular genetics) and
   - food intolerance test.
2. **Radiology examinations** - Ultrasound and colour Doppler diagnostics, X-ray diagnostics (with and without contrast);
3. **Diagnostic endoscopic procedures** (gastroscopy and colonoscopy), one procedure each during the insurance year, except:
   - transoesophageal heart ultrasound (endoscopic-ultrasound diagnostics)
   - bronchoscopy and arthroscopy;
4. **Biopsies and punctures, HP analyses** for the material obtained in diagnostic procedures, but not for material obtained during surgery for which there is no coverage; the immunohistochemical analysis of pathohistological findings obtained during surgery for which there is no coverage is also excluded;
5. **Ergometry;**
6. **Spirometry;**
7. **Tympanometry audiometry and vestibulometry;**
8. **EEG, EMNG, EMG, ECG, Holter ECG and Holter TA;**
9. **Nuclear diagnostics** (scintigraphy, micturition scintigraphy, myocardial SPECT);
10. **MR and CT** (magnetic resonance imaging and computed tomography - scanner) with and without contrast, except: MR or CT coronary angiography and MR and CT enterography; One procedure can be contracted during the insurance year;

2) **Examinations and diagnostic procedures, laboratory tests, tests and analyses necessary for the examination of the reproductive system** (sterility, infertility and preparation for pregnancy) at the recommendation of an authorized physician;

3) **Outpatient interventions** - primary wound treatment (wound rinsing, wound edge treatment and wound suturing), primary burn treatment, removal of sutures with dressing, removal of ticks and other foreign bodies from the skin, ear, throat and nose, fixation and
immobilization of the joint, as well as the treatment of the mucous membranes and natural cavities, placement of tamponade with the medicine, incision of the abscess, therapeutic puncture of the joint and connective tissue, orthopaedic reposition of luxations and fractures without anaesthesia at the recommendation of an authorized physician;

4) **Ambulance transport** includes the transport by an ambulance due to illness or injury that is dangerous for the life of the Insured, to the nearest health institution, as well as ambulance transport that is justified and medically necessary and ordered by a physician of the appropriate specialty with the approval of the Insurer;

5) **Prescribed therapy in outpatient conditions** at the recommendation of the
authorised physician implies the compensation for the work of the authorised physician and qualified medical technician, the costs of use of medical, i.e. technical equipment,
costs of prescribing medicines and radiological material and other material costs of implementing the following types of therapies: medication (registered medicines according to the National Drug Register), injection, inhalation and
infusion (infusion or inhalation solution are also covered);

6) **Domiciliary care in urgent cases** represents a home visit by an authorized physician and the application of drug therapy in emergency medical situations with the obligatory prior authorization granted by the Insurer.

7) **Radiotherapy and chemotherapy in outpatient conditions;**

8) **Examinations and diagnostic procedures, and laboratory tests, in relation to the problems arising due to**

Covid-19 infection during the period of not more than 6 months after the diagnosis;

9) **Mental health** depending on the contracted package may include the following services:
   1. Examinations by psychiatrist/neuropsychiatrist and psychologist in crisis situations.
      The crisis situations are the conditions caused by:
      - Physical abuse
      - Rape
      - Death of a close family member
      - Coping with a serious illness - malignancy;
      - Postpartum depression
      - Divorce procedure
      - Termination of employment
      - Recovery from Covid.
   2. Examinations by paediatric psychiatrist/neuropsychiatrist and medical associates - psychologists and defectologist, including psychology and defectology treatments.
10) **Urgent dentistry** due to an accident includes the dental interventions for the restoration or replacement of healthy natural teeth damaged in an accident, with mandatory reporting to the Insurer within 48 hours after the intervention;
    The healthy teeth are such teeth on which there are no cracks or teeth on which no dental
    treatment services have been done prior to the insured event to treat dental diseases (crowns, fillings, etc.).
    Damage to the teeth from chewing food does not entail the right to urgent dental treatment.
    The urgent dental treatment can be done as inpatient or outpatient treatment.
11) **Medical– technical aids** - only if prescribed by an authorised physician and approved by the Insurer, in particular the following:
    - Prosthetic devices - prostheses (for upper and lower extremities, eye prostheses, breast prostheses)
    - Orthotic devices - orthoses (for upper and lower extremities, spinal orthoses)
    - Special types of aids - wheelchairs other than motorized, armpit and forearm crutches, metal walking stick with support points, walking stand)
    - Voice and speech aids
    - Other types of medical-technical aids if they are contracted and specified in the insurance policy.
      The medical-technical aids are medical devices that serve for the purpose of functional and aesthetic replacement of lost body parts, i.e.
      to provide support, prevent the formation of deformities and correct the existing deformities and facilitate the performance of basic vital functions.

(3) For the use of outpatient treatment services, the Insured has the right to reimbursement of costs up to the agreed sum insured and set limits agreed by the policy, i.e. the insurance agreement for this coverage during the insurance year.

INPATIENT TREATMENT

Article 14

(1) Inpatient treatment implies the reimbursement of the costs of medical treatment, i.e. treatment at an institution which, in accordance with the law, is considered a hospital as a provider of health services, which is registered in accordance with the provisions of the law and established in accordance with the legal system of the country in
which the insurance coverage applies, where the insured person is under constant supervision of medical staff, and which has a sufficient number of diagnostic, laboratory, surgical and therapeutic equipment.
In inpatient treatment, the medical services must include scientifically recognized methods that have been clinically tested and accepted in the country where the insurance coverage is valid under the policy.

(2) The hospital stay (hospital treatment) is the time the insured spends in treatment that requires the presence at the hospital for at least 24 hours, as well as the time spent in the day hospital in case of surgery.

(3) For the purposes of these Special Terms and Conditions, a day hospital implies a special organizational unit of a healthcare institution organized for performing surgical interventions, observations and therapeutic endoscopic procedures during daily work.

(4) The inpatient treatment is not the accommodation of the Insured person at the institutions of the stationary type, such as:
   1) day hospitals (except in cases defined by paragraph 2) of this Article);
   2) addiction treatment facilities;
   3) mental hospital;
   4) stationary health facilities specializing in rehabilitation and spas;
   5) hydroclinics;
   6) Sanatoriums;
   7) Patient nursing homes;
   8) nursing homes, i.e. geriatric institutions;
   9) spas, centres for rest, weight loss or recovery.

(5) Inpatient treatment services shall include solely the following:
   1) **Reimbursement of costs for hospital accommodation and food** which is medically permitted and recommended by an authorized physician during inpatient treatment.
      When it comes to reimbursement of accommodation and food costs, if the hospital where the insured is being treated has the capacity and ability to provide such services to the Insured, the Insurer shall reimburse the costs in case of accommodation in standard rooms available at the healthcare service provider.
      A private apartment accommodation at the personal request of the Insured will be covered only if it is contracted by the policy and if it exists at the healthcare provider's facility;
   2) **Compensation for authorized physicians of all specialties** from a health institution, i.e. a hospital where an Insured was admitted for hospital treatment, which includes an examination
      by a specialist of any specialty according to the medical indication;
   3) **Compensation for diagnostic methods -** procedures, laboratory tests, tests and analyses according to medical indications and only at the recommendation of an authorized physician that are necessary to regain the health, improve the health or prevent the deterioration of Insured's health. Diagnostic methods, which are required by an authorized physician, and in accordance with the medical indication and diagnosis, shall include the following:
      1. laboratory tests and all the necessary laboratory diagnostics (except genetic tests),
      2. Radiology examinations, in particular the following: Ultrasound, X-ray, radiography, radioscopy, CT and MR,
      3. endoscopy procedure,
      4. biopsy,
      5. ergometry;
      6. spirometry, EEG, EMG, EMNG, ECG, Holter ECG,
      7. other medically indicated diagnostic procedures.
   1) **Compensation for prescribing therapy**, which represents a compensation for an authorized physician and qualified medical technicians, the cost of using medical, i.e.

technical equipment, costs of prescribing medicines and radiological material and other material costs of administering the following therapies: medical, injection, infusion, early physical, early rehabilitation, radiotherapy and chemotherapy;

2) **Compensation for medicines and medical material, blood and blood products** prescribed for use during inpatient treatment with the exclusion of compensation for medicinal and mineral water, medical wines, nutrients and products for strengthening, tonics, cosmetics, personal hygiene products and unregistered medicines and preparations according to the national register of medicines;
3) **Compensation for the costs of medical-technical aids**, up to a maximum amount of the limit set in the insurance policy;
4) **Compensation for the costs of surgery, i.e. intervention,** (in local, general endotracheal anaesthesia, laparoscopic interventions) which includes the compensation for the work of the surgeon, anaesthesiologist, assisting physicians and support staff (qualified medical technicians and other healthcare workers), including the costs of preoperative preparation incurred from admission to hospital treatment until surgery, intensive care and subsequent treatment (postoperative care until discharge from the hospital), up to the maximum sum insured under the policy.
   The costs of the surgical procedure also include the implants prescribed by an authorized physician, up to the agreed limit per insured person.
5) **Reimbursement of costs of accompanying parent/guardian** during inpatient treatment for children under 18 years of age;
6) **Emergency unit treatment;**
7) **Emergency dentistry due to an accident** includes dental interventions for the restoration or replacement of healthy natural teeth damaged in an accident, with mandatory reporting to the Insurer within 48 hours from the intervention.
   The healthy teeth are such teeth on which there are no cracks or teeth on which no dental treatment services have been done prior to the insured event to treat dental diseases (crowns, fillings, etc.). Damage to the teeth from chewing food does not entail the right to urgent dental treatment.

(6) For the use of inpatient treatment services, the insured has the right to reimbursement of costs up to the agreed sum insured and set limits, agreed under the policy, i.e. the insurance agreement for this coverage during the insurance year.

HEALTH PROTECTION OF PREGNANT WOMEN

Article 15

(1) Maternity healthcare protection is insurance coverage on the basis of which the Insured is entitled to reimbursement of the costs of medically justified treatments incurred during outpatient or inpatient treatment, up to a maximum limit specified in the insurance policy, and within the sum insured.

(2) The obligation of the Insurer in the case of coverage of healthcare services for pregnant women is excluded in case of pregnancy that started before the commencement of the insurance coverage, as well as during the waiting period specified in the policy.
   It is considered that the pregnancy has started before the commencement of the insurance if the gynaecologist of the insured determined that the date of delivery before the expiration of the period of nine months counting from the day of the commencement of the insurance coverage for such Insured.

(3) Paragraph (2) of this Article shall not apply in the event that the insured person had contracted healthcare coverage for pregnant women under the previous policy with the same Insurer or with another Insurer and if there was no interruption in the insurance.

(4) In any case, if during the insurance period new persons are included in the capacity of the spouse or extramarital partner of the Insured, there is no obligation of the Insurer to cover the healthcare services for pregnant women and for childbirth if the pregnancy started before the commencement of insurance for such person.

(5) The maximum annual coverage for the costs of healthcare for pregnant women includes the following medically justified treatments, i.e. the compensations:

1) **for gynaecological examinations, swabs, laboratory analyses** such as complete blood count, basic biochemistry, urine analyses, all according to the recommendation of an authorized physician - gynaecologist who manages the pregnancy;
2) **foetus ultrasound examination costs;**
3) **additional ultrasound** (so called expert ultrasound);
4) **additional ultrasound in case of high-risk pregnancy or complications,** on the basis of a reasoned documented opinion of an authorized physician - gynaecologist about the medical necessity;
5) **CTG examination** during the third trimester;
6) **biochemical screenings for chromosomal aberrations** (Double, Triple and Quadruple test), according to the medical indication of the gynaecologist who manages the pregnancy;
7) **costs of prenatal vitamins**, iron preparations and hormonal medicines as indicated by a gynaecologist or physician of another specialty only if they are related to pregnancy and are intended for proper foetal development, and are not intended for general use.
8) In collective insurance, **one non-invasive prenatal test** (NIPT) for the detection of foetal chromosomal abnormalities (for the detection of baby's sex, trisomy 21, 18 & 13, sex chromosome aneuploidy) with contracted co-payment **or an invasive prenatal diagnostic test** (Chorionic villus sampling or amniocentesis or cordocentesis) in case of high-risk pregnancy;

(6) In case of collective insurance, if an additional premium is agreed and paid separately, the insurance coverage also includes the **childbirth costs**, which imply the total cost of childbirth up to the amount determined by the policy (for epidural anaesthesia, apartment accommodation, father's presence at childbirth, fees for doctors, medical technicians, anaesthesiologists), caesarean section only if medically indicated).
   The maximum annual coverage for childbirth costs includes the following:

1. **one control examination** - complete **routine gynaecological examination** after childbirth;
2. **public health nursing for new-borns** provided by qualified medical technicians (midwives) immediately after the expiration of the period of public health nursing to which the insured is entitled under compulsory health insurance, for a period not longer than the first month of life of the new-born, and on the recommendation of an authorized physician, as well as the health protection of new-borns during the first month of their life up to the limit specified in the insurance policy;
3. **five routine examinations of the new-born,** during the insurance year, which include monitoring the growth and development of the child.

MEDICAL EXAMINATION

Article 16

(1) Medical examination implies a package (set) of healthcare services that are being performed for the purpose of preventive healthcare.
(2) It is possible to contract several packages of medical examinations under one policy, provided that the Insured can use each contracted package only once during the insurance year.
(3) When new insured persons, including new-borns, are included during the insurance year, such persons are entitled to full medical examination coverage regardless of the actual duration of insurance for them, with the obligation of the policyholder to pay the full annual medical examination premium for such persons.
(4) The content of the medical examination is determined by the insurance policy.
(5) Medical examination can be performed in the health institution with which the Insurer has contracted a medical examination package, with mandatory appointment through the Sava Call Centre, unless otherwise agreed.

OPHTHALMOLOGY SERVICES

Article 17

(1) During the insurance period, the insured is entitled to reimbursement of costs for ophthalmological services and aids, which include:
   1) specialist examinations by ophthalmologists, i.e. a vision check, determination of the existence or control of existing refractive anomalies and prescribing ophthalmic aids;
   2) purchase of one prescription frame with prescription lenses,
   3) and/or one pair of prescription glasses,
   4) and/or prescription contact lenses.
(2) In the case of continuity insurance, the Insured acquires the right to change the frame and lenses if his dioptre has changed;
(3) If the insurance is continuous and there is no change in dioptre, the Insured has the right to purchase a frame for glasses and prescription lenses in accordance with the previous paragraph, once every two years.
(4) In case of loss or damage of aids, the Insured does not acquire the right to purchase new ones at the expense of the insurance.
(5) The Insurer's obligation is excluded in the following cases:
   1) radial keratomy or any other surgical procedure (including laser treatments to improve vision);
   2) sunglasses and/or related accessories for glasses.

DENTAL SERVICES

Article 18

(1) Dental services imply the following:
   1) **Preventive treatment** – includes routine examinations, dental instructions, fluorine treatment for persons below the age of 18.
   2) **Basic restorative** – includes amalgam and composite fillings, Compoglass restorations and tooth removal.
   3) **Major restorative** - includes filling of roots, crowns and fillings at a higher level (inlay), bridges, laboratory costs, anaesthesia, surgical removal of wisdom teeth, periodontal descaling (once a year) and root cleaning.
   4) **Orthodontic treatment –** models for analysis (including panoramic X-rays), molds, mobile wired and fixed dentures. Orthodontic treatment is allowed only with the written consent of the Insurer and only for insured persons below the age of 19.
(2) For the use of dental services, the insured person has the right, during one insurance year, to receive reimbursement for the amount of costs up to the limit for dental services defined in the insurance policy.
(3) The Insurer's obligation is excluded in the following cases:
   1) Cosmetic and aesthetic dental treatments;
   2) surgical interventions such as apicotomy, lobe surgery, implant placement;
   3) artificial teeth (total and partial dentures);
   4) any ceramic restorations on dental implants;
   5) multisurface filling (onlay),
   6) veneers and all the accompanying costs,
   7) teeth whitening, and
   8) all other dentistry aids.
(4) There must be a written medical indication and a report on the performed service for all performed treatments. The report must state the number of teeth on which the treatment was performed, and the Insurer has the right to request X-rays (OTP, 3D, retroalveolar, retrocoronary, etc.) if necessary. For metal-ceramic crowns and bridges, digital photographs of the clinical condition before and after the treatment must be enclosed.

MEDICINES

Article 19

(1) A medicine is a product which has been approved for marketing in the Republic of Serbia, as well as a product that has not been approved for marketing in the Republic of Serbia and which is imported on the basis of the approval of the Serbian Medicines and Medical Devices Agency, in accordance with the law that regulates the area of medicines.
(2) In case of an individual insurance agreement, only the prescription medicines are considered to be medicines, while in the case of a collective insurance agreement, in addition to prescription medicines, the ordered medicines are also interpreted as medicines.
(3) Prescription medicines include the medicines prescribed by an authorized physician for a medical indication.
The insurer will cover the costs of medicines only if they are prescribed in therapeutic doses for a maximum period of sixty (60) days.
(4) Ordered medicines include the medicines prescribed by an authorized physician for a medical indication, which are administered in an outpatient setting.
The insurer will cover the costs of medicines only if they are prescribed in therapeutic doses for a maximum period of ten (10) days.
(5) The maximum amount of compensation, i.e. the limit for the costs of medicines is set in the insurance policy, per insured person, during the insurance year.
(6) This coverage does not cover the medicines given at the hospital during inpatient treatment or during surgery or other interventions, as well as when staying at the hospital due to risky pregnancy and maintenance of pregnancy.
(7) The Insurer shall not cover the following:
   1) biological, immunological, herbal medicines, blood and plasma medicines, advanced therapy medicines, while the traditional and homeopathic medicines are covered exclusively by the coverage for
   "Traditional medicine", if contracted;
   2) medical cosmetics;
   3) vitamins that are in the register of medicines, except in the case of a diagnosis of reduced concentration of a particular vitamin in the blood;
   4) all medical devices (including syringes, needles and bandages) not covered by these conditions, as well as dietary supplements, except:
      1. probiotics with antibiotic therapy and during therapy,

2. iron preparations for anaemia (with a medical report specifying that the insured reacts negatively to the registered preparation),
3. eye preparations (artificial tears) in the diagnosis of dry eye or conjunctivitis.

PHYSICAL AND SPEECH THERAPY

Article 20

(1) Physical therapy and medical rehabilitation procedures include the physical therapy procedures performed by a physiotherapist in an outpatient setting, according to a medical indication not older than 3 months, and include the following: electrotherapy, laser therapy, magnetotherapy, thermotherapy, ultrasound therapy, kinesitherapy, with the exclusion of all types of massage, lymphatic drainage, endermology (LPG) and ozone therapy.

(2) Physical therapy is limited exclusively to the following diseases and injuries that were first diagnosed after the first inclusion in the insurance: fractures, dislocations and partial dislocations of joints, sprains and ruptures of tendons and ligaments, spinal cord injuries, conditions after implantation of artificial joints, carpal tunnel syndrome, stroke,
Parkinson's disease, muscular dystrophy, osteoarthritis, unless otherwise agreed.

(3) The costs of physical therapy performed at home are reimbursed only if the insured person is immobile, with the prior approval of the Sava Call Centre, and according to the recommendation of the authorized physician who has previously treated the insured person.

(4) The insurer may limit the coverage for physical therapy and medical rehabilitation in the case of chronic diseases and conditions of the spine and locomotor system, which is determined by the insurance policy.

(5) Speech therapy services are provided by a defectologist and speech therapist in case of speech disorders, as well as for voice and speech therapy due to laryngeal injury.

COMPLEMENTARY MEDICINE

Article 21

(1) If this coverage is contracted, the Insurer shall cover the costs of quantum medicine, homeopathy (including homeopathic medicines), acupuncture and other methods, in accordance with the Insurance agreement.

(2) Complementary medicine procedures are recognized only if they are performed in accordance with the law governing this area by authorized physicians and if it is used as treatment for a disease covered by these Special Terms and Conditions.

SPECIAL COVERAGE IN CASE OF TUMOURS

Article 22

(1) If specifically contracted, the Insurer will pay a one-time financial compensation determined in the insurance policy, after the expiration of the mandatory waiting period for this coverage of 6 months in the event that the insured is diagnosed with a malignant tumour.

(2) The total sum insured is exhausted, i.e. reduced by the paid amount of the one-time financial compensation from the previous paragraph. Maximum liability of the Insurer for the payment of compensation cannot exceed the contracted sum insured.

(3) For the purposes of these Special Terms and Conditions, a malignant tumour is a histologically proven tumour with uncontrolled, invasive growth and a tendency to form metastases, which is classified in the international classification of tumours. Severe diseases, in the sense of these Special Terms and Conditions, also include the forms of blood tumours, blood-forming organs and the lymphatic system, including leukaemia (other than chronic lymphocytic leukaemia) and lymphomas (other than stage II Hodgkin's disease).

(4) The following malignant tumours, in the sense of these Special Terms and Conditions, are not considered:
- tumours “in situ” (including cervical dysplasia CIN-1, CIN-2 and CIN-3) or premalignant forms of
- melanoma, histologically proven, less than 1.5 mm thick or with penetrating depth less than Clark level 3
- all hyperkeratosis and skin basal cell carcinomas - carcinomas of the skin epithelium, unless it shows the characteristics of invasive growth and/or metastasis
- Kaposi's sarcoma and other tumours in the coexistence of HIV infection or AIDS patients
- Prostate cancer with histologically proven TNM classification T1 (including T1(a), T1(b) or some other comparable or lower classification).

(5) The diagnosis of a malignant tumour is made by a specialist pathologist based on a microscopic examination of the tissue (PH finding).

SECOND MEDICAL OPINION

Article 23

(1) If a premium is agreed and paid separately, the Insured may request a second medical opinion if the following conditions are met:
1) The Insured has been diagnosed with the disease - the Insured must be officially diagnosed by a competent physician as a precondition for providing the second medical opinion;
2) The insured has been examined by a competent physician in the last 12 months, but not before the first inclusion in the insurance - a precondition for obtaining a second medical opinion is the existence of recent medical documentation;
3) The Insured did not have an acute or life-threatening condition;
4) No physical examination of the insured is required - certain conditions will always require an on-site examination and evaluation of the insured (for example, mental illness) and in such cases it is not possible to obtain a second medical opinion.

(2) To obtain a second medical opinion, the Insured addresses the Insurer, who provides the form required for further proceedings. The Insured has to fill in the received documentation and together with the medical documents in his possession has to submit it to the Insurer. The Insured will receive a proposal from the Insurer of a medical institution which, according to the diagnosis of the disease, would issue a second medical opinion. If the insured does not accept the Insurer's proposal, in agreement with his/her physician, the Insured can request the second medical opinion from two other medical institutions.

(3) The insured will receive the second medical opinion, translated into his/her mother tongue, within ten working days from the delivery of the medical documentation to the selected world-renowned health institution. The second medical opinion contains a comment on the diagnosis of the disease, a comment on the treatment procedure and possible recommendations.

(4) The program of the second medical opinion does not include a physical examination of the Insured, a change in the method of treatment or a different

treatment of the insured because it is primarily based on the submitted medical documents.

(5) The insured opts for the second medical opinion only at his/her own risk and bears all the consequences of such a decision. The insurer is not liable for any damages nor is it entitled to request any health information obtained as part of the second medical opinion.

(6) The costs for the second medical opinion are not included in the contracted insurance coverage and set limits, and are borne in full by the Insurer.

EXCLUSION OF THE OBLIGATIONS OF THE INSURER

Article 24

(1) According to these Special Terms and Conditions, the Insurer is not obliged to reimburse the costs incurred as a consequence of:
   1) the fact that the Insured did not follow the instructions of the physician;
   2) the fact that the Insured refused to release the doctor who made the diagnosis from the obligation of secrecy and thus prevented the Insurer from obtaining the necessary information;
   3) policy, i.e. document abuse,
   4) examinations by physicians for the purpose of issuing certificates for administrative purposes (kindergarten, playing sports, driver's license, travel abroad, remittances for sick leave, etc.).

Article 25

(1) The Insurer's obligation is excluded for all coverage that is not listed in the policy or its attachment and for which the insurance premium has not been paid.

(2) Any event that is not an insured event in accordance with these Special Terms and Conditions and the agreed insurance policy, as well as the consequences of such an event, are excluded.

(3) The obligation of the Insurer for the costs of filing a claim for damages incurred by the Insured in the name of hiring a lawyer or on any other basis is excluded.

(4) If the insured event has occurred and lasts at the time of conclusion of the Insurance agreement, i.e. if the costs of treatment of the Insured's illness he/she suffered from at the time of conclusion of the Insurance agreement are in question, unless otherwise agreed;

(5) If the insured event occurred during the insurance period, and the treatment of the Insured continues after the expiration of the insurance agreement, the Insurer shall be obliged to pay the costs of health protection, i.e. to pay the agreed compensation incurred up to the day until which the Insurance agreement lasted, except in the case when the Insurance agreement was renewed.

(6) The coverage of costs incurred after the expiration of the insurance coverage, which are a consequence of an accident, illness or pregnancy incurred during the insurance period, is excluded.

(7) The obligation of the Insurer to reimburse the costs of preventive immunization programs and chemoprophylaxis, which are mandatory under the law governing the protection of the population from infectious diseases in the country of coverage, is excluded. The vaccine will not be covered if it contains a component of the vaccine that is required by law.

(8) Coverage is excluded for services performed at institutions that are not considered healthcare providers in accordance with these Special Terms and Conditions such as gyms, fitness centres, sports clubs, counselling centres, beauty salons and alike, whether or not some of the services they provide can be considered medical.

(9) Coverage is excluded for treatments that are not in accordance with the treatment protocol (guidelines of good clinical practice) for a particular diagnosis or in the opinion of the censor, i.e. that are not related to the symptoms of the disease, and their performance is not justified by the current clinical situation.

(10) The coverage is excluded for new methods of treatment, diagnostic and therapeutic treatments, drugs and other health services that did not exist on the market of the Republic of Serbia at the time of the commencement of the insurance year under the policy, unless the Insurer has decided to cover such particular service.

(11) The Insurer's obligation is excluded for costs incurred as a consequence of or in relation to:
   1) Provided medical services not indicated by the relevant medical specialist or not intended for the treatment of the Insured;
   2) reproductive treatment, in particular the following:
      1. to prevent conception for men and women (contraception and its consequences);
      2. vasectomy and sterilization, as well as return to pre-sterilization status;
      3. treatment of sexual dysfunction, treatment with Viagra or generic replacement;
      4. termination of pregnancy at the personal request of the insured which is not medically justified, and its consequences;
      5. stem cell collection and storage costs and all associated costs,
      6. examination and treatment of infertility, as well as all preparatory treatments for assisted reproduction and medicines and all forms of assisted reproduction (insemination, in vitro fertilization, etc.), unless otherwise agreed;
   3) Surgical and other procedures and treatments at personal request of the Insured which are not medically justified and indicated, and corrective aids, as follows:
      1. elimination of physical defects and anomalies, cosmetic treatment, aesthetic treatment whether for psychological reasons or not, as well as the consequences of such treatments, except for implants that will be covered for total mastectomy;
      2. dental aesthetic treatment (teeth whitening, decoration, etc.);
      3. laser treatment for vision correction, cataract surgery;
      4. removal of moles and other changes at personal request;
      5. gender reassignment surgery, including psychological and hormone therapy, gender reassignment surgery and breast surgery;
      6. circumcision - if not medically indicated;
   4) procurement of sunglasses or related accessories for glasses and hearing aids;
   5) all costs of cryopreservation and implantation or reimplantation of living cells, plasma therapy (except blood transfusion) and autologous sera (e.g. PRP, orthokin, BMC and similar therapies);
   6) procurement of orthopaedic shoes or other foot support aids, sole support and orthotic aids and materials; all aids arising from the diagnosis of weak, overstrained, unstable or flat feet or lowered soles; or tarsalgia, metatarsalgia;
   7) all costs related to blisters, corns and hyperkeratosis, ingrown toenails, cuticles or calluses;
   8) Experimental medical treatment involving a scientifically or medically unrecognized treatment;
   9) sleep study treatment and sleep apnoea treatment;
   10) ambient therapy for rest and/or observation;

11) examination and treatment of autonomic nervous system function, hyperhidrosis, syncope test;
12) Procurement of protetical and corrective aids which are not medically necessary intraoperatively or relevant aids except prosthodontics or medical-technical aids used as an integral part of the treatment prescribed and approved by the relevant medical specialist;
13) treatment of malocclusive or temporomandibular joint disease (TMJD), examination and treatment of disturbed normal occlusion;
14) organ and tissue transplant surgery, regardless of whether the insured is a recipient or a donor;
15) training for pregnant women and preparation for childbirth;
16) treatment of astigmatism and strabismus, nystagmus, myopia, hyperopia or presbyopia, including radical keratotomy surgery;
17) orthoptics and pleoptics (eye exercises); treatment or weight loss program, gastric balloon, bypass or ring implant surgery;
18) examinations, analyses and training related to nutrition, nutrition advice;
19) salt room treatments;
20) hyperbaric chamber treatments;
21) alopecia of the chin and regions other than the hairy part of the head;
22) therapy with synthetic chondroprotectives; circumcision, if not medically indicated;
23) Procurement of medical devices not contracted by insurance, medical preparations used for treating mucous membranes in natural cavities, antiseptics for local use, vitamin preparations for immunity strengthening (vitamins and minerals), preparations for problematic skin care (creams, gels, lotions, shampoos, etc.), food supplements, as well as all other general use items, cosmetics, services and items for personal care and hygiene;
24) by purchasing the following: hospital bed, trapeze for hospital bed, motorized wheelchair, room crane, anti-decubitus mattresses, items to increase comfort, items used to change the air quality or temperature, insulin pumps, exercise bikes, sun or heat lamps, heating cushions, bidets, toilet seats, bathtub seats, saunas, elevators, Jacuzzis, exercise equipment and similar items;
25) the cost of training for the use and maintenance of durable medical equipment;
26) the cost of adapting the vehicle, bathroom or residential building to personal needs;
27) pain therapy.

Article 26

(1) Unless otherwise contracted, according to these Special Terms and Conditions, the Insurer is not obliged to reimburse the costs incurred for the treatment of the following diseases:
1) chronic diabetes and complications,
2) Alzheimer disease,
3) aneurysms of cerebral arteries and large arteries of systemic circulation,
4) Angina pectoris,
5) condition after myocardial infarction or stroke with functional disorders,
6) Hepatic cirrhosis,
7) Brain tumours with neurological symptoms,
8) chronic renal insufficiency of moderate and severe degree,
9) Any organ malignancy,
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) Rheumatic arthritis,
18) non-psychotic psychiatric disorders,
19) epilepsy,
20) Systemic lupus.

Article 27

(1) In any case, under these Special Terms and Conditions, the Insurer's obligation to reimburse all costs incurred as a result of or in connection with the following diseases and disorders is excluded:
1) Addictions,
2) obesity,
3) AIDS, a complex syndrome related to AIDS (ARCS) and all diseases caused by and/or related to the HIV virus,
4) psychotic psychiatric disorders.

EXERCISING THE INSURANCE RIGHTS AND REPORTING OF AN INSURED EVENT

Article 28

(1) In the event of an insured event, the Insured shall be obliged to call the Sava Call Centre before using the medical service, which shall schedule the type, date and time of the examination or other medical services at the healthcare institution belonging to the Network of healthcare institutions.
(2) It is deemed that the insured person has fulfilled its obligation to call the Sava Call Centre of the Insurer if before using the medical services the Insured calls the Call Centre of the Insurer and answers the questions relating to his/her current health condition for the purpose of execution of the Insurance agreement.
(3) If the insured uses the services of health institutions outside the Network of health institutions, THE Insured shall pay the costs of medical treatments, and submit the request for reimbursement to the Insurer. The use of services outside the Network of health institutions may include co-payment (which is determined by the insurance policy).
(4) If the Insured uses the services of a health institution from the Network of Health Institutions, which are not agreed between the health institution and the Insurer, the same rules apply as in the case of using services outside the Network of health institutions.

Article 29

(1) After the provided medical services, the institution from the Network of health institutions submits to the Insurer the documentation specified by the business cooperation agreement.
(2) In case of reimbursement of costs, it is necessary for the Insured to submit the following within one month of the service provided:
1) insured event report form;
2) medical report with the diagnosis;
3) prescribed prescription/order for medicines/aids by an authorized physician;
4) original invoice for the medical services;

(3) The reports can only be made for treatment actually received during the insurance period and costs will only be reimbursed if incurred before the insurance expires.

(4) In the process of resolving the claim and if they believe it is necessary, the Insurer has the right to ask the Insured to provide the Insurer's authorized persons with an excerpt from medical documents and to obtain information available to third parties about the current and previous health condition of the Insured (excerpt from the medical documents for the specific insured event, reports of specialist doctor's offices, copies, i.e. excerpts from medical history in hospital institutions).

(5) At the request of the Insurer, the Policyholder is obliged to provide the Insurer with access to all the records kept by the Policyholder, in order to determine important circumstances related to the insured event, in accordance with the Law.

(6) If the Policyholder is not able to provide the necessary documentation, as well as when the Insured believes that it is in his/her interest, the insured may waive the claim.

(7) If the costs, which arose from the use of insurance rights, are less than the stated maximum limits for individual coverage, i.e. the contracted sum insured provided by the policy, i.e. by the agreement, the insured person is not entitled to the payment of the difference in case of expiration of the insurance.

(8) The Insurer shall reimburse the costs of treatment and financial compensation to the Insured/Medical institution that provided the service, in accordance with these Special Terms and Conditions, on the basis of the Insurance agreement,
i.e. the policy that was valid at the time of the insured event, within 14 days from the day when they received the completed evidence and established the existence of the obligation.

(9) The Insurer shall be obliged to conclude a contract with the healthcare service provider in accordance with the Law, except in cases when it has agreed with the Insured, i.e. the Policyholder that the Insurer would pay the costs in full to the Insured's account, i.e. a part of the costs incurred by the Insured due to exercising the rights under voluntary health insurance or pay the Insured the agreed financial compensation.

(10) In accordance with the Insurance agreement, i.e. the policy and the Special Terms and Conditions, the Insurer shall be obliged to reimburse the costs or part of the costs incurred by exercising the rights from the Insurance agreement to the healthcare service provider with whom it has concluded a contract for the provision of healthcare services or to the Insured.

TRANSITIONAL AND FINAL PROVISIONS

Article 30

(1) These Special Terms and Conditions may be amended in accordance with the procedure and in the manner in which they were adopted.

(2) The amended conditions apply only to newly concluded Insurance agreements, i.e. the policies.

(3) For the insurance agreements which are ongoing, until the expiry of the insurance year, the General Terms and Conditions and Special Terms and Conditions shall apply on the basis of which these agreements were concluded, except if the conditions were changed due to legislation changes to which the Insurer had no influence.

(4) If the Insurer changes the Special Terms and Conditions, they are obliged to inform the Policyholder thereabout in writing, i.e. the Insured with whom they have concluded an agreement for multi-year insurance.

Article 31

(1) For relations between the Insurer and the Policyholder which are not regulated by these Special Terms and Conditions, the provisions of the General Terms and Conditions shall apply, and if the provisions of the General Terms and Conditions are in conflict with the provisions of the Special Terms and Conditions, the Special Terms and Conditions shall apply.

Article 32

(1) These Special Terms and Conditions shall enter into force on the eighth day from the day of their publication on the Company's notice board, and **shall apply from 15.08.2021.**