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The Executive Board of UNIQA neživotno osiguranje a.d.o Beograd, 134g Milutin Milanković Street (hereinafter referred to as: the Company), according to the Companies Act ("RS Official Gazette", no. 36/11, 99/11, 83/14-as amended, 5/2015), and Article 10 of the consolidated text of Articles of Association 01/NŽ-SA/02 dated 01 March 2016, and based on the Decision dated February 6th 2019 enacted this document.

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

I INTRODUCTORY PROVISIONS

Article 1

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

(2) Particular terms in these special terms and conditions mean:

1) **Insurance provider** (hereinafter: **the Insurer**) – "UNIQA neživotno osiguranje a.d.o." Belgrade that organizes and provides voluntary health insurance in accordance with the law;

2) **Policyholder** – is a legal or natural entity, and any other legal entity which concludes a Contract on voluntary health insurance with the Insurer and undertakes to effect payment of insurance premium from their own funds or from the funds of the Insured;

3) **Insured** – in collective insurance the Insured is an individual who is a student or a person employed by the Policyholder, a member of the Policyholder or consumer of Policyholder's services, who, based on the concluded insurance contract, exercises the rights defined in the contract in case of the insured event occurrence.

4) **Family members** – are the spouse or common-law partner, children (born in wedlock, out of wedlock and/or adopted) of the Insured who, according to the law are deemed dependents until they turn the age of 18, or until they turn the age of 26 in case they are full-time students. Age limits are not applicable to children who are incapable of living on their own due to such degree of physical or mental disorders that prevents them from performing usual motor or bodily functions;

5) **Insurance coverage** – means the contracted basic insurance coverage, and if separately contracted and additional premium is paid also supplemental insurance coverage;

6) **Newly insured person** – is a person who is put on voluntary health insurance during the term of insurance contract;

7) **Limit** – is the maximum amount posing the obligation of the Insurance provider per single medically justifiable treatment within the scope of the contracted insurance coverage for each insured person in the course of the insurance year, which is stated in the policy, i.e. insurance contract, and is in accordance with these Special terms and conditions;

8) **Country of Residence** – is the country where the insured person, at the time when the insurance contract is concluded, has registered residence, that is, who, in accordance with applicable provisions of law, has been issued a permanent residence or temporary residence permit, no matter whether the person is a domestic or foreign national who lives or performs his/her employment duties within the borders of the country of residence. The country of residence, within the meaning of these Special terms and conditions, shall be solely the Republic of Serbia;

9) **Licensed physician** – is any individual holding a degree from a recognized faculty of medical professions, is licensed and authorized to practice medicine in the Republic of Serbia in accordance with applicable provisions and the legal system, unless a licensed physician is the Insured itself, Policyholder itself, or the spouse of the same;

10) **Medically justifiable treatment** – a health service, medical-technical aids, implants, medical supplies or a medicine that is medically justifiable if:

1. It is proper and necessary to diagnose or treat a disease or injury covered by the Policy and defined under these Special terms and conditions;
2. It does not exceed in scope, duration or intensity the level of protection needed to provide safe and proper treatment;
3. Prescribed by a licensed physician;
4. Occurs during the term of insurance contract;
5. It is in accordance with widely accepted professional standards of medical practice in the insured person's country of residence;
6. Its primary purpose is not personal comfort or the comfort of a patient, family, physician or other healthcare provider;
7. It is neither a part of the education or professional training of a patient nor in connection with the same;
8. It is not experimental or in a research phase.

11) **Medical emergency** – is any disease or injury which, without immediate medical help, can lead to endangering the life of the insured person, or irreparable and serious damage to their health, or death. Emergency medical care also means the medical care that is provided within 12 hours from admitting the insured person in order to avoid the expected development of emergency medical condition;

12) **Accident** – is any occurrence that is sudden and independent of the will of the insured person which, acting mainly from the outside and abruptly onto the body of the insured person, results in health damage that requires medical care;

13) **Pre-existing health condition** – means any health condition that is a consequence of any previously diagnosed disease or which had required inpatient treatment, treatment or medication before the insurance contract came into effect, that is, before the insurance inception, and of which the Insured was aware at the moment of concluding the insurance contract. The pre-existing health condition particularly means any chronic disease, injury, illness or condition that is expected to last for a longer period of time with no reasonably foreseeable end date, and which may be characterized by remissions requiring permanent or temporary care, as needed;

14) **Surgical procedure** – means any invasive medical procedure, performed manually or with instruments, during the surgery that is undertaken for the purpose of diagnosing a disease or treating the insured person suffering from a disease;

15) **Outpatient treatment** – is an event when the insured person receives a medical therapy in a healthcare institution, which is established and registered in accordance with the law and the legal system of the country in which it performs its registered activity, and where the insured person does not stay for 24 consecutive hours;

16) **Inpatient treatment** – is an event when the insured person is admitted to a healthcare institution, which is established and registered in accordance with the law and the legal system of the country in which it performs its registered activity, for the period longer than

24 hours, when he/she occupies a bed in healthcare institution and undergoes diagnostic evaluations or is treated from the consequences of a disease or injury;

17) Chain of healthcare institutions – healthcare institutions, private practices and other providers of healthcare services, which have concluded a contract with the Insurer on providing services, which is in effect, and where the insured person uses the services contracted by the policy and in the manner defined by these terms and conditions;

18) Co-payment – the Insured's mandatory share of portion of costs of specific, contracted, medically justifiable treatment that the Insured person must pay if so be agreed in the Policy, or the Insurance contract or if set forth under these terms and conditions.

II GENERAL PROVISIONS

INSURANCE CONTRACT

Article 2

(1) The insurance contract can be concluded as collective insurance for either definite or indefinite term.

(2) By the Insurance contract, the Policyholder undertakes to pay the premium to the Insurer, whereas the Insurer undertakes, when the insured event within the meaning of these Special terms and conditions occurs, to cover the treatment expenses, that is, the expenses of medically justifiable treatment within the scope of the contracted insurance coverage.

(3) The compensation for treatment expenses provided by the Insurer may not exceed the maximum sum insured contracted and stated in the policy in the course of the contracted insurance period, i.e. it is not to exceed the limit defined in the Policy for certain treatments within the scope of insurance coverage.

(4) According to these Special terms and conditions, the insurance contract can be concluded to cover the expenses of treatment and medical services as:

1) Basic insurance coverage,
2) Supplemental insurance coverage.

(5) The insured person is obliged, in accordance with the contracted insurance coverage, to use contracted medically justifiable treatments on the territory of the Republic of Serbia, in an institution which is, according to the General terms and conditions, considered a healthcare service provider, and in the manner defined under the insurance contract.

(6) The insurance coverage applies on the territory of the Republic of Serbia.

(7) Notwithstanding paragraphs (5) and (6) hereof, the Insurer may extend the insurance coverage to: Croatia, Bosnia and Herzegovina, (the Republic of Srpska), Macedonia, Albania, Bulgaria, Romania, Hungary, and Montenegro, whereas the Policyholder is obliged to pay the additional premium and provided that the Policyholder is the employer who is taking out the insurance for its employees (hereinafter: regional coverage).

(8) Within the meaning of paragraph (7) hereof, in case of the insured event occurrence the Insurer shall reimburse for the justifiable treatment expenses incurred regarding the agreed insurance coverage by the application of Article 9 of these Special terms and conditions, upon the return of the Insured from travel, regarding the expenses that the Insured paid to the healthcare provider in the country where the regional coverage applies, whereas the Insured is obliged to submit all the documents required according to Articles 23 and 24 of these Special terms and conditions including the proof that the Insured went on travel based on the official instruction of the Policyholder for the purpose of a business trip, for the purpose of conducting some temporary business in the countries specified in paragraph (7) hereof, professional training or specialization.

(9) The insurance coverage from paragraph (7) hereof refers only to the possibility of using the scope of healthcare services defined under the basic insurance coverage, except for coverage for pregnancy and delivery if defined in the basic coverage.

(10) In case of contracting for the coverage referred to in paragraph (7) hereof, the Insurer reserves the right to exclude certain healthcare services from the basic coverage in the insurance contract.

Article 3

(1) The insurance contract is concluded on the basis of a written Proposal, made on the Insurer's form.

(2) The Proposal makes integral part of the Contract on voluntary health insurance and both contracting parties are obliged to sign it.

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

(4) In the collective insurance contract, any insured person may add to insurance members of his/her family, while it must bear the premium expenses for their family members.

(5) The identity of the added family members may be exposed in the list of the insured persons of the existing collective policy of the Policyholder, or a separate policy can be issued to cover family members of the Insured only. If the separate policy is issued, the Policyholder is a natural person - the Insured who adds their family members to the insurance.

(6) In case of the collective insurance contract, the policy for family members is issued for the same insurance term as the collective policy.

OBTAINING THE STATUS OF THE INSURED

Article 4

(1) According to these Special terms and conditions, under the collective insurance a group comprising at least twenty (20) people who are employed by or are service consumers or are members of the Policyholder may be insured.

(2) The contracted insurance coverage envisaged by these Special terms and conditions refers also to the family members of the Insured if their identity is exposed in the policy, insurance contract or the list of insured persons and provided that the premium is paid for them.

(3) After the insurance contract enters into effect, a new person may be added to the insurance coverage only if such new person to be put on the insurance is:

1) In the capacity as new person who has started the employment, has become a consumer of Policyholder's services, i.e. has become a member of Policyholder – when the Insurer is to be provided with a verified certificate of the Policyholder, i.e. employer stating that such person started the employment, i.e. became a member of the Policyholder or a consumer of Policyholder's services after the commencement of the insurance contract, i.e. that the contracted employment terms have been changed for this person if the Insured is employed by the Policyholder, or that the contracted terms and conditions for being a member of the Policyholder have been changed, or that the contracted terms and conditions have been changed for them as consumers of Policyholder's services;
2) In the capacity as family member of the new person in accordance with item 1) paragraph (3) of Article 4.
3) In the capacity as spouse or common-law partner of the Insured – with the obligation to provide the Insurer with the documents, such as a marriage certificate proving that the spouse obtained the capacity as such after the commencement of the insurance contract, or by providing documents that prove the existence of a common-law marriage.
4) In the capacity as new-born child of the Insured – with the obligation to provide the Insurer with the birth certificate, proving that the child was born after the commencement of the insurance contract, or the Decision on adoption issued by the Centre for Social Work as the proof that the child obtained the capacity as such after the commencement of the insurance contract.

(4) In the events defined in paragraph (3) hereof, the Policyholder is obliged to provide the Insurer with the specified documentation within thirty (30) days as of the change occurrence.

(5) Exclusion of a certain Insured person from the insurance before the expiry of the agreed insurance period is possible in cases stipulated in Article 5, paragraphs (7) and (8) of these Special Conditions, whereby the Policyholder is obliged to notify the Insurer of the termination of insurance for such insured person and provide the Insurer with a certificate stating that one of the events defined in Article 5, paragraphs (7) and (8) of the Special

terms and conditions occurred, and to provide the Document of voluntary health insurance (hereinafter: the Document) for such insured person.

(6) In case of exclusion of a person from the insurance before the expiry of the agreed insurance period, the Insurer is entitled only to the premium up to the date until which the insurance for such person lasts, unless otherwise agreed, and in accordance with the provisions of the General terms and conditions.

(7) In case of misuse of the document that is not returned to the Insurer in due time after an insured person is excluded from the insurance, the costs incurred per insured event are borne by the Insured person or the Policyholder.

(8) In each case of excluding or including persons in the insurance contract, after the commencement of the same, the Insurer reserves the right to request additional documentation to prove the existence of grounds for termination or commencement of the insurance.

COMMENCEMENT AND EXPIRY OF THE INSURER'S OBLIGATION

Article 5

(1) The obligation of the Insurer commences at the expiry of 24th hour on the date indicated in the Policy as the commencement date provided that the premium or a premium instalment has been paid, unless otherwise agreed.

(2) If the first stipulated premium has not been paid by the date indicated in the policy as the commencement date, the Insurer's liability commences at the expiry of 24th hour on the date when the first stipulated premium is paid in its entirety.

(3) If the qualifying period (the waiting period) has been stipulated, the Insurer's liability commences at the expiry of 24th hour on the date following the expiry date of the waiting period provided the premium has been paid, unless otherwise agreed.

(4) The liability of the Insurer ends at the expiry of 24th hour of the date specified in the policy as the insurance expiry date, or in other events provided for in these Special and General terms and conditions.

(5) The Insurer shall not compensate for the expenses incurred due to a medical therapy or treatment that occurs after the expiry of the Insurer's liability regardless of whether the treatment is initiated during the insurance contract period.

(6) The insurance ceases to apply for any insured person, regardless of the contracted insurance period, in case:

1) Of the death of the Insured, except for the insured family members of the Insured until the expiry of the existing policy, if the premium for the remaining period of insurance is paid;
2) The insured person loses the status of the person covered by the compulsory health insurance;
3) The insured person gains the status of the person covered by the compulsory health insurance – in cases of private voluntary health insurance;
4) The employment or membership of the Insured with the Policyholder ends, or the capacity as a consumer of Policyholder's services ends whereby this capacity was the basis for obtaining the capacity of the insured person, regarding the collective insurance;
5) Other events defined by the General terms and conditions occur.

(7) In any case, regarding the collective insurance, with the end of the insurance for the Insured the insurance for the family members of the Insured ends as well, regardless of the reason for the end of the insurance for the Insured, except in case defined in the preceding paragraph item 1 of this Article.

WAITING PERIOD

Article 6

(1) A qualifying period (hereinafter: the waiting period) is the period of time during which the liability of the Insurer is excluded if an insured event occurs, regardless of the fact that the insurance contract is in effect.

(2) The waiting period starts from the commencement of the insurance contract, or the commencement of insurance for a newly-insured person provided that by that date the first due contracted premium is paid, unless otherwise agreed.

(3) If due premium has not been paid by the commencement of the insurance contract, the waiting period starts at the expiry of 24th hour of the date when the first contracted premium is paid.

(4) The general waiting period is two (2) months, except in the events defined in Article 12 of these Special terms and conditions.

(5) The waiting period is not applicable to persons with continuous insurance, that is, is not applicable to the persons who have already gained the insured person status under the previous policy and for whom the waiting period already expired during the term of previous policy.

(6) The waiting period is not applicable in the event of an accident (casualty), as well as surgical interventions resulting from accident.

(7) The waiting period is not applicable in cases of a disease or injury that without immediate medical help may lead to a life danger of the insured person.

(8) When renewing the insurance, if for a particular insured person the waiting period did not fully expire during the previous policy period, the remaining time of the previous waiting period is transferred to the next period of insurance under a new policy.

OBLIGATION OF THE POLICYHOLDER

Article 7

(1) During the insurance contract period, the Policyholder is obliged to report to the Insurer any new circumstances that arise related to the insured person, such as the change of insured status under compulsory health insurance, change of address, profession or marital status, and to submit information about any other relevant change that affects the information given when concluding the insurance contract or given when first putting such insured person on insurance.

(2) The Policyholder is obliged to acquaint all the persons insured under these Special terms and conditions with the contents thereof.

INSURED EVENT

Article 8

(1) An insured event represents a future uncertain event when due to a disrupted health condition (a disease or injury) the insured person undergoes a medically justifiable treatment, which is subject-matter of the insurance contract and the costs of which are to be paid to a medical institution, a private practice, other provider of healthcare services or to the insured person.

(2) The disrupted health condition within the meaning of Paragraph (1) of this Article must be established by a licensed physician.

(3) The insured event is also the treatment expenses of an emergency dental care treatment incurred as a result of an accident. The emergency dental care treatment is a treatment necessary to restore or replace sound natural teeth damaged in the accident. Sound teeth are the teeth with no cracks, or teeth which had not been subject to dental services of treating dental diseases (crowns, fillings, etc.) before the insured event took place. Teeth damage from chewing food does not entitle one to the emergency dental care treatment. The emergency dental care treatment can be provided either as inpatient or outpatient treatment.

(4) Only if separately contracted and additional premium has been paid shall the insured event be deemed to be the expenses of medically justifiable treatment, or treatment pertaining to supplemental insurance coverage that may be contracted as coverage for expenses of:

1) General health check-ups,
2) Ophthalmology services,
3) Dental care services,
4) Physical therapy,
5) Prescription and ordered medicines.

(5) The insured event commences with the beginning of medical therapy, or treatment, and ends at the moment when, from the medical perspective, there is no more need for the treatment, because the health condition is restored or stabilized, and thus its further betterment or worsening is not certain.

(6) In any case, the insured event ends on the insurance contract expiry date.

COMPENSATION FOR TREATMENT EXPENSES

Article 9

(1) When the insured event occurs, the Insurer shall provide compensation to a medical care provider for reasonable and usual expenses that develop in relation with the treatment of the insured person, maximum up to the amount of the sum insured stated in the policy, or for certain healthcare services up to the limit for such services defined in the insurance contract, i.e. the policy.

(2) All the expenses related to the treatment and medical services exceeding the amount of contracted sum insured, or exceeding the disposable amount of defined limits are borne by the Insured itself.

(3) The reasonable and usual expenses within the meaning of Paragraph (1) of this Article are considered to be the medical therapy expenses that do not exceed the general level of expenses in similar institutions in the Republic of Serbia when it comes to the same or similar medical therapy – treatment, services or help to persons of the same gender and similar age, regarding a similar disease or injury.

(4) Treatment or a medical therapy is any medical or surgical procedure which is, according to generally acknowledged rules of the medical profession, deemed proper to ease the symptoms of a disease, improve health, or prevent its deterioration, i.e. to treat a disease for recuperation purposes, that is, to recover from a disease.

(5) Treatment or a medical therapy can be provided either as inpatient and/or as outpatient treatment.

(6) The maximum contracted sum insured, i.e. the limits regarding particular coverage are stated in the policy and insurance contract.

BASIC INSURANCE COVERAGE

OUTPATIENT TREATMENT SERVICES

Article 10

(1) The outpatient treatment includes expenses of a medical therapy or treatment that the insured person receives in a medical institution, i.e. a health service provider, which is officially recognized as a place where such treatment can be conducted. In outpatient treatment, medical services must be scientifically acknowledged methods that are clinically tested and accepted in the country wherein the insurance coverage applies in accordance with the policy, while the insured person does not stay in the institution for 24 consecutive hours (does not stay overnight, that is does not occupy a hospital bed).

(2) Outpatient treatment services include the following insurance coverage:

1) Compensation for examination by a licensed physician in an institution from the Chain of healthcare institutions where the Insured is receiving outpatient treatment, which includes the examination by a general practitioner and/or medical specialist of any specialty area per medical indication, except for a psychiatric (neuropsychiatric) medical specialist and physical medicine specialist, unless otherwise agreed;
2) Ambulatory surgical intervention of stitching (in case of stings, lacerations, and cuts of up to 4 stitches or sutures);
3) Expenses for home visits by licensed physicians are compensated for only in the event of emergency (a life-threatening conditions) as may be assessed by a licensed physician and per medical indication, whereby the approval from MedUNIQA contact center of the Insurer is obligatory;

4) Compensation for diagnostic methods – procedures, laboratory examinations, tests and analyses as medically indicated and solely on recommendation (not older than 6 months) from a licensed physician, which are required for recuperation, improvement of a disease, or prevention of the Insured's health worsening. Diagnostic methods, requested by a licensed physician, in accordance with the medical indication and diagnosis include:

1. Laboratory tests, excluding genetic testing;
2. Diagnostic procedures:
   - RTG screening, ultra-sound screening, roentgenography, roentgenoscopy
   - CT and MRI procedures, one (1) of each per insurance year;
   - Endoscopic procedures, one (1) of each per insurance year;
   - Diagnostic punctures and biopsies; HP analyses of the material obtained by diagnostic procedures; however, not for the material that is obtained by any surgical intervention which is not covered; also, excluded are immunohystochemical analyses of pathohistological results obtained by any surgical intervention which is not covered,
   - Spirometry, ergometry
   - Audiometry, tympanometry
   - EEG, EMG, EMNG, holter TA, holter ECG,

5) Compensation for expenses of ambulance transportation in a vehicle owned by private practice, only in the event of medical emergency and provided that the transportation is requested by a licensed physician;
6) Compensation for the ordering or administering of therapy, which is the compensation for the efforts of a doctor in charge and medical technicians in administering the therapy with medicines for which the permit to be put on the market of the territory of Republic of Serbia is issued in accordance with the law;
7) Compensation for medical-technical aids – temporary and permanent medical equipment and prosthetics only if prescribed by a licensed physician and that can be contracted up to the maximum limit defined in the policy, excluding myoelectric and esthetical prosthesis.

(3) If specifically contracted in the policy, outpatient treatment services may also include the following coverage:

1) The compensation for homeopathy and acupuncture up to the maximum limit specified in the policy;
2) The compensation for nursing care or home care provided by qualified medical technicians, immediately after hospital treatment, or treatment recommended by a licensed physician and provided that there is ongoing treatment carried out by the licensed physician and only if the medical treatment is required to be carried out at home of the Insured person (insured person is immobile), with the annual limit specified in the policy whereas it is mandatory to obtain the consent of MedUNIQA Contact Centre of the Insurer.;
3) The compensation for costs when diagnostic procedures, laboratory examinations, tests and analysis are carried out for the purpose of fertility testing, not to exceed the limit specified in the policy;
4) The compensation for a speech therapist and speech exercises not to exceed the limit specified in the policy;
5) The compensation for evaluation by an authorized medical specialist in psychiatry and psychotherapy not to exceed the limits specified in the policy.

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

INPATIENT TREATMENT SERVICES

Article 11

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

(2) The inpatient treatment does not include placing the insured person in residential type institutions such as:

1) Day-care hospitals,
2) Addiction quitting institutions,

3) Mental hospitals,
4) Residential health institutions specialized in rehabilitation (spas),
5) Hydro-clinics,
6) Sanatoriums,
7) Nursing homes,
8) Retirement homes or geriatric institutions,
9) Health resorts, centers for rest, weight loss and recovery.

(3) Inpatient treatment services include solely:

1) Compensation for expenses of accommodation in a healthcare institution and the medically allowed food that is recommended by a licensed physician in the course of inpatient treatment. As for the compensation for accommodation and food expenses, if the healthcare institution wherein the insured person is being treated has the capacity and the possibility to provide the same to the insured person, the Insurer shall compensate the expenses for:
   1. Accommodation in a room (so-called suite accommodation) that includes one or two beds per room, air-conditioning, TV, phone, bathroom and water closet within the suite, a qualified medical technician providing additional care, as well as the medically allowed food recommended by a licensed physician during the inpatient treatment.
   2. Accommodation in a room with three or four beds per room with air-conditioning, bathroom and water closet within the room, a qualified medical technician providing additional care, as well as the medically allowed food recommended by a licensed physician during the inpatient treatment.
2) Compensation for licensed physicians of all specialist areas in the healthcare institution where the insured person is receiving inpatient treatment, including the evaluation by a medical specialist of any specialist area as per medical indication except for a psychiatric (neuropsychiatric) medical specialist and physical medicine specialist, unless otherwise agreed;
3) Compensation for diagnostic methods – procedures, laboratory examinations, tests and analyses as medically indicated and solely on recommendation by a licensed physician, which are required for recuperation, improvement of a disease, or prevention of the Insured's health worsening. Diagnostic methods requested by a licensed physician, based on the medical indication and diagnosis, include:
   1. Laboratory tests, excluding genetic testing;
   2. Diagnostic procedure:
   - RTG screening, ultra-sound screening, roentgenography, roentgenoscopy
   - CT and MRI procedures, one (1) of each per insurance year;
   - Endoscopic procedures, one (1) of each per insurance year;
   - Diagnostic punctures and biopsies;
   - Spirometry, ergometry
   - Audiometry, tympanometry
   - EEG, EMG, EMNG, holter TA, holter ECG,
4) Compensation for therapy ordering, which is the compensation for the efforts of a licensed physician and qualified medical technicians, the expenses for using medical or technical equipment, expenses of ordering medicines and radiological material and other material expenses of administering the following types of therapies: medical, injection, infusion, as long as there are funds within the sublimit for medications, early physical, and early rehabilitation;
5) Compensation for interventions that include: interventions with local anesthesia, interventions with general endotracheal anesthesia and laparoscopic interventions;
6) Compensation for medicines up to the sublimit agreed in the Policy in the amount of 25% of the sum insured and medical supplies prescribed to be used in the course of inpatient treatment, excluding the compensation for healing and mineral water, medical wines, nutritional supplements and strengthening products, tonics, cosmetics, personal care products and unregistered drugs and preparations according to the national registry of drugs;
7) Compensation for expenses of medical-technical aids, not to exceed the limit defined in the policy;
8) Compensation for expenses of surgical procedure, which includes the compensation for work of the surgeon, the anesthesiologist, assisting doctors and supporting staff (qualified medical technicians and other healthcare workers), including expenses of preoperative care incurred from admission to inpatient treatment to surgery, intensive care and subsequent treatment (postoperative care until discharge from the healthcare institution), not to exceed the sum insured contracted in the policy. The expenses of the surgical procedure include implants prescribed by a licensed physician, not to exceed the limit of EUR 3,000 per insured person per year;

(4) For using the services of inpatient treatment, the Insured is entitled to expense compensation up to the maximum of the sum insured and defined limits, contracted in the policy, i.e. insurance contract, for this type of coverage in the course of the insurance year.

PREGNANCY HEALTHCARE AND DELIVERY

Article 12

(1) Pregnancy healthcare and delivery means the insurance coverage based on which the insured person is entitled to compensation for expenses of medically justifiable treatments incurred during outpatient or inpatient treatment up to the maximum limit defined in the policy for the relevant coverage.

(2) The Insurer's obligation related to the healthcare of pregnant women commences after the waiting period of nine (9) months expires.

(3) Pregnancy is deemed to have occurred before the insurance inception date if the licensed gynecologist of the insured person determines the delivery date to be before the expiry of a nine(9)–month period, counting from the date when the insured person was first included in insurance, or counting from the date when the due premium was paid in case it had not been paid by the insurance contract inception date.

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

(5) In any event, if during the insurance period new persons are put on the insurance in the capacity of a spouse or common-law marriage partner of the Insured, there is no liability on the part of the Insurer for pregnancy healthcare and delivery services if the pregnancy commenced before the insurance inception date.

(6) The maximum annual coverage for the expenses of pregnancy healthcare and delivery includes the following medically justifiable treatments, i.e. the compensation for:

1) Examinations by a chosen supervising gynecologist, swabs, laboratory analyses such as complete blood count (CBC), basic biochemistry, and urine analysis, according to the recommendation of the licensed physician – pregnancy supervising gynecologist;
2) The first medical examination of a pregnant woman and four (4) follow-up fetal ultrasound screenings, except in case of high-risk pregnancy;
3) Additional ultrasound screening (so-called expert ultrasound);
4) Additional ultrasound screening in case of a high-risk pregnancy or complications, based on the explained and documented opinion of the licensed gynecologist on medical necessity;
5) Biochemical screenings for chromosome aberrations (Double, Triple, and Quadruple tests) as per medical indication of the supervising gynecologist;
6) Invasive prenatal diagnostics (early amniocentesis, chorionic villus biopsy, cordocentesis) if indicated by a gynecologist in charge;
7) Total expense of the delivery up to the maximum limit defined in the policy (epidural anesthesia, suite accommodation, and presence of the father in a delivery room, compensation for the doctor, medical technicians, anesthesiologists, and the Caesarean section only if medically indicated).

(7) The liability of the Insurer is excluded for:

1) Physical and mental preparation of a pregnant woman for the labor (education and exercises intended for pregnant women);
2) Prenatal non-invasive diagnostics, which include analysis of DNA from fetal cells in maternal blood samples (NIFTY, PRENA, NIPT, TRANQUILITY TEST and the like).

(8) If specifically agreed in the policy, the following coverage can be included:

1) the visiting nursing care provided by midwives immediately after the term of visiting nursing care the insured person is entitled to as mandatory insured person ends, and lasting no longer than the first month of life of the newborn, as recommended by an authorized physician up to the maximum amount of costs specified in the policy;
2) for the healthcare of newborn babies in the first month of life, up to the maximum amount of costs specified in the policy;
3) for prenatal vitamins up to the amount of 100 Euros per year, provided that they are prescribed by a licensed gynecologist.

SUPPLEMENTAL INSURANCE COVERAGE

Article 13

(1) In addition to the basic insurance coverage, and provided that the additional premium has been paid, coverage for expenses incurred due to medically justifiable treatments can also be contracted through supplemental insurance coverage, namely for:

1) General health check-up,
2) Ophthalmology services,
3) Dental care services,
4) Prescription and ordered medicines,
5) Physical therapy.

(2) If one policy covers several insured persons, it is possible to contract for supplemental insurance coverage only under condition that the supplemental coverage includes all of the insured persons.

(3) Notwithstanding the agreed sum insured per policy and contracted additional coverage, there are limits defined in the policy.

(4) The exclusions defined in Articles 20 and 21 under these Special terms and conditions apply to all the types of supplemental coverage.

GENERAL HEALTH CHECK-UP

Article 14

(1) A general health check-up means one general health check-up annually per insured person in the course of the insurance year which includes the following:

1) Regarding insured persons older than 18 years of age:
   1. Laboratory analyses:
      i. Qualitative test on urine including sediment
      ii. Complete blood count (Er, Le, Hb, Hct, Le formula), Se, Glucose in blood
      iii. AST
      iv. ALT
      v. Urea, creatinine, triglycerides
      vi. Cholesterol – total HDL cholesterol and LDL cholesterol
   2. Gynecological examination, colposcopy, VD, Papanicolau test, ultra-sound, ultra-sound breast screening (for women),
   3. Examination by an urologist and ultra-sound imaging of the prostate (for men),
   4. Examination by an internist including ECG,
   5. Ultra-sound screening of the upper abdomen
   6. Final examination and summary.
2) A baby (up to one year of age)
   1. Blood count,
   2. Qualitative test on urine including sediment,
   3. Hips ultra-sound imaging,
   4. Anthropometric measurements,
   5. Pediatric evaluation.
3) A child from one to 18 years of age
   1. Blood count,
   2. Qualitative test on urine including sediment,
   3. Clinical pediatric evaluation,
   4. Anthropometric measurements,
   5. A nose and throat specimen,
   6. Ophthalmology, otolaryngology or orthopedic specialist examinations.

OPHTHALMOLOGY SERVICES

Article 15

(1) Ophthalmology services include examinations by an ophthalmology specialist (except in case of eye injuries and infections, in which case the costs are recovered as outpatient treatment services) ophthalmology diagnostic procedures and the following ophthalmology services in the course of the insurance year:

1) Frames procurement,
2) Monofocal lens,
3) Contact lenses.

(2) For using ophthalmology services, the insured person is entitled, during one insurance year, to compensation for expenses up to the limit for ophthalmology services defined in the policy. A half of the limit is intended for examinations and diagnostics, whereas the other half is intended for procurement of ophthalmological aids. The Insured is entitled to a pair of glasses on an annual basis, except in such cases when he/she has the indication to use two pairs (for short-sightedness and long-sightedness respectively), when the diopter changes or when a previously obtained pair of glasses is damaged, which must be proved by submitting such pair of glasses to the Insurer for inspection purposes.

(3) The liability of the Insurer is excluded in the following events:

1. Costs of frames and lenses for sunglasses, and/or related supplies for sunglasses;
2. Anti-reflective lenses and photo progressives (photo grey, photo brown), multifocal lenses.

DENTAL CARE SERVICES

Article 16

(1) Dental care services include:

1) A preventive treatment – includes routine examinations, dental care instructions, fluoride treatment.
2) A basic restorative treatment – includes amalgam and composite fillings, compomer restoration and extractions.
3) A greater restorative treatment – includes root canal filling, crowns, fillings, and bridges (including laboratory and anesthesia expenses), wisdom teeth extraction, periodontal plaque removal and root cleansing, oral surgical interventions.
4) An orthodontic treatment – analysis models (including panoral X-rays), casts, and mobile wire apparatus (braces). The orthodontic treatment is allowed only with a written approval of the Insurer and only for the insured persons of up to 20 years of age.

(2) For using dental care services, the insured person is entitled, in the course of a single insurance year, to compensation for expenses up to the limit for dental care services defined in the policy.

(3) The liability of the Insurer is excluded in case of the following:

1. Cosmetic treatment, teeth whitening, tooth adornment (tooth gems);
2. Artificial teeth;
3. Any ceramic veneers on dental implants;
4. Dental implants;
5. Fixed braces;
6. Multi-surface fillings (Onlays);
7. Facets and all accompanying expenses;
8. Construction of retention foils, splints.

PRESCRIPTION AND ORDERED MEDICINES

Article 17

(1) Prescription medicines include medicines prescribed by a licensed physician following medical indication. The maximum amount of compensation, that is the limit for expenses of prescription medicines, is defined in the policy, whereas the maximum of medicines allowed to be prescribed at once is a therapy dosage for the next sixty (60) days.

(2) Ordered medicines include medicines prescribed by a licensed physician to be used during the time of the Insurant receiving inpatient treatment.

(3) A medicine is deemed to be a product that has been granted the permit to be put on the market in the Republic of Serbia, and a product that has not been granted the permit to be put on the market in the Republic of Serbia but is imported based on the approval of the Medicines and medical devices agency of Serbia, in accordance with the law governing medicines.

PHYSICAL THERAPY

Article 18

(1) Physical therapy services include an examination by a physiatrist specialist and the following therapies per medical indication, if conducted either as outpatient or inpatient treatment:

1) Kinesiotherapy,
2) Electro-therapy,
3) Laser therapy,
4) Magnet therapy,
5) Ultra-sound therapy,
6) Thermotherapy.

(2) Therapy treatment from the field of physical medicine can be provided by qualified therapists only. Only in case that the insured person is immobile can a physical therapy be conducted at home, with previous mandatory approval obtained from MedUNIQA contact center.

(3) For using physical therapy, the insured person is entitled, in the course of a single insurance year, to compensation for expenses up to the limit for physical therapy defined in the policy.

(4) The liability of the Insurer is excluded in the event of the following:

1) Any type of massage;
2) Shockwave – acoustic wave therapy;
3) High Intensity Laser (HIL);
4) T-care therapy;
5) LPG – endermologie;
6) Ozone and plasma therapy;
7) Examination by a doctor of sports medicine and chiropractor.

MEDICAL ASSISTANCE

Article 19

(1) The Insurer can, at the Insured person's request, arrange five (5) psychiatric appointments in the event of:

1) HIV positive test result;
2) Cancer and leukemia;
3) Multiple sclerosis;
4) Accidental death of a close family member (a spouse, parents, children).

(2) The expenses of medical assistance are not included in the contracted insurance coverage and defined limits, and are borne entirely by the Insurer.

(3) The expenses of medical assistance apply solely to the policies with contracted inpatient and outpatient treatments with the contracted sums insured of EUR 10,000 and more.

GENERAL EXCLUSIONS OF THE INSURER'S OBLIGATION

Article 20

(1) The Insurer's liability to compensate for the expenses of programs of preventive vaccination, immunoprophylaxis and chemoprophylaxis that are mandatory according to the program of population immunization against certain types of infectious diseases in the Republic of Serbia is excluded.

(2) Excluded is the Insurer's liability to compensate for medical expenses incurred as a result of or in connection with:

1) Reproduction treatment, as follows:
   1. For contraception for men and women (mechanical and hormonal methods of contraception and consequences thereof);
   2. Vasectomy and sterilization;
   3. Sexual dysfunction;
   4. Abortion and consequences thereof - if carried out for psychological or social reasons, except for the abortion in cases of medical emergencies or for medical reasons, such as: structural or chromosomal fetal aberrations, medical conditions that endanger the life of the mother, miscarriage, and medically indicated abortion;
   5. Laboratory testing and diagnostic procedures for the purpose of fertility testing and infertility treatment, any preparatory treatments for artificial insemination and medicines, and any form of artificial insemination;
   6. After sterilization, a return to a previous state;
   7. Sex reassignment surgery;
   8. Viagra or generic substitution treatment;
2) A medical treatment or care which starts prior to the insurance inception;
3) A medical treatment or care which starts during the waiting period, namely pertaining to diseases defined in Article 22, Paragraph 4;
4) Preventive medical examinations (the examinations necessary to prevent a disease from occurring – preventive health care);
5) Hip replacement surgery with installation of endoprothesis, and knee replacement surgery with installation of endoprothesis;
6) Any kind of vaccine and serum;
7) Examinations and treatment of fingernail and toenail fungus-related diseases, and examinations and treatment of ingrown nails and cuticles;
8) PRP treatment using blood plasma;
9) Examinations by a general practitioner or medical specialist for the purpose of issuing certificates needed for kindergarten, recreation classes, a driving license, travel abroad, visa, and for any other administrative needs;
10) Any preventive and screening examinations, and diagnostic procedures indicated by age group, positive family anamnesis, or at the personal request of the Insured, notwithstanding medical indication;
11) Evaluation of autonomic nervous system, syncope evaluation;
12) Homeopathy and acupuncture;
13) Psychiatric (neuropsychiatric) evaluations, psychoanalysis and psychotherapy;
14) Procurement of preparations used for mucosal toilet of natural orifice, antiseptics for local application, vitamin preparations to strengthen the immune system (vitamins and minerals), preparations for problematic skin care;
15) Any costs related to treating astigmatism, strabismus, myopia, hypermetropia, presbyopia, including a surgical intervention of radical keratotomy;
16) Cataract surgery;
17) Laser vision correction;
18) Surgical procedures of tissue and organ transplantation, regardless of whether the Insured is a recipient or a donor.
19) Surgical procedures per personal choice, implants and corrective medical-technical aids such as:
   1. Those used for aesthetic purposes, whether for psychological reasons or not, including also dental cosmetic treatments, and consequences thereof, except for implants in total mastectomy;
   2. Surgeries and procedures per personal choice, treatment and/or surgical procedure that is not medically required;
   3. Moles removal per personal choice;
20) Circumcision (foreskin removal) - unless medically indicated;
21) Hearing aids procurement;
22) Using the capacities of emergency medical service provider for cases that are not the cases of medical emergency;
23) Ambient therapy for rest and/or observation purposes;
24) Therapeutic actions of addiction quitting of any kind;
25) Services or treatments within inpatient treatment in all long-term care facilities, hydro-clinics, inpatient healthcare facilities specializing in rehabilitation (spas), sanatoriums or retirement homes (geriatric facilities);
26) Any expenses of cryopreservation and implantation or re-implantation of living cells;
27) Procurement of orthopedic shoes, orthopedic insoles or other foot support aids, such as: foot support and orthotic aids and supplies, any aids that result from the diagnosis of weak, overstrained, unstable or flat feet or fallen arches, and tarsalgia or metatarsalgia;
28) Any expenses related to specific foot injuries such as blisters, corns, hyperkeratosis, and bunions;
29) Body weight reduction treatment or body weight reduction program, gastric balloon surgery, nutritional advice, diet education;
30) Rejuvenation treatments;
31) Psychological services, services of speech therapists and special education teachers;
32) Salt room treatments;
33) Assessments, analyses and trainings with regard to diet, nutrition advice;
34) Pain management therapy;
35) Exercise therapy, except kinesiotherapy, regardless of whether they are prescribed by a licensed physician;

36) Long-term rehabilitation therapy (lasting for longer than a month), regardless of whether it is prescribed by a licensed physician;
37) Compensation for treatments provided by persons who are not licensed to provide healthcare services;
38) Services, preparations, and products which are not prescribed by a licensed physician and are not intended for treatment of the insured person;
39) Healthcare services which are not approved by a licensed physician of the insured person, except for emergency medical treatment when the insured person's licensed physician is fully informed about the treatment and can support the compensation claim;
40) Experimental medical treatment including:
    1. A treatment which is not scientifically or medically acknowledged;
    2. Sleep studies and other treatments related to respiratory arrest during sleep;
41) Other expenses including:
    1. Any expenses exceeding the standard and usual expenses within the meaning of these Special terms and conditions;
    2. Any expenses of additional insurance coverage which is not contracted and for which no additional premiums have been paid;
    3. Expenses of purchasing personal care items during the stay in healthcare institution;
    4. Expenses of biological medicines, advanced therapy medicines, herbal medicines, traditional medicines and traditional herbal medicines, magistral and galenic medicines used to treat cold, medicines at experimental and research stage, healing and mineral waters, medical wines, nutritional products and products for strengthening the immune system, vitamins, tonics, cosmetics, personal care products and unregistered drugs and preparations;
    5. Expenses of an innovative, i.e. original prescription drug when there is also a generic substitute, unless a doctor indicates that the stated medication is necessary;
    6. Expenses incurred because a healthcare institution has practically become and could be regarded as a home or permanent residence to the insured person;
    7. Any non-medical expenses;
    8. Expenses associated with medical treatment incurred after the policy expiry date, which are result of accidents, illnesses or pregnancy during the insurance year, unless the policy is renewed, or if the expenses incurred are in connection with a medically justifiable treatment in people with continuous insurance, excluding prescribed drugs in a therapeutic dosage in the amount allowed for sixty (60) days, which are prescribed during the insurance year and provided that this coverage has been contracted for;
    9. Instructions for use and maintenance of durable medical equipment;
    10. Adaptation of vehicles, bathrooms or a residing facility to one's personal needs;
    11. Expenses for any medical-technical aids that are issued without an order;
    12. Medical-technical aids from within the group of other auxiliary aids and sanitary devices for use in outpatient conditions and for permanent purposes, such as: insulin pumps, motor wheelchair or bed, hospital bed with a harness, extra wheels, RT Crane, antidecubitus mattresses, belts, items to increase comfort (such as phone holders and tables that are placed over the bed), items used to change the air quality or temperature (such as air-conditioners, humidifiers, dehumidifiers and air purifiers), disposable supplies, stationary bicycles, sun or heat lamps, heating pads, bidets, toilet seats, bath seats, sauna, elevator, Jacuzzi, work-out equipment and similar items;
42) Evaluation and treatment of temporomandibular joint disorder, evaluation and treatment of disturbed normal occlusion;
43) Inpatient treatment in a medical institution, hospitals, a ward or similar residential-type facility for mental health;
44) The liability of the Insurer to compensate for the costs of evaluation by a general practitioner or medical specialist if the costs incurred are a result of giving a second opinion in case a surgical intervention is recommended by a licensed physician.

Article 21

(1) Any liability of the Insurer is excluded:

1) If the insured event occurs before the first inclusion into the insurance and is still lasting at the time of concluding the insurance contract under which the insured person acquires the insured status or if the insured event lasts past the expiration of the insurance contract (a pre-existing condition);
2) When the insured event requires inpatient treatment and is a consequence of a person's pre-existing health condition present before the first inclusion in the insurance;
3) Regarding any supplemental coverage defined in Article 13 of these terms and conditions, unless additional premium has been contracted and paid;
4) The Insurer shall not compensate for the expenses of transportation to an institution in the Chain of healthcare institutions;
5) The Insurer shall not compensate for expenses incurred due to the medical therapy or treatment that is initiated before the commencement of the insurance;

(2) Any liability of the Insurer is excluded if the insured event occurs also:

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

(3) If any compensation claim should be found false on any grounds or based on false information and misrepresentation, the Insurer shall not be liable;

(4) Excluded is the liability of the Insurer to compensate for treatment expenses incurred by the insured persons who suffer from and are treated for the following pre-existing conditions:

1) Chronic diabetes with complications,
2) Alzheimer's disease,
3) Aneurysm of cerebral arteries and large arteries of systemic circulation,
4) Angina pectoris,
5) Condition after cardio-vascular insult (infarction) with functional disorders,
6) Cirrhosis of the liver,
7) Brain tumors with neural disturbance,
8) Moderate and severe chronic renal failure,
9) Malignant disease in all organs,
10) Multiple sclerosis,
11) Motor neuron disease,
12) Paralysis / paraplegia,
13) Parkinson's disease,
14) Chronic lung disease,
15) Muscular dystrophy,
16) Pre-senile dementia,
17) Rheumatoid arthritis,
18) Mental disorders,
19) Epilepsy,

20) AIDS, Acquired constriction ring **syndrome** related to AIDS (ARCS) and any diseases caused by HIV and/or related to it.

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

Article 22

(1) In case of the insured event occurrence, the Insured is required, prior to any use of medical services, to place a call to MedUNIQA contact center of the Insurer, which arranges the type, date and time of examination or other medical services on behalf of the insured person within healthcare institutions from within the Chain of healthcare institutions.

(2) The insured person is deemed to have fulfilled their obligation to contact MedUNIQA contact center of the Insurer if they, prior to using medical services, contact MedUNIQA call center of the Insurer and answer questions asked by a medically educated person of MedUNIQA contact center about their current health condition in order to carry out the insurance contract.

(3) If the insured person is unable to fulfill the obligation referred to in Paragraphs (1) and (2) of this Article for justifiable reasons, an authorized person of the healthcare service provider shall fulfill it instead.

(4) The right to compensation for expenses, according to these Special terms and conditions and the insurance contract, the Insured may exercise only within the Chain of healthcare institutions, except in case of the coverage referred to in the following Articles of these Special terms and conditions:

1) Article 2, Paragraph (8),
2) Article 10, Paragraph (7),
3) Article 17

And in case there is no institution from within the Chain of healthcare institutions in the place of residence (based on the address stated in the Proposal) of the Insured.

(5) The Chain of healthcare institutions is published on the Insurer's website.

Article 23

(1) After having provided medical services, the institution from the Chain of healthcare institutions shall submit to the Insurer the documentation specified in the agreement on business cooperation.

(2) The Insured is entitled to reimbursement of expenses borne by them only in the events stipulated in Article 22, Paragraph (4) of these Special terms and conditions.

(3) In case of reimbursement of expenses, the Insured must submit the following:

1) A claim notification form
2) A medical report with the diagnosis stated
3) A prescription for medicines/supplies by a licensed physician
4) The original receipt for medical services
5) A copy of the document on Voluntary Health Insurance
6) A copy of ID Card
7) A current account number.

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

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

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

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

FULFILMENT OF THE INSURER'S OBLIGATION

Article 24

(1) The Insurer shall compensate the institution from within the Chain of health institutions or the Insured for the treatment expenses in accordance with these Special terms and conditions, based on the insurance contract, i.e. policy that is applicable at the time of the insured event occurrence, within 14 days of the date of receiving the complete documentation and establishing the existence of its obligation.

III TRANSITIONAL AND FINAL PROVISIONS

Article 25

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

(2) These Special terms and conditions apply to the insurance contracts, i.e. policies that are concluded starting from the date of these Terms and Conditions' entering into force.

(3) The Insurer must publish these Terms and Conditions on its website.

Article 26

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

(2) In case of any dispute between the Policyholder or the Insured and the Insurer, the court based on the registered seat of the Insurer shall have the subject-matter jurisdiction.

Article 27

(1) Any claims related to the insurance contract are subject to the statute of limitations as defined by the provisions of the Law of Contract and Torts.

Article 28

(1) These Special Terms and Conditions enter into force on and start to apply as of January February 11th to any new contracts concluded starting from this date.

NOTE: This is a mere translation of the original Serbian wording, and in case of any discrepancies between the languages, the Serbian wording prevails at all times.