PRECONTRACTUAL INFORMATION FOR THE POLICYHOLDER – PRIVATE VOLUNTARY HEALTH INSURANCE OF FOREIGN NATIONALS DUE TO OCCURRENCE OF A MEDICAL EMERGENCY DURING THEIR STAY IN THE REPUBLIC OF SERBIA

Pursuant to Articles 82 and 84 of the Insurance Law (Official Gazette of RS, No. 139/2014 and 44/2021), in the following text you will find the information about all the essential elements for concluding a contract for Private Voluntary Health Insurance of Foreign Nationals due to Occurrence of a Medical Emergency during Their Stay in the Republic of Serbia:

1.Insurance Terms and Conditions and applicable law

The insurance contract shall be subject to positive legal regulations of the Republic of Serbia (Law of Contract and Torts, Insurance Law, Law on Consumer Protection, Law on Non-Life Insurance Premium Tax), General Terms and Conditions of Voluntary Health Insurance (hereinafter: General Conditions) and Special Terms and Conditions of Private Voluntary Health Insurance of Foreign Nationals due to the Occurrence of a Medical Emergency during Their Stay in the Republic of Serbia (hereinafter: Special Conditions).

2.Term of the contract

Insurance shall begin at 24.00 hours on the date specified in the policy as commencement of insurance. Insurance contract shall be concluded for a definite term not exceeding 12 months.

3.Covered risks

Insured event shall be a sudden illness or accident of the Insured resulting in the provision of emergency medical assistance to the Insured and provision of healthcare services necessary for treatment of medical emergencies occurred immediately after the provision of emergency medical assistance caused by the incurred treatment expenses borne by the Insured.
The reimbursement of treatment of medical emergencies may not exceed the stipulated sum insured specified in the policy during the agreed insurance period.
The reimbursement of treatment of medical emergencies shall be limited to medically necessary procedures of inpatient and outpatient treatment.
According to the Special Terms and Conditions hereof, inpatient treatment shall mean an event when the Insured has been provided with medically justified treatment for the purpose of treating medical emergencies up to the moment when, pursuant to medical standards, life of the Insured is no longer threatened, and maximum up to 30 days.
According to the Special Terms and Conditions hereof, inpatient treatment shall mean an event when the Insured has been provided with medically justified treatment for the purpose of treating medical emergencies, at an institution which in accordance with healthcare regulations is considered a general hospital, where the Insured is constantly monitored by medical personnel, which has sufficient number of diagnostic, lab, surgical and therapeutic equipment, and which limits medical services to scientifically recognized methods, clinically tested in the Republic of Serbia, where the Insured occupies a bed for more than 24 hours.
According to the Special Terms and Conditions hereof, outpatient treatment shall mean an event when the Insured is provided with medically justified treatment for the purpose of treating medical emergencies, which is received by the Insured at a healthcare institution providing medical services, or at the place of medical emergency officially recognized as a place where such a treatment can be conducted and shall limit medical services to scientifically recognized methods, clinically tested in the country where insurance coverage is valid pursuant to the policy, provided that the Insured has not spent at such institution consecutive 24 hours (stayed overnight and/or occupied a bed).
In case of occurrence of the insured event, the Insurer shall indemnify for:

1) Paid treatment expenses only for the following medical services:
a. Ambulatory care (outpatient treatment);
b. Medical supplies and medications prescribed by an authorised doctor;
c. Medical and technical aids which are necessary part of treatment for fractured limbs and injuries, prescribed by an authorised doctor;
d. X-ray diagnostics (X-ray imaging);
e. Outpatient treatment (hospitalization);
f. Surgeries and surgical expenses;
g. Surgical expenses shall also include implants prescribed by an authorised doctor, but not exceeding the annual limit of EUR 1,000 per Insured.
2) Paid transportation expenses incurred due to the provision of emergency medical assistance:
a. Transport of the Insured to the nearest doctor or hospital by ambulance;
b. Transport of the Insured to the nearest doctor or hospital by some other means of conveyance, if medically justified and necessary but not exceeding the limit of EUR 50;
c. Transport to and accommodation of the Insured in the specialized hospital or hospital which is more appropriate for treatment of critical health condition.

Exclusions

The Insurer's liability shall be excluded for the expenses related to:

- Treatment of illness or accident of any kind not requiring provision of emergency medical assistance;
- Treatment of cancer, AIDS and sexually transmitted diseases as well as treatment of final stages of chronic diseases;
- Deliberate termination of pregnancy with no medical reasons;
- Explantation or transplantation of organs, tissues or cells;
- Treatment of pre-existing medical condition;
- Preventive, routine and/or follow-up examinations, home visits by a doctor, medical diagnostic methods, medical research or treatments unrelated to the occurrence of the insured event;

- Use of contraceptives;
- Vaccination, except for the necessary post-exposure protection against tetanus, rabies and hepatitis B;
- Medications of any kind not prescribed by a doctor treating the Insured;
- Experimental medical methods or methods used for research purposes, but not generally recognized;
- Treatment of the consequences of any medical methods applied on the Insured which were not covered under these Special Terms and Conditions;
- Cosmetic and corrective treatment and surgery;
- Preventive medications, recovery in thermal and medical centres, sanatoriums, recovery centres or other similar institutions, as well as expenses for massages, ambient therapy, psychiatric treatment, treatment of mental illnesses and their effects;
- Alternative and complementary medicine;
- Purchase, repair and use of glasses, contact lenses as well as prosthetic aids of any kind;
- Dental treatment not requiring urgent intervention;
- Accommodation in single-bed or private room at the hospital, unless an authorised doctor found such accommodation necessary.

If it is established that the Insured has known or has been warned by an authorised doctor in the country of residence that his/her health condition is such that his/her life has been possibly threatened due to possible acute complications, but can be treated conservatively or surgically in the country of residence, the Insurer's liability to reimburse the treatment expenses for such condition in the Republic of Serbia shall be excluded, and it shall be considered that when coming to the Republic of Serbia, the Insured has wilfully taken the risk of occurrence of possible consequences of such health condition.
The Insurer's liability shall be excluded in case of the insured event resulting from:

1) Pregnancy or delivery, as well as any other illness or complication related to pregnancy;
2) Following diseases: smallpox, plague, cholera, viral haemorrhagic fevers (except for haemorrhagic fever with renal syndrome), malaria or yellow fever and other infectious diseases for which the person is placed under medical supervision in accordance with the regulations governing the protection of the population from infectious diseases).

The Insurer's liability shall be excluded if treatment expenses have resulted from the provision of healthcare services not provided for under these Special Terms and Conditions and the Insurance Contract.
All liabilities of the Insurer shall be excluded if an insured event occurred:
• Outside the territory of the Republic of Serbia where insurance is valid or the insured event has occurred before the commencement of the insurance period and/or after the expiry of the insurance period, or has occurred after the return to the country of origin;
• As a consequence of engaging in high-risk sports and activities, which include: participation of the Insured in aviation, automobile, motorcycle, nautical and other speed competitions, racing and training for them, test runs and test flights; engagement of the Insured in sports and activities requiring the use of special equipment, such as diving at depths greater than 40 m, parachuting, kitesurfing, acrobatics, freeflying, skysurfing, freestyle, paragliding, bungee jumping, mountaineering, acrobatic skiing, speleology, rafting, base jumping, jumps from height; training and participation of the Insured in sports competitions as a registered member of a sports organization, namely: boxing, kickboxing, muay thai, and other martial arts; handling pyrotechnics, ammunition and explosives; trips to polar regions and expeditions, as well as engaging in all other sports and similar physical activities that carry an increased risk of endangering life and health, especially those performed with mandatory use of protective equipment or involving the use of special equipment;

- As a consequence of all other diseases not threatening the life of the Insured pursuant to enclosed medical records related to the insured event and opinion of a medical advisor of the insurance company.

The Insurer's liability shall be excluded when indemnification for the insured event is subject to payment in some other manner and/or when a foreign national has exercised his/her right to treatment pursuant to mandatory health insurance, special regulations of the Republic of Serbia, bilateral treaties, motor third party liability insurance, other insurance policies, etc.
The Insurer shall have the right to refuse to pay the reimbursement of medical expenses in case:

1) The Insured's statement , which forms the basis for the conclusion of the policy, or statement of the Insured arising in the process of claim notification, is false, misrepresented or conceals facts for the purpose of deliberate fraud, etc.;
2) The Insured failed to pay or provide any proof that he/she has paid for the costs of treatment.

4. Amount and payment method of insurance premium, amount of contributions, taxes and other charges calculated in addition to insurance premium, and the total amount for payment

Insurance premium shall be calculated based on the effective Tariffs of Globos osiguranje. The amount and the premium payment method is stipulated in the Insurance Contract and/or the Policy.
The Insurer shall have the right to charge the Policyholder and/or the Insured, the statutory default interest for each day of exceeding the deadline in which he or she is obliged to pay the due premium.
The sum insured shall be the upper limit of the Insurer's liability.
There shall be no taxes, contributions and other charges.
Total amount for payment is shown in the Proposal /Insurance Policy.

5. Right to cancel or waive the contract and cancellation terms

Cancellation: According to the Law on Consumer Protection, the Policyholder has the right to request cancellation of the contract within 14 days from the insurance inception date without any consequences, provided that during that period no insured event occurred for which the Insurer has paid indemnity.

6. Period within which the application is binding on the insurance company

A written application to the Insurer for the conclusion of an insurance contract shall be binding upon the applicant for a period of eight days from the date when the Insurer has received the application, unless the applicant has specified a shorter period.
If the Insurer fails to reject the application which is not in contravention to the terms and conditions under which the Insurer provides the insurance applied for, the Insurer shall be considered to have accepted the application and the contract shall be considered concluded.

7. The manner and term for submitting a claim for insurance indemnity

The Policyholder shall be obliged to notify the Insurer of the occurrence of the insured event not later than within three days from becoming aware of the occurrence. The Policyholder shall report to the Insurer any circumstances necessary for determining the liability of the Insurer or the amount thereof and shall deliver necessary substantive evidence.

The insured event may be notified in writing to the Insurer's address, through the claims report form available at the Insurer's website *www.globos.rs* or in person.

8. Manner of protection of the rights and interests of insurance service consumers with the insurance company

The insurance service consumer may file a complaint to the Company due to the violation of rights or interests in relation to the Company's work, and particularly in relation to the actions of the Company or a person who represents the Company in insurance business or in relation to the decisions of the Company in connection with the insurance contract or performance thereof.

A written complaint to the Insurance Company may be submitted:

▪in the offices of the Company and any other business premises where the Company offers insurance services to its customers or

▪ by mail, at the address: Globos osiguranje ado Beograd Bulevar Mihaila Pupina 165d, 11070 Novi Beograd or Bulevar Mihajla Pupina 14, 21000 Novi Sad

▪ via e-mail at *prigovori@globos.rs*

The complaint shall be filed to the Company in any chosen form, and must contain the following details and documents:

▪ name, surname and address of the complainant if the complainant is an individual, or business name and seat of a legal entity and name and surname of a legal representative of the business entity or authorised person if the complaint is filed for and on behalf of the legal entity;

▪ reasons for complaint and requests of the complainant;

▪ evidence supporting the allegations made in the complaint;

▪ date of complaint;

▪ signature of the complainant or its representative or proxy, except when the complaint is filed in electronic format;

▪ enclosed to the complaint filed through proxy, a special power of attorney shall be submitted authorising the proxy to file a complaint against the operations of the Company for and on behalf of the service consumer and to take actions in the procedure following the complaint and the service consumer shall also agree that such proxy has access to the information relating to the service consumer which represents personal data within the meaning of the law governing personal data protection i.e. to have access to the restricted data within the meaning of other laws or regulations.

The Company shall inform the complainant of the course of procedure relating to the complaint.

If the insurance service consumer intends to complain orally, the Company shall be obliged to warn him or her that the Company is not obliged to consider an oral complaint and shall instruct the consumer about the manner of filing the complaint.

In the event of a written complaint, upon the request of the insurance service consumer, the Company shall issue a confirmation of receipt of the complaint, indicating the place and time of receipt, as well as the person employed by the Company who received the complaint.

When the complaint is submitted orally using the telephone - the Company is obliged to record that complaint, by entering in the appropriate records the data about the consumer, the content of the complaint, as well as the date and time of receipt of the complaint. If the consumer has filed a complaint via the website, e-mail or in any other appropriate manner in electronic form, the Company shall immediately confirm the receipt of the complaint by e-mail or any other appropriate manner in electronic form.

The company shall be obliged to consider the complaint and provide the consumer with a written reply within 15 days from the date of receipt of the complaint. In the event that the Company is unable to provide an answer within 15 days, for the reasons beyond its will, the specified deadline may be extended by a maximum of 15 days, whereof the Company shall be obliged to inform the insurance service consumer in writing, within 15 days from the date of receipt of the complaint. The notice must contain the reasons for which it is not possible to submit the answer within the deadline, as well as the deadline by which the answer will be submitted.

The Company shall send to the consumer a written response to the complaint by post or in the form of an electronic document, by e-mail, in another appropriate manner in electronic form or via the Company's website, so that the date and time of receipt of the response and its content can be determined, and if the consumer has expressly agreed to such method of delivery in electronic form.

The Company may submit an answer to the complaint by mail in the form of a printed copy of the electronic document (hardcopy), and thereafter, the consumer has the right to request that the original copy of the electronic document or its certified copy containing a qualified electronic signature or a qualified electronic stamp of an authorized person of the Company be delivered to him or her.

If the Company finds that the complaint is well-founded, it shall inform the complainant that the reasons for the complaint have been eliminated, that is, it shall inform the complainant of the deadline for their elimination and the measures to be taken for their elimination.

The Company shall not charge the insurance service consumer a fee or any other costs of handling the complaint.

9.Name, seat and address of the authority in charge of business operations of the Insurer and the manner of protecting rights and interests of the Policyholder by such authority

The authority in charge of supervising the company's operations – National Bank of Serbia, Kralja Petra 12, 11000 Beograd.

If the insurance service consumer is not satisfied with the response to the complaint or such response was not delivered to him or her within the deadline specified in this Information, before filing a lawsuit, the insurance service consumer may submit a written proposal for mediation or complaint to the National Bank of Serbia (hereinafter: NBS):

▪ through the website of the National Bank of Serbia by clicking the text *Podnesite pritužbu/prigovor na rad davaoca finansijskih usluga/predlog za posredovanje.*

▪ by mail to the address: Narodna banka Srbije, *Poštanski fah 712, 11000 Beograd*

After initiating the mediation procedure, the consumer may not submit a complaint to the National Bank of Serbia, except in the case that the procedure ended with suspension or waiver.

The complaint must contain the information that enables the identification of the consumer (name, surname and address, that is, for legal entities, business name, seat, registration number and name and surname of the legal representative) and the service provider (business name and seat), determining the relationship of the user with the service provider, as well as the reasons for filing a complaint, i.e. for the request in the complaint.

The deadline for submitting a complaint to the NBS is six months from the date of receipt of the Company's response or the expiry of the deadline for submitting the response. The insurance service consumer shall enclose to the complaint about the Company's activities sent to the NBS, the complaint submitted to the Insurance Company, its response (if the provider has sent it) and the documents based on which the allegations stated in the complaint to the National Bank of Serbia may be weighed.