SPECIAL CONDITIONS FOR VOLUNTARY HEALTH INSURANCE FOR OUTPATIENT AND INPATIENT TREATMENT

PU-DZOVBB-01/24

INTRODUCTORY PROVISIONS

Article 1

(1) These Special Terms and Conditions for Voluntary Health Insurance for Outpatient and Inpatient Treatment (hereinafter: Special Conditions) and the General Terms and Conditions for Voluntary Health Insurance (hereinafter: General Terms and Conditions) are an integral part of the Health Insurance Contract (hereinafter: the Insurance Contract) that the Policyholder voluntarily concludes with the insurance provider Sava neživotno osiguranje a.d.o. Belgrade (hereinafter referred to as the Insurance Company).

(2) Certain terms in these Special Terms have the following meanings:

1. **Insurance coverage** – costs for health services, medicines and medical devices specified in these Special Terms and Conditions and the insurance policy;
2. **New Insured Person** - is a person who is included in voluntary health insurance during the term of the Insurance Contract;
3. **Limit** - is the maximum amount that represents the Insurer's obligation 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 Contract which is in accordance with these Special 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 disease or injury;
5. – Participation in costs is expressed either in a fixed amount of money, or as a percentage of the amount of costs incurred by the use of insurance rights;
6. **Certified physician -** a person with a degree in medical, dental, or other appropriate faculty, who has a license and is authorized to practice medicine in the Republic of Serbia in accordance with the applicable regulations and legal system;
7. **Medically justified treatment** - a health service, medical-technical aids, implants, medical supplies or a medicine that is medically justified if:

- is appropriate and necessary for the diagnosis or treatment and control of the insured person's illness or injury, if they correspond to his clinical needs in scope, doses, and duration and in accordance with the contracted insurance policy,
- are necessary for the healthcare of pregnant women or for the prevention or early detection of diseases during a physical examination, if these orders have been contracted,
- are contracted in accordance with these Special Terms and Conditions and defined in the insurance policy,
- It was prescribed by a licensed physician
- does not exceed, in scope, duration and intensity, the level of protection necessary for safe, adequate, and appropriate treatment according to the guidelines of good clinical practice (the procedures to be performed must be related to the symptoms of the disease and their performance must be justified by the current clinical picture),
- It was during the course of the insurance contract.
- is in accordance with widely accepted professional standards of medical practice in the country of residence of the Insured,
- its primary purpose is not personal comfort or comfort of the patient, family, physician, or other healthcare provider.
- It is not part of the patient's education or professional training, nor is it related to the same.
- if it is not experimental or at the expense stage;

8. **Treatment** - medically justified treatment which, according to the generally recognized rules of the medical profession, is considered appropriate for relieving the symptoms of illness or injury, restoring health, or preventing the deterioration of health, and which is contracted by an insurance policy;
9. **A medical emergency is an** illness or injury that, without immediate medical assistance, can lead to a life-threatening threat to the insured person, i.e. irreparable and serious damage to his health or death. Emergency medical assistance is also understood as medical assistance provided within 12 hours from the moment of admission of the insured person;
10. **Hospital** - a health institution that performs inpatient healthcare activities, as well as specialist-consultative activities at the secondary and tertiary level of healthcare;
11. **Medicine**- a product containing a substance or combination of substances manufactured and intended for the treatment or prevention of disease in humans, diagnosis, improvement or alteration of physiological functions, as well as for the achievement of other medically justified purposes, and which has been granted a marketing authorisation in accordance with the law governing the field of medicinal products;
12. **Medical and technical aids** - medical devices that serve for functional and aesthetic replacement of bulging parts of the body, i.e. providing support, preventing the occurrence of deformities and correcting existing deformities, as well as facilitating the performance of basic life functions;
13. **Implant** - a medical device that is surgically implanted into the human body;
14. **Complementary medicine -** traditional methods and procedures of prevention, diagnosis, treatment and rehabilitation, which have a beneficial effect on human health or the state of health and which, in accordance with the current medical doctrine, are not covered by the methods and procedures of conventional medicine, and which are practiced exclusively in a health institution

or private practice established as a general or specialist office of a medical doctor. doctor of dentistry, polyclinic, healthcare clinic or rehabilitation clinic and are provided exclusively by a health professional who has a license to perform methods and procedures of alternative and complementary medicine.

15. **Sava Contact Center** - the Insurer's telephone service through which insured persons are provided with assistance in the realization of insurance in the manner provided for in these Special Terms and Conditions.

INSURANCE CONTRACT

Article 2

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

(2) By the Insurance Contract, the Policyholder undertakes to pay the premium to the Insurer, and the Insurer undertakes, in the event of the occurrence of an insured event, to reimburse the costs of treatment, i.e. medically justified treatment or to pay other financial compensation in accordance with the Insurance Contract.

(3) Under these Special Conditions, the following may be contracted:

1. Collective insurance, a group of at least 10 persons, if the Policyholder is a legal entity or other subject of law that contracts insurance for its employees, service users, students or other persons with whom it is in a contractual relationship.
   With the consent of the policyholder, members of the Insured's family may also be included in the insurance coverage.
   An integral part of the concluded insurance contract is a list of insured persons.
2. Individual insurance if the Policyholder is a natural person and arranges insurance only for himself, for himself and members of his family or only for members of his family, if the Insured is at the same time insured under another collective insurance policy in accordance with these Special Conditions.

(4) The reimbursement of medical costs provided by the Insurer may not exceed the maximum agreed sum insured indicated on the policy during the agreed insurance period, i.e. up to the maximum limit defined by these Special Terms and Conditions and the insurance policy for individual treatments within the insurance coverage.

(5) According to these special conditions, the Insurance Contract may conclude coverage of the costs of medical treatment and medical services such as:

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

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

(7) Insurance coverage is valid 24 hours a day, in the territory contracted by the policy.

QUESTIONNAIRE ON THE HEALTH STATUS OF THE INSURED PERSON

Article 3

(1) A questionnaire on the state of health is mandatory with individual voluntary health insurance.

(2) During the first inclusion in collective insurance, i.e. concluding the Insurance Contract, the Insurer has the right to require the insured to fill in a questionnaire when concluding the Insurance Contract.
In this case, the questionnaire is an integral part of the Insurance Contract.

(3) The insured is not obliged to fill in the questionnaire during the renewal of insurance, i.e. if the Policyholder re-concludes the Insurance Contract with the same insurance coverage for this person and the next insurance year.

(4) The insured person is obliged to truthfully answer the questions asked in the questionnaire form and to report any other circumstance that is known to him, and is of importance for the risk assessment.

CHANGES IN THE LIST OF INSURED PERSONS DURING THE INSURANCE PERIOD

Article 4

(1) After the entry into force of the Insurance Contract, it is possible to include a new person in the insurance coverage, only if the person to be included in the insurance is:

1) in the case of collective insurance - in the capacity of a new person who has entered into employment, has become a user of the services of the Policyholder, i.e. has become a member of the Policyholder, after the commencement of the Insurance Contract, i.e. that the contractual terms and conditions of employment have been changed for this person, if the Insured is employed by the Policyholder, or the contractual conditions for members of the Policyholder have been changed, i.e. the contractual conditions as a user of the Policyholder's services have been changed;
2) in the capacity of a spouse or common-law partner of the Insured Person, which status he acquired after the entry into force of the Insurance Contract;
3) as a newborn child of the Insured, for a child born after the beginning of the Insurance Contract or a decision on adoption from the Center for Social Work, as proof that the adopted child acquired this status after the beginning of the Insurance Contract.

(2) In the cases defined in paragraph (1) of this Article, the Policyholder is obliged to notify the Insurer of the inclusion of a new person within 30 (thirty) days from the date of the change.

(3) In the case of inclusion of a person in insurance after the beginning of the contracted insurance period, the Insurer is entitled to a proportionate part of the premium from the date of inclusion of that person until the end of the agreed insurance period, for basic coverage and supplementary coverage, except for a annual physical examination where the Insurer is entitled to the annual insurance premium, unless otherwise agreed.

(4) Exclusion of a certain insured person from insurance before the expiry of the agreed 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 particular insured person within 7 days of the occurrence of the change and to submit to the Insurer

a confirmation that one of the cases defined in Article 14, paragraph (1) of the General Terms and Conditions has occurred, as well as to submit the Voluntary Health Insurance Document for that insured person.

(5) In the event of exclusion of a person from insurance before the expiry of the agreed insurance period, the Insurer is entitled to a proportional part of the premium to the day until which the insurance lasted for that person, for basic and supplementary coverage, except for the premium for a physical examination, which is retained in full, unless otherwise agreed.

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

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

PROPOSAL FOR INSURANCE WITH CHANGED CONDITIONS

Article 5

(1) The insurer has the right to accept a person who, based on the Health Status Questionnaire, has the right to accept a person into insurance with changed conditions.

(2) If the Insurer, based on the data from the Health Questionnaire determines that a person poses an increased risk for admission to insurance, it may request additional medical examinations and analyses for the person concerned for the purpose of adequate risk assessment.

(3) If the Insurer assesses that it is necessary for the Insured to undergo a medical examination in order to assess admission to insurance, the Insured is obliged to perform the following medical examinations and analyses at his own expense and obtain:

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

(4) The Insurer also has the right to extend the content of the necessary medical examination, at the discretion of the Insurer's doctor.

(5) In the event that, after receiving the offer, the Insurer requests additional information in accordance with paragraphs (2) and (3) of this Article, i.e. requests a medical examination, the offer shall be considered received when the Insurer receives the requested additional data, i.e. the required medical reports after the medical examination.

(6) If the bidder, at the written request of the Insurer, fails to submit the requested information within 8 (eight) days, counting from the date of receipt of the written request of the Insurer for the delivery of the requested information, or within 30 (thirty) days in the case of a request for a medical examination, it will be considered that the bidder has withdrawn from its offer.

(7) Standard risk is a person who, at the time of submitting the Questionnaire and/or medical examination, does not have any subjective physical or mental problems (illnesses) or has diseases with a slight risk in the opinion of the Insurer, i.e. diseases that do not involve either recurrences or consequential diseases.

(8) An increased risk is a person who does not have major subjective physical or mental 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 for which outpatient or inpatient treatment or therapy was required before the start of insurance.

(9) The degree of increased risk in accordance with paragraph (2) of this Article shall be determined by the medical censor and/or risk-taker of the Insurer based on the 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 is obliged, within eight (8) days from the receipt of the Questionnaire and/or the medical examination, to send to the Policyholder, in writing, a proposal for insurance with changed conditions and inform the Insured thereof.

(11) If it is determined in the risk assessment procedure that the person concerned represents an increased risk, the Insurer may propose to the Policyholder insurance with changed conditions, as follows:

- limitation or exclusion of certain insurance coverages;
- increase in insurance premiums;
- application of certain special waiting periods.

(12) If the Policyholder does not accept the proposed amendment to the terms and conditions in writing within fourteen (14) days of receipt of the Insurer's proposal, it shall be considered that it has withdrawn from the insurance for the person who poses an increased risk.

(13) The insurer may propose insurance with changed conditions even after the conclusion of the Contract, if the insured suffered from diseases at the time of concluding the Insurance Contract that he did not report when submitting the offer in one of the following ways:

1) after a systematic or other examination, i.e. when using the services covered by the voluntary health insurance contract,
2) from communication with the SAVA contact center and subsequently submitted medical documentation.

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

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

INSURED AMOUNT

Article 6

(1) The agreed insured amount 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 agreed sum insured, i.e. the limits (limits) for individual insurance coverages are specified in the insurance policy.

(3) The reduction referred to in the previous paragraph shall be realized by subtracting from the available insured amount and limit the compensation paid (in RSD), converted into EUR according to the middle exchange rate of the National Bank of Serbia on the day of the claim calculation.

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

WAITING PERIOD (WITHDRAWAL PERIOD)

Article 7

(1) The withdrawal period is contracted by the insurance policy.

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

(3) The withdrawal period does not apply to persons with continuous insurance.

(4) In any case, if the withdrawal period for the Insured has not expired during the period of the previous policy, the remaining period of the previous grace period is carried over to the next insurance period under the new policy.

(5) In the event that, after the expiration of the policy, a policy with a new coverage is concluded to which the grace period applies, for the services used under the new coverage, the grace period begins to be calculated from the date of commencement of insurance for the Insured under the new policy.
All medically justified treatments occurring after the expiry of the withdrawal period in connection with the treatment of diseases diagnosed during the withdrawal period are covered by insurance in accordance with these Special Conditions.

INSURED EVENT

Article 8

(1) An insured event is a future uncertain event when a medically justified treatment has been performed on the Insured due to a health disorder (illness or injury), which is the subject of the Insurance Contract and the costs of which need to be settled in a health institution, private practice, other healthcare provider, or the insured, depending on the contracted insurance coverage defined by the policy.

(2) A disorder of health within the meaning of paragraph (1) of this Article must be determined by a licensed medical practitioner.

(3) If an insured event occurs within the meaning of these Special Conditions, the Insurer is obliged to reimburse reasonable and usual costs up to the agreed amount of coverage incurred during the term of the Insurance Contract.

(4) Only if a premium has been separately agreed and paid, the costs of medically justified treatment, i.e. treatment for supplementary insurance coverages that can be contracted to cover costs, are considered to be an insured event:
1) hospital treatment;
2) healthcare of pregnant women and newborn babies;
3) annual physical examinations;
4) ophthalmological services;
5) dental services;
6) prescription drugs and orders;
7) physical and speech therapy;
8) complementary medicine;
9) special coverage in the event of a tumor;
10) A second medical opinion.

(5) An insured case begins with the beginning of medical treatment, i.e. treatment, and ends at the moment when, from a medical point of view, there is no longer a need for treatment, because a cure or stability of the health condition has been achieved, and its further improvement or deterioration is not certain.

(6) In any case, the insured event ends on the day of expiry of the Insurance Contract.

REIMBURSEMENT OF MEDICAL EXPENSES

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 person, to the provider of medical services, up to the maximum amount of the sum insured specified in the policy, or for certain health services up to the limit for such service, provided for in the Insurance Contract, i.e. polis.

(2) All costs, related to treatment or medical services, which exceed the amount of the insured amount, i.e. exceed the available amount of the defined limits, are borne by the Insured himself.

(3) The Insurer will not cover the costs of medical treatment if the Insured has exercised its right to reimbursement of medical costs from compulsory health insurance or based on voluntary health insurance concluded with another Insurer for a specific insured case.

(4) Treatment or medical treatment is considered to be any medical or surgical procedure that, according to the generally recognized rules of the medical profession, is considered appropriate for relieving the symptoms of the disease, improving health, or preventing exacerbation, or treating the disease in order to restore health or cure the disease.

(5) Treatment, i.e. medical treatment, can be provided as inpatient and/or outpatient treatment.

SHARE OF THE COSTS

Article 10

(1) A contract on voluntary health insurance can be arranged with a general participation in the costs that include the participation of the Insured in each medically justified treatment provided, for basic and additional coverage, if contracted.

(2) If mandatory participation in the costs for certain coverages or health services and/or health institutions is agreed upon, this participation is also stated on the insurance policy.

(3) If two or more types of participation are applied to a particular service, each subsequent one is added.

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

AUTHORISATION

Article 11

(1) Authorisation of medical treatment means the procedure for approving the cost of health services prior to their use, in the cases referred to in paragraphs (2) and (3) of this Article, except in the case of a medical emergency.
(2) The application for authorization, on the Insurer's form, must be submitted by the insured person, i.e. the health institution at least 14 days in advance in the following cases:
   1) Hospital treatment that is not urgent.
   2) surgical interventions that are not urgent,
   3) For all medical treatments over €300,
   4) For the sake of childbirth,
   5) for prenatal diagnostics,
   6) for the procurement of permanent medical-technical aids.
(3) The policy can also define other cases for which authorization is required.
(4) Authorization may be requested by the Insured or an authorized person of the health service provider in which the medically justified treatment will be carried out, whereby the Insured must be familiar with the request for authorization and the Insurer's response to the request.
(5) Along with the request for authorization, the insurer shall be provided with all relevant documentation (medical documentation, pro forma invoices and all other documentation that the Insurer additionally requests).
(6) The written approval of the Insurer shall state whether the proposed medically justified treatment is in accordance with the conditions and with the agreed coverage, or whether it is an exclusion in this particular case.
(7) In the event of non-compliance with the provisions of this Article, the Insurer shall be entitled to reduce the insurance compensation and limit its liability to reasonable and normal costs.
(8) Services related to a medical emergency when the life of the insured is endangered are not subject to authorization.

INSURANCE COVERAGE (RISKS COVERED BY INSURANCE)

Article 12

(1) The insurance policy shall conclude the basic package of coverage of outpatient treatment, defined in Article 13 of these Special Conditions, and the following additional coverages may be arranged:
   1. hospital treatment,
   2. healthcare for pregnant women and newborn babies,
   3. An annual physical examination ,
   4. ophthalmological services,
   5. dental services,
   6. prescription drugs and order,
   7. physical and speech therapy,
   8. complementary medicine services;
   9. special coverage in the event of a tumor;
   10. A second medical opinion.
(2) The selected insurance coverage (package of coverage) is determined by the consent of the Insurer and the Policyholder.
(3) The contracted insurance coverage package with a precisely defined scope and content of health services (Table of Coverage) is an integral part of the insurance policy.
(4) At the request of the Policyholder, the Insurer may accept to select the scope of health services, the specified exclusions of the Insurer's obligations, as well as the amount of the limit.

OUTPATIENT TREATMENT

Article 13

(1) Outpatient treatment includes the cost of medical treatment, i.e. treatment received by the insured person in a health institution as a health service provider, which is officially recognized as a place where such treatment can be carried out. In the outpatient treatment of medical services, methods that have been clinically tested and accepted in the Republic of Serbia must be scientifically recognized, and that the insured person has not spent 24 hours in the institution (staying overnight, i.e. occupying a hospital bed).
(2) Within the framework of outpatient treatment, the following coverages can be arranged, i.e. the following health services:
   1) **Examinations and diagnostics**
   Examinations – examinations of general practitioners and doctors of all specialties Examinations include the first examinations, control examinations.
   Diagnostics - includes the following diagnostic procedures, if they are contracted in accordance with the Insurance Contract and only on the recommendation of an authorized doctor (given during the insurance period, i.e. during the period of the previous insurance policy in continuity) in accordance with the medical indication and diagnosis:
      1. **Laboratory** – hematological, biochemical, hormonal tests, tumor markers, serological and microbiological diagnostics including molecular diagnostics (PCR microbiology) and pathohistology, panels of inhalation, nutritional and other allergens.
      Laboratory diagnostics do not include:
- genetic testing (cytogenetics, molecular genetics) and
- food intolerance testing.

      Radiological examinations – Ultrasound and color Doppler diagnostics, X-ray diagnostics (with and without contrast);
      2. **Diagnostic endoscopic procedures** up to the agreed sub-limit, except:
- transesophageal ultrasound of the heart (endoscopic-ultrasound diagnostics)
- bronchoscopy and arthroscopy;

      Biopsies and punctures, HP analyses for material obtained in diagnostic procedures, but not for material obtained during a surgical intervention for which there is no coverage, immuno-histochemical analysis of histopathological findings obtained during a surgical intervention for which there is no coverage, is also excluded;
      3. **ergometry;**
      4. **Spirometry;**
      5. **Tympanometry, audiometry and vestibulometry;**
      6. **EEG, EMNG, EMG, ECG, Holter ECG and blood pressure holter**;
      7. **Nuclear diagnostics** (scintigraphy, voiding scintigraphy, myocardial SPECT);
      8. **MRI and CT** (magnetic resonance imaging and computed tomography – scanner) with and without contrast, up to the agreed sub-limit;
   2) **Examinations and diagnostic procedures, laboratory tests, tests and analysis necessary for the examination of the**

reproductive system (sterility, infertility and preparation for pregnancy) on the recommendation of a licensed physician;

3) **Outpatient interventions** - primary treatment of the wound (rinsing the wound, treating the edges of the wound and suturing the wound), primary treatment of the burn, removal of sutures with bandages, removal of ticks and other foreign bodies from the skin, ear, throat, and nose, fixation and immobilization of the joint, as well as toilet mucous membranes and natural openings, placement of a drug strainer, incision of the abscess, therapeutic puncture of the joint and connective tissue, orthopedic reposition of luxations and fractures without anesthesia on the recommendation of a licensed physician;
4) **Ambulance transport** includes transport by ambulance due to illness or injury that is life-threatening to the insured to the nearest health institution, as well as ambulance transport that is justified and medically necessary and ordered by a doctor of the appropriate specialty with the approval of the Insurer;
5) Administered therapy in outpatient conditions - remuneration for administering, i.e. administering therapy, which represents remuneration for the work of the competent physician and medical technicians for the implementation of therapy with drugs for which a marketing authorization has been issued in the territory of the Republic of Serbia in accordance with the law and the cost of the drug according to the agreed sub-limit
6) **Home treatment in an emergency** is a home visit by an authorized doctor and the application of drug therapy in medical emergencies with the mandatory prior authorization of the Insurer.
7) **Examinations and diagnostic procedures, and laboratory tests, in connection with problems arising from confirmed Covid-19 infection for a period of no longer than six months after the diagnosis**;
8) **Mental health,** depending on the contracted package, may include the following services:
   1. Examinations by psychiatrists/neuropsychiatrists and psychologists in crisis situations up to the agreed sub-limit
   Crisis situations are considered to be conditions due to:
- Physical abuse
- Rape
- Death of a close family member
- Coping with a serious illness – malignancy;
- Postpartum depression
- Divorce process
- Dissmisals
- Covid support.

   2. Psychiatric examinations and psychotherapeutic work outside of crisis situations, provided that they are medically necessary.
   3. Examinations by a child psychiatrist/neuropsychiatrist and medical associates, psychologists, and special education specialists, including psychological and special education treatments.
9) **Emergency dentistry** due to an accident is a dental intervention for the restoration or replacement of healthy natural teeth damaged in an accident, with a mandatory report to the Insurer within 48 hours of the intervention;
   Healthy teeth are teeth that do not have cracks or teeth on which dental services for the treatment of dental diseases (crowns, fillings, etc.) have not been performed before the occurrence of the insured event.
   Damage to the teeth from chewing food does not entitle you to immediate dental treatment.
   Emergency dental treatment can be provided through inpatient or outpatient treatment.
10) **Medical-technical aids** - only if they have been prescribed by an authorized physician and approved by the Insurer, as follows:
- Prosthetics - 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 motor wheelchairs, armpit and forearm crutches, metal walking stick with support points, walking stand)
- Aids to enable voice and speech
- Other types of medical and technical aids if they are contracted and listed in the insurance policy.
- Medical aids are medical devices that serve for the functional and aesthetic replacement of lost parts of the body, i.e. to provide support, prevent the occurrence of deformities and correct existing deformities and facilitate the performance of basic life functions.

(3) For the use of outpatient treatment services, the Insured is entitled to reimbursement of costs up to the agreed sum insured and the defined limits agreed upon by the policy, i.e. insurance policy for this insurance during the insurance year.

HOSPITAL TREATMENT

Article 14

(1) Hospital treatment means the reimbursement of the costs of medical treatment, i.e. treatment in an institution that is considered a hospital as a provider of health services in accordance with the law, 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 is valid, where the insured person is under the constant supervision of medical staff, who has a sufficient number of diagnostic tests, laboratory, surgical and therapeutic equipment. In hospital treatment, medical services must be scientifically recognized methods that have been clinically tested and recognized in the country where the insurance coverage is valid in accordance with the policy.
(2) Hospital stay (hospital treatment) is considered to be the time spent by the insured person on treatment that requires presence in the hospital for at least 24 hours, as well as the time spent in a day hospital in the event of a surgical intervention.
(3) Within the meaning of these Special Conditions, a day hospital is a special organizational unit of a health institution organized for the performance of surgical interventions, observations and therapeutic endoscopic procedures during daily work.
(4) Hospital treatment is not considered to be the accommodation of an insured person in inpatient institutions such as:
   1) (except in the cases referred to in paragraph 2 of this Article);
   2) addiction rehab facilities;
   3) mental hospitals;
   4) inpatient medical institutions specializing in rehabilitation (spas) and spa centers;
   5) hydroclinic;
   6) sanatoriums;
   7) nursing homes;

8) nursing homes, i.e. geriatric institutions;
9) health resorts, rest centers, weight loss or recovery.

(5) Hospital treatment services include exclusively:

1) **Reimbursement of hospital accommodation and meals** that are medically permitted and recommended by a licensed physician during hospital treatment.
When it comes to reimbursement of accommodation and food costs, the Insurer shall, if the hospital in which the insured person is undergoing treatment has the capacity and capabilities to provide them to the insured person, reimburse the costs in the case of accommodation in standard rooms available in the health service provider.
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 in the health service provider;
2) **Reimbursement for authorized doctors of all specialties** from the health institution, i.e. the hospital in which the person is insured for hospital treatment, which includes an examination by a specialist of any specialty according to the medical indication;
3) **Reimbursement for diagnostic methods –** procedures, laboratory tests, tests and analyses according to medical indications and only on the recommendation of an authorized physician that are necessary to establish health, improve health or prevent deterioration of health of the Insured. Diagnostic methods, which are required by an authorized doctor, and in accordance with the medical indication and diagnosis, include:
   1. laboratory tests and all necessary laboratory diagnostics (except genetic testing),
   2. Radiological examinations, namely: ultrasound, X-ray, radiography, radioscopy, CT and MRI,
   3. endoscopic procedures,
   4. Biopsy
   5. ergometry,
   6. spirometry,
   7. EEG, EMG, EMNG, ECG, Holter ECG,
   8. other medically indicated diagnostic procedures.
1) **Reimbursement for the administration of therapy**, which is a fee for an authorized physician and qualified medical technicians, the costs of using medical or technical equipment, the costs of administering drugs and radiological material and other material costs of the implementation of the following therapies: medicament, injection, infusion, early physical, early rehabilitation, radiotherapy and chemotherapy;
2) **Reimbursement for medicines and medical supplies, blood and blood products** prescribed for use in the course of hospital treatment, excluding reimbursements for medicinal and mineral water, medicinal wines, nutritional preparations and strengthening agents, invigorants, cosmetics, personal hygiene products and unregistered medicines and preparations according to the national register of medicines;
3) **Reimbursement for the costs of medical and technical aids**, up to the limit defined in the insurance policy;
4) **Reimbursement for the costs of surgery, i.e. interventions** (in local, general endotracheal anesthesia, laparoscopic interventions), which includes reimbursement for the work of the surgeon, anesthesiologist, assisting physicians and support staff (qualified medical technicians and other health professionals), including the costs of preoperative preparation incurred from admission to hospital treatment to surgery, intensive care and subsequent treatment (postoperative care until discharge from the hospital). hospital), up to the maximum amount of insurance contracted by the policy.
The costs of the surgery also include implants prescribed by an authorized doctor, up to the maximum agreed limit per insured person.
5) **Reimbursement of the costs of accompanying parents/ guardians** during hospital treatment, for children up to 18 years of age;
6) **Treatment in the emergency department;**
7) **Emergency dentistry due to an accident** is a dental intervention for the restoration or replacement of healthy natural teeth damaged during an accident, with a mandatory report to the Insurer within 48 hours of the intervention
Healthy teeth are teeth that do not have cracks or teeth on which dental services for the treatment of dental diseases (crowns, fillings, etc.) have not been performed before the occurrence of the insured event.
Damage to teeth from chewing food does not entitle you to immediate dental treatment

(6) For the use of hospital treatment services, the insured is entitled to reimbursement of costs up to the agreed sum insured and defined limits, agreed upon by the policy, i.e. insurance policy for this insurance during the insurance year.

HEALTH CARE OF PREGNANT WOMEN

Article 15

(1) Health care of a pregnant woman is an insurance coverage based on which the insured person is entitled to reimbursement of the costs of medically justified treatments, incurred during outpatient or inpatient treatment, up to the limit defined in the insurance policy, and within the sum insured.
(2) The Insurer's obligation in the case of healthcare coverage for pregnant women is excluded in the case of a pregnancy that began before the start of the insurance coverage, as well as in the grace period specified in the policy.
A pregnancy is considered to have occurred before the commencement of insurance if the insured person's gynecologist has determined that the due date is before the expiry of the period of nine months, counting from the date of commencement of insurance coverage for that Insured.
(3) Paragraph (2) of this Article shall not apply in the event that the insured person had contracted coverage for the healthcare of pregnant women under a previous policy with the same Insurer or with another Insurer and if there was no interruption in insurance.
(4) In any case, if during the insurance period new persons are included in the capacity of spouse or extramarital partner of the Insured, there is no obligation of the Insurer to use the healthcare service of a pregnant woman and childbirth if the pregnancy began before the commencement of insurance for that person.
(5) The maximum annual coverage for the costs of healthcare of pregnant women includes the following medically justified treatments, i.e. Reimbursements:
   1) **for gynecological examinations, swabs, laboratory analysis** such as CBC, basic biochemistry, urine analysis, and according to the recommendation of an authorized doctor – gynecologist who manages the pregnancy;
   2) **costs for ultrasound examinations of the fetus;**
   3) **additional ultrasound** (so-called expert ultrasound);

4) **additional ultrasound in case of high-risk pregnancy or complications**, based on a reasoned documented opinion of a licensed physician-gynecologist on medical necessity (expert ultrasound and fetal echocardiography);
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 gynecologist who manages the pregnancy;
7) **The cost of prenatal vitamins**, iron preparations and hormonal drugs as indicated by a gynecologist or doctor of another specialty only if they are related to pregnancy and are intended for the proper development of the fetus, and are not intended for general use.
8) In the case of collective insurance, **one non-invasive prenatal test** (NIPT) for the detection of chromosomal abnormalities of the fetus (for the detection of the sex of the baby, trisomy of chromosomes 13, 18, 21, aneuploidy of sex chromosomes) with contracted participation **or one invasive prenatal diagnosis** (biopsy of chorionic villus or amniocentesis or hordocentesis) in the case of high-risk pregnancy;

(6) In the case of collective insurance, if an additional premium is separately contracted and paid, the insurance coverage also covers **the costs of childbirth**, which includes the total cost of childbirth up to the amount defined by the policy (for epidural anesthesia, apartment accommodation, presence of the father at the birth, compensation for doctors, medical technicians, anesthesiologists), caesarean section only if medically indicated).
The maximum annual coverage for childbirth costs includes:
1. one follow-up examination - a complete **routine gynecological examination** after childbirth;
2. **Community care provided by midwives immediately after the expiry of the period of community care to which the insured person is entitled as a compulsory insured person, and no longer than the first month of the newborn's life, on the recommendation of a certified physician up to the maximum amount of costs specified in the insurance policy.**
3. **Five routine check-ups of the newborn** during the year of coverage, which include monitoring the growth and development of the child.

ANNUAL PHYSICAL EXAMINATION

Article 16

(1) An annual physical examination is a package (set of health services) that are provided with the purpose of preventive healthcare.
(2) With one policy, it is possible to contract several packages of physical examinations, with the Insured being able to use each contracted package only once during the insurance year
(3) When, during the insurance year, new insured persons, including newborn children, are enrolled, they are entitled to full health check coverage, regardless of the actual duration of the insurance for them, with the obligation of the policyholder to pay the full annual premium to cover the physical examination for those persons.
(4) The content of the physical examination is defined by the insurance policy.
(5) A physical examination can be performed in a health institution with which the Insurer has contracted a package of physical examinations, with a mandatory appointment through the Sava Contact Center, unless otherwise agreed.

OPHTHALMOLOGICAL SERVICES

Article 17

(1) During the insurance period, the insured person is entitled to reimbursement of costs for ophthalmological services and aids that include:
1) specialist examinations by an ophthalmologist, i.e. examination of vision checks, determination of the existence or control of existing refractive anomalies and prescription of ophthalmic aids;
2) purchase of a prescription frame with prescription glasses,
3) and/or a pair of prescription glasses,
4) and/or prescription contact lenses.

(2) In the case of continuous insurance, the Insured acquires the right to change the frame and glass if his diopter is changed;
(3) If the insurance is continuous and there has been no change in diopters, the Insured has the right to purchase glasses frames and prescription glasses in accordance with the previous paragraph, once every two years.
(4) With the loss or damage of aids, the Insured does not acquire the right to purchase new ones at the expense of insurance.
(5) The obligation of the Insurer is excluded in the following cases:
1) radial keratoma or any surgical procedure (including laser treatments to improve vision);
2) sunglasses and/or related glasses accessories.

DENTAL SERVICES

Article 18

(1) Dental services include:
1) **Preventive treatment** – includes routine check-ups, dental instructions, fluoride treatment for persons up to 18 years of age.
2) **Basic restorative** – includes amalgam and composite fillings, compomer restorations and tooth extractions**.**
3) **Larger restorative** – includes root filling, crowns and fillings at a higher level (inlay), bridges, laboratory costs, anesthesia, surgical wisdom tooth extraction, periodontal removal of tartar (once a year) and root cleaning.
4) **Orthodontic treatment** – models for analysis (including panoramic X-rays), impressions, mobile wired and fixed appliances (dentures).
Orthodontic treatment is allowed only with the written consent of the Insurer and only for insured persons up to 19 years of age.

(2) For the use of dental services, the insured person is entitled, during one insurance year, to reimbursement of the amount of costs up to the limit for dental services defined in the insurance policy.
(3) The obligation of the Insurer is excluded in the following cases:
1) Cosmetic and aesthetic dental treatments;
2) surgical interventions such as apicoectomy, flap surgery, implant placement;
3) artificial teeth (total and partial dentures);
4) any ceramic restorations on dental implants;
5) multi-surface fillings (onlay),

6) facets and all associated expenses,
7) teeth whitening and
8) all other dental aids.

(4) For all treatments performed, there must be a written medical indication and a report on the service performed. The report states 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 are also attached.

MEDICINE

Article 19

(1) A medicinal product is considered to be a product that has received a marketing authorisation in the Republic of Serbia and a product that has not received a marketing authorisation in the Republic of Serbia, and which is imported based on an authorisation from the Agency for Medicinal Products and Medical Devices of the Republic of Serbia, in accordance with the law governing the field of medicinal products.
(2) In the case of an individual insurance contract, only prescription drugs are considered medicines, while in a collective agreement on insurance medicines, in addition to prescription drugs, prescription drugs are also considered prescription drugs.
(3) Prescription drugs are medications prescribed by a licensed physician with a medical indication.
The insurer will cover the cost of medications only if they are prescribed in therapeutic doses for a maximum of sixty (60) days.
(4) Prescription drugs are medications prescribed by a licensed physician with a medical indication, which are carried out in an outpatient setting.
The insurer will cover the cost of medications only if they are prescribed in therapeutic doses for a maximum of ten (10) days.
(5) The maximum amount of compensation, i.e. The limit for the cost of medicines is defined in the insurance policy, per insured person, during the insurance year.
(6) This coverage does not cover medications given in the hospital during hospital treatment or during surgery or other interventions, as well as when bedridden for high-risk pregnancy and maintenance.
(7) The insurer will not cover:
1) biological, immune, herbal medicines, medicines from blood and blood plasma, drugs for advanced therapy, while traditional and homeopathic medicines are exclusively covered by the coverage of “Traditional medicine”, if contracted;
2) medical cosmetics;
3) vitamins that are in the register of drugs, except in the case of a diagnosis of a 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 for the duration of therapy,
2. iron preparations for anemia (with a doctor’s report 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
(2) procedures of physical therapy and medical rehabilitation in an outpatient setting, provided by qualified therapists according to the medical indication of a physiatrist or not older than 3 months. Physical therapy and medical rehabilitation procedures include electrotherapy, laser therapy, magnetotherapy, thermotherapy, ultrasound therapy, kinesitherapy, voice and speech therapy due to laryngeal injury, excluding all types of massage, lymphatic drainage, endermology (LPG) and ozone therapy .
(3) The costs of physical therapy performed at home are reimbursed only in the event that the insured person is immobile, with the prior approval of the Sava Contact Center, and according to the recommendation of the authorized doctor who has previously treated the insured person.
(4) Physical therapy coverage can be arranged for chronic diseases and conditions of the spine and locomotor system by paying an additional premium, which is defined by the insurance policy.
(5) Speech therapy services are provided by a special education speech therapist in the case of speech disorders, as well as voice and speech therapy due to laryngeal injury.

COMPLEMENTARY MEDICINE SERVICES

Article 21

(1) If this coverage is contracted, the Insurer provides coverage for the costs of quantum medicine, homeopathy (including homeopathic remedies), acupuncture, and other methods, in accordance with the Insurance Contract.
(2) Complementary medicine procedures are recognized only if they are performed in accordance with the law governing this area, when they are provided by licensed physicians and when they constitute a treatment for a disease covered in accordance with these Special Conditions.

SPECIAL COVERAGE IN THE EVENT OF A TUMOR

Article 22

(1) If separately agreed, the Insurer will pay a one-time monetary compensation defined in the insurance policy, after the expiration of the mandatory grace period for this coverage of 6 months in the event that the insured is diagnosed with a malignant tumor.
(2) The total insured amount shall be exhausted, i.e. reduced by the paid amount of the one-time financial compensation referred to in the previous paragraph. The maximum obligation of the Insurer for the payment of compensation may not exceed the agreed sum insured.
(3) A malignant tumor within the meaning of these Special Conditions is considered to be a histologically proven tumor with uncontrolled, invasive growth and a tendency to form metastases, which is classified in the International Classification of Tumors. Serious disease, within the meaning of these Special Conditions, is also considered to be forms of tumors of the

blood, blood-producing organs and lymphatic system, including leukemia (except chronic lymphatic leukemia) and lymphomas (except stage II Hodgkin's disease).

(4) Malignant tumors, within the meaning of these Special Conditions, are not considered to:
- tumors "in situ" (including cervical dysplasia CIN-1, CIN-2 and CIN-3) or premalignant forms
  Melanomas with a histologic thickness of less than 1.5 mm or a penetrating depth of less than Clark level 3
  All hyperkeratoses and basal cell carcinomas of the skin, unless they show signs of invasive growth and/or metastasis.
- Kaposi's sarcoma and other tumors with concomitant 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 tumor is made by a specialist pathologist based on a microscopic examination of tissue (PH findings).

A SECOND MEDICAL OPINION

Article 23

(1) If a separate contract is made and an additional premium is paid, the Insured may request a second medical opinion if the following conditions are met:
   1) The insured person has been diagnosed with the disease – the insured must have an official diagnosis from the competent doctor as a prerequisite for securing a second medical opinion;
   2) The insured person has been examined by a competent doctor in the last 12 months, but not before the first inclusion in the insurance – a prerequisite for obtaining a second medical opinion is the existence of recent medical documentation;
   3) The Insured has not developed an acute condition or a condition that is life-threatening;
   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 shall contact the Insurer, who shall submit the form necessary for further proceedings. The insured must fill out the obtained documentation and, together with the medical documentation in his possession, submit it to the Insurer. The insured will receive a proposal from the Insurer from a medical institution that, according to the diagnosis of the disease he has, would issue a second medical opinion. If the insured does not accept the Insurer's proposal, in agreement with his doctor, he can request a second medical opinion from two other medical institutions.

(3) Within ten working days of submitting the medical documentation to the selected world-renowned health institution, the insured person will receive a second medical opinion, translated into the mother tongue. The second medical opinion contains a comment on the diagnosis of the disease, a comment on the procedure for treatment 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 documentation.

(5) The insured person decides to obtain a second medical opinion only at his own risk and bears all the consequences of such a decision. The insurer is not responsible for any damages nor is it entitled to request any health information obtained within the framework of a second medical opinion.

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

EXCLUSIONS OF INSURERS' LIABILITIES

Article 24

(1) Under these Special Conditions, the Insurer is not obliged to reimburse the costs incurred as a result of:
   1) the fact that the Insured did not comply with the doctor's instructions;
   2) the fact that the Insured refused to release the doctor who made the diagnosis from the obligation of secrecy and thereby prevent the Insurer from obtaining the necessary information;
   3) misuse of the policy, i.e. documents,
   4) examination by a doctor with the purpose of issuing certificates for administrative purposes (kindergarten, sports, driver's license, trip abroad, remittances for sick leave, etc.).

Article 25

(1) The Insurer's obligation is excluded for all coverages that are not specified in the policy or its annex 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 the contracted insurance policy, as well as the consequences of such an event, are excluded.

(3) The Insurer's obligation for the costs of filing a claim incurred by the Insured on behalf of the engagement of a lawyer or on any other basis is excluded.

(4) If the insured event occurred and lasts at the time of concluding the Insurance Contract, i.e. if it concerns the costs of treatment of the Insured's illness from which he suffered at the time of concluding the Insurance Contract, unless otherwise agreed;

(5) If the insured event occurred during the insurance period, and the treatment of the Insured continues even after the expiration of the Insurance Contract, the Insurer is obliged to pay the costs of healthcare, i.e. pay the agreed fees that were incurred until the day until which the Insurance Contract lasted, except in the case when the Insurance Contract was renewed.

(6) Cover for costs incurred after the expiry of the insurance coverage as a result of an accident, illness or pregnancy occurring during the insurance period is excluded.

(7) The Insurer's obligation 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. A vaccine will not be covered if it contains a component of the vaccine that is required by law.

(8) Excluded is coverage for services performed in institutions that are not considered providers of health services in accordance with these Special Conditions, such as gyms,

fitness centers, sports clubs, counseling centers, beauty salons, etc., regardless of whether some of the services they provide can be considered medical.

(9) Excluded is coverage for treatments that are not in accordance with the treatment protocol (guides of good clinical practice) for a particular diagnosis or in the opinion of the censor doctor, or that are not related to the symptoms of the disease and their performance is not justified by the current clinical picture.

(10) Coverage for new methods of treatment, diagnostic and therapeutic treatments, medicines and other health services that did not exist on the market of the Republic of Serbia at the time of the beginning of the insurance year under the policy is excluded, unless the Insurer has made a decision to cover a particular service.

(11) The Insurer's liability is excluded when the costs arise as a result of or in connection with:

1) health services that are not indicated by a doctor of the appropriate specialty or are not intended for the treatment of the insured person;
2) Reproductive treatment, such as:
   1. for the prevention of conception for men and women (contraception and its consequences);
   2. vasectomy and sterilization, as well as restoration to the state before sterilization;
   3. treatment of sexual dysfunction, treatment with Viagra or generic replacement;
   4. termination of pregnancy at the personal request of the insured person, which is not medically justified, and its consequences;
   5. the costs of harvesting and storing stem cells and all related costs,
   6. 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 the personal request of the Insured that are not medically justified and indicated, as well as corrective aids, as follows:
   1. removal of physical defects and anomalies, cosmetic treatment, aesthetic treatment whether for psychological reasons or not, as well as the consequences of such treatments, with the exception of implants that will be covered in a total mastectomy;
   2. dental aesthetic treatment (teeth whitening, decoration and the like);
   3. laser treatment of vision correction, cataract surgery;
   4. removal of moles and other changes at personal request and if not medically indicated, and in the opinion of the physician, censor, the Insurer;
   5. sex reassignment surgery, including psychological and hormonal therapy, surgical reconstruction of sex and breasts;
   6. circumcision – if not medically indicated;
4) procurement of sunglasses or related glasses accessories and hearing aids;
5) all costs of cryopreservation and implantation or reimplantation of living cells, blood plasma therapy (other than blood transfusions) and autologous sera (e.g. PRP, orthokine, BMC and similar therapies);
6) procurement of orthopaedic shoes or other foot support aids, sole support and orthotic aids and materials; any aids resulting 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 bunions;
8) experimental medical treatment that involves treatment that is not scientifically or medically recognized;
9) sleep study treatment and treatment related to respiratory arrest in sleep;
10) ambient therapy for rest and/or observation;
11) examination and treatment of the function of the autonomic nervous system, hyperhidrosis, syncope test;
12) procurement of prosthetic and corrective aids that are not medically obligatory intraoperatively or appropriate devices, with the exception of prosthetics or medical-technical aids used as an integral part of the treatment prescribed and approved by a doctor of the appropriate specialty;
13) treatment of malocclusive or temporomandibular joint disease (TMJD), examinations and treatment of conditions of disturbed normal occlusion;
14) Surgical transplantation of organs and tissues, regardless of whether the insured is a recipient or a donor;
15) classes for pregnant women and preparations for childbirth;
16) treatment of astigmatism and strabismus, nystagmus, myopia, hyperopia or presbyopia, including radial keratotomy surgery;
17) orthoptics and pleoptics (eye exercises); treatment or weight loss program, gastric balloon surgery, bypass or ring surgery;
18) examinations, analyses and training related to nutrition, nutritional advice;
19) treatments in the salt room;
20) treatments in a hyperbaric chamber;
21) alopecia of the chin and other regions, except for the capillary;
22) therapy with synthetic chondroprotectants; circumcision, if it is not medically indicated;
23) procurement of medical devices that are not contracted by insurance, medical preparations used for the toilet of mucous membranes of natural openings, antiseptics for local use, vitamin preparations for strengthening immunity (vitamins and minerals), preparations for the care of problematic skin (creams, gels, lotions, shampoos, etc.), dietary supplements, as well as all other items for general use, cosmetic preparations, services and items for personal care and hygiene;
24) by procuring the following: hospital bed, hospital bed trapezoid, motor wheelchairs, room crane, anti-decubitus mattresses, items to increase comfort, items used to change air quality or temperature, insulin pumps, stationary bicycles, solar or heat lamps, heating pads, bidets, toilet seats, bathtub seats, saunas, elevators, jacuzzis, exercise equipment and similar items;
25) training costs for the use and maintenance of durable medical equipment;
26) the cost of adapting a vehicle, bathroom or residential building to personal needs;
27) pain therapy.

Article 26

(1) The insurer's obligation to reimburse the costs of medical treatment incurred by insured persons who suffer from and are being treated for the following previous health conditions is excluded, unless otherwise agreed:
   1) chronic diabetes mellitus with complications
   2) aneurysm of cerebral arteries and large arteries of the systemic circulation,
   3) angina pectoris,
   4) condition after myocardial infarction or stroke with functional disorders,
   5) brain tumors with neural outbursts,
   6) malignant diseases of all organs,
   7) chronic lung disease,

Article 27

(1) In any case, subject to these Special Terms and Conditions, unless otherwise agreed, 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) Diseases of addiction ,
   2) obesity,
   3) AIDS, complex syndrome related to AIDS (ARCS) and all diseases caused by and/or related to HIV,
   4) psychotic psychiatric illnesses
   5) Alzheimer's disease
   6) cirrhosis of the liver
   7) chronic renal failure of moderate and severe degree
   8) multiple sclerosis,
   9) motor neuron disease,
   10) paralysis/paraplegia,
   11) Parkinson's disease
   12) muscular dystrophy,
   13) premature dementia,
   14) rheumatic arthritis,
   15) non-psychotic psychiatric illnesses,
   16) epilepsy
   17) Systemic lupus

EXERCISING INSURANCE RIGHTS AND REPORTING AN INSURED EVENT

Article 28

(1) In the event of an insured event, the Insured Person shall call the Sava Contact Center before using the medical service, which shall arrange for the insured person the type, date and time of the examination or other medical services within the health institutions belonging to the Network of Health Care Institutions.
(2) It is considered that the insured person has fulfilled his obligation to call the Sava Contact Center of the Insurer if, before using medical services, he calls the Contact Center of the Insurer and answers the questions asked regarding his current health condition for the purpose of realization of the Insurance Contract.
(3) If the insured uses the services of health institutions outside the Network of Health Care Institutions, the costs of medical treatments are paid by the insurer himself, and the request for reimbursement of the same is submitted to the Insurer. The use of services outside the Network of Health Care Institutions may involve participation (which is defined by the insurance policy).
(4) If the Insured uses the services of a health institution from the Network of Health Care Institutions, which are not contracted between the health institution and the Insurer, the same rules apply as in the case of using services outside the Network of Health Care Institutions.

Article 29

(1) After the provided medical services, the institution from the Network of Health Care Institutions submits to the Insurer the documentation defined in the business cooperation agreement.
(2) In the 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 Registration Form;
   2) medical report with the specified diagnosis;
   3) prescribed prescription/order for medicines/aids by a licensed physician;
   4) The Specification of Medical Services.
(3) Applications can only be submitted for treatment actually received during the insurance period and the costs will only be reimbursed if they were incurred before the expiry of the insurance.
(4) In the process of resolving the claim, and if it deems it necessary, the Insurer has the right to request the Insured to provide the authorized persons of the Insurer with an extract from the medical documentation and obtaining information available to third parties, on the current and previous health condition of the Insured (excerpt from the medical documentation for a specific insured case, reports of specialist offices, copies, i.e. excerpts from the history of illness in the hospital institutions).
(5) At the request of the Insurer, the Policyholder is obliged to provide the Insurer with access to all records kept by the Policyholder, in order to determine important circumstances related to the insured event, in accordance with the Law.
(6) If he is unable to provide the necessary documentation, as well as when he considers it to be in his interest, the insured may withdraw from the claim.
(7) If the costs incurred by the use of insurance rights are lower than the stated maximum limits for individual coverage, i.e. the agreed sums insured provided for in the policy, i.e. By contract, the insured person is not entitled to the payment of the difference in the event of the expiry of the insurance.
(8) The insurer reimburses the costs of treatment and financial compensation to the insured/Medical Institution that provided the service, in accordance with these Special Terms and Conditions, based on the Insurance Contract, i.e. the policy that was valid at the time of the occurrence of the insured event, within 14 days from the day on which he received the complete evidence and established the existence of the obligation.
(9) The Insurer is obliged to conclude a contract with the health service provider in accordance with the Law, except in cases where the Insured or the Insurance Contractor has agreed that it will pay to the Insured's account the full costs, i.e. part of the costs incurred by the Insured by exercising the rights from voluntary health insurance, or pay the agreed financial compensation.
(10) The insurer is obliged, in accordance with the Insurance Contract, i.e. the policy and the Special Conditions, to reimburse the health service provider with whom it has concluded a contract for the provision of health services or the

Insured for the costs or part of the costs incurred by exercising the rights of the Insurance Contract.

TRANSITIONAL AND FINAL PROVISIONS

Article 30

(1) These Special Terms and Conditions may be amended by the procedure and in the manner in which they are adopted.
(2) The amended terms apply only to newly concluded insurance contracts, i.e. policies.
(3) For Insurance Contracts that are in progress, until the end of the insurance year, the Special and General Terms and Conditions based on which these Contracts were concluded apply, unless the change in terms and conditions occurred due to a change in legal regulations, which the Insurer cannot influence.
(4) If the Insurer changes the Special Terms and Conditions, it is obliged to inform the Policyholder, i.e. the Insured with whom it has concluded a multi-year insurance contract, in writing.

Article 31

(1) For relations between the Insurer and the Policyholder that 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 shall enter into force on the date of publication and shall apply from 16.05.2024. Publication is made by displaying it on the notice board of the Company on the day of its adoption.
(2) For all insurance contracts entered into prior to the entry into force of these Terms and Conditions, the Terms and Conditions in force at the time of the conclusion of such contract shall apply.