General terms and conditions for collective health insurance policy SP-KZP-24

INTRODUCTION

1. What is a collective health insurance policy?

1.1. The collective medical insurance policy is health insurance (hereinafter: insurance) that allows your employees, through our assistance, quick access and coverage of medical services that may be provided outside the scope of the public healthcare network.

1.2. As a rule, the insurance is intended for company employees.

1.3. In the event of an illness or accident, the insurance provides the organization and coverage of costs of specialist outpatient services, simple and complex diagnostic examinations, second specialist opinion, rehabilitation, dental services, medications, simple and complex surgical procedures and prevention. It is stated on your insurance contract which coverages were selected for employees.

1.4. The general terms and conditions for the collective health insurance policy (hereinafter: terms) are an integral part of the insurance contract (hereinafter: contract). By concluding the contract, you agree with the provisions of these terms and accept them in their entirety.

2. Definitions of frequently used terms

Term	Definition
You / yours	Relates to you as: • An offerer that wishes to conclude insurance with us and submits an offer to us for this purpose • An insurer when you conclude the contract with us • An insured person that is provided agreed coverage by way of inclusion in insurance, and that is entitled to the agreed insurance indemnity.
We / ours	Means us, Vzajemna zdravstvena zavarovalnica, Vošnjakova ulica 2, 1000 Ljubljana.
Accession statement	The written offer that is, as a rule, signed by the insured person, and that represents a written consent for accession to insurance.
Contract / policy	The deed with which we confirm the existence of your insurance based on the concluded contract.
Premium	Means the amount you pay us in accordance with the contract and which represents the condition for the validity of insurance coverage.
Insurance year	The period of one year from the start or renewal of insurance.
Sum insured	Means the amount that represents the maximum limit of our obligation for a specific coverage.
Insurance indemnity	Means the amount that we pay you or the contractor for an individual insured event in accordance with the contract.
Waiting period	Means a specific period starting from the commencement of insurance for which you must pay us the premium and in which you are not yet entitled to claim a right under the contract, unless you are involved in an accident.
Illness	Absence of health determined by a doctor and that is not the result of an accident.
Accident	Is every sudden, unforeseen event that acts externally and swiftly on the insured person's body, independent of their will, and during which the insured person is injured.
Newly-acquired illness, condition, injury	Means an illness, condition or injury that occurs during the insurance coverage.
Recurring illness, condition, injury	Means an illness, condition or injury that is recurring with intermittent remission periods, by exchanging better and worsened medical condition. It is deemed that an illness, condition or injury is recurring when this is medically established or when the insured person claims the right to cover costs for more than three (3) insured events based on the same cause.
Chronic illness, condition, injury	Means an illness, condition or injury that develops slowly, is long-lasting and is recurring or is likely to recur, causes permanent medical consequences, requires constant medical supervision, mitigation of symptoms, treatment and rehabilitation or healthcare. This also includes unexpected complications of a chronic illness.
Existing medical condition	Means an illness, condition or injury that occurred before the commencement of insurance.
Referral	Means a referral form or a doctor's report on the primary or secondary level, or referral by Varuh zdravja (Health guardian) issued by our contractual doctor and which is used exclusively for claiming services under this insurance.
Insured event	Means an event due to which the insured person requires our assistance and which results in our obligation under the contract.
Claim	A claim is used by you to inform us in the agreed manner that you require a medical service from insurance, or that you have, after our prior approval, already received it and wish to be reimbursed for the costs of medical services.
Contractor	Means a provider of a medical service that holds a valid licence to perform medical services or activities related to medical services (e.g. specialist doctor).
Authorised doctor	Doctor that is authorised by us for the examination and assessment of medical documentation, etc.

GENERAL INFORMATION ABOUT INSURANCE

3. About your contract

3.1. The contract that you concluded with us as the insurer is, as a rule, comprised of the offer, policy, terms, eventual special written statements of contracting parties, clauses and other schedules and annexes to the policy.

3.2. The contract is concluded when you agree with us about its essential elements, or upon the payment of the first premium, if we agree accordingly.

3.3. We will consider the number of included employees and their average age in the contract that you conclude with us in a previously agreed manner, and we may also consider the insurer's activity and types of work performed by employees.

3.4. You may conclude the contract based on a written offer or by contract signature by both contracting parties, or them otherwise confirming their agreement on the essential elements of the contract, such as determining the scope of coverage, premiums, insurance period and sum insured. You must submit the completed and signed offer to us in written or electronic form using our form, and it constitutes a proposal for concluding a contract. The offer must state all facts that are essential for the conclusion of the contract. The questionnaire on medical condition may also be an integral part of the contract.

3.5. The signature of the offerer on the offer is considered as the signature of the insurer on the insurance contract. We may request upon the inclusion of an insured person in insurance that such insured person completes and signs the accession statement that may include a questionnaire on medical condition. By signing the contract, you declare that you were informed of the terms of conclusion and performance of the insurance before the conclusion of the contract, and that the contractual provision correspond to our agreement.

3.6. The signed offer for the conclusion of the contract that was submitted to us is binding on the offerer for eight (8) days as of the date of our receipt, and

thirty (30) days if a medical examination of an insured person is required. If we do not decline your offer within this deadline and your offer does not deviate from the terms, it is deemed that your offer was accepted by us and that the contract was concluded on the date when we received your offer.

3.7. The conclusion of the contract may require a consult of the medical documentation and/or medical examination which is organized for the insured person by us.

3.8. If our response to your offer proposes an amendment, determines an additional payment or exclusion, it is deemed that we declined your offer and submitted to you a counter offer. The counter offer is accepted when we receive your statement that you agree with the counter offer.

3.9. If we do not receive your statement of acceptance of the counter offer within fifteen (15) days after the issuance of the counter offer, it is deemed that the contract was not concluded. In such instance, we shall refund you for the eventual premium paid or anything we may have received from you. In doing so, we may settle eventual costs that we incurred due to the medical examination.

3.10. We may decline your offer for the conclusion of the contract without stating the reasons therefor.

3.11. After accepting your offer, we shall issue you a policy based on the information stated in the offer. The policy represents proof of the concluded contract and includes, in addition to the information stated in the offer, other information in accordance with applicable law.

3.12. If any provision of the policy deviates from the offer or any of your other statements, you may object to the content of the policy in writing within thirty (30) days as of your receipt of the policy. If you do not act in this manner, the content of the policy shall apply.

3.13. In cases of remote contract, you signature may be replaced by the first premium payment, if we determine accordingly. In such instance, it is deemed that the contract is concluded when you pay the first premium. In the event of remote conclusion of insurance, you are entitled to terminate the contract in accordance with the law regulating consumer protection. You may do so without providing reasons therefor within fifteen (15) days as of the conclusion of insurance.

3.14. With the contract, you undertake to pay us the premium in the agreed manner and form, and we undertake to fulfil our obligations upon the occurrence of an insured event, as stipulated in the contract.

3.15. All claims and statements that we submit to each other must be in written form. Written form shall mean written communication via post or electronic communication. All documents are deemed submitted on the date when they are received by the addressee.

4. Why is it important that you submit to us true information upon conclusion?

4.1. Prior to the conclusion of the contract and throughout its duration, you are obliged to inform us of any circumstances that are known to you or that could not stay unknown to you and that are important for the assessment of the risk that we undertake with the conclusion of insurance. Important circumstances are especially those with regard to which we have asked you questions on the offer or the questionnaire on medical condition, if you have completed the latter.

4.2. If you have purposely reported an untrue circumstance or purposely withheld a circumstance of such nature that we would not have concluded the contract with you, if we had known about the true state of affairs, we may request the annulment of the contract or decline the payment of the insurance indemnity or the performance of a service, if such insured event occurred before we were informed of such circumstance. If the contract was annulled, we retain the already paid premiums and are entitled to claim the payment of the premium for the insurance period in which we requested the annulment of the contract.

4.3. If you have reported anything untrue or omitted a due notification, and did not do so on purpose, we may, within one (1) month as of the date when we became aware of the untruthfulness or incompleteness of the report, state that we are withdrawing from the contract or propose an increase of the premium in proportion to the greater risk. In such instance, the contract is terminated after fourteen (14) days as of the date when we notified you that we are withdrawing from it. If we propose an increase of the premium, the contract is terminated ex lege, if you do not accept the proposal within fourteen (14) days as of the date when you received it.

4.4. If an insured event occurred before the untruthfulness or incompleteness of the report was found or thereafter, but before the termination of the contract or the agreement on an increase of the premium, the insurance indemnity shall be decreased in proportion to the degree of the paid premiums and the degree of premiums that should have been paid given the true risk.

4.5. In the event of fraud, counterfeit or abuse by the insurer or insured person, we may withdraw the agreement without notice period and claim the reimbursement of the paid indemnity along with statutory default interest and therewith incurred damage and costs, whereby we retain the already paid premiums and are entitled to claim the payment of the premium for the period in which we requested the withdrawal of the contract.

5. Who is eligible for insurance?

5.1. As a rule, persons that have permanent or temporary residence in the Republic of Slovenia and are employed with you are eligible to be insured.

5.2. As a rule, persons that are on sick leave based on the decision of the Health Insurance Institute of Slovenia are not eligible to be included in the insurance.

6. Are family members of employees eligible to be included in the insurance?

6.1. Along with employees, their family members may also be included in the insurance, namely the spouse or cohabiting partner and their children that have a permanent or temporary residence in the Republic of Slovenia.

6.2. The children of an insured person may be included until they reach 25 years of age. They may be included in the insurance until they reach 27 years of age.

6.3. Family members may be included in the insurance only upon the condition that the relevant employee is included in the insurance as well. They may be included in the insurance by completing and signing the accession statement that may include a questionnaire on medical condition.

7. When does insurance commence, how is it prolonged and when is it terminated?

7.1. Insurance commences at 00.00 hours on the date that is stated on the policy as the date of the commencement of insurance and is terminated at 24.00 hours on the date that is stated on the policy as the date of insurance termination.

7.2. If an employee or their family member who meets the eligibility requirements for entry into the insurance is included in the insurance during the duration of the insurance contract, the insurance coverage for them starts at 00:00 hours on the first (1st) day of the following month after the date of acceptance into the collective insurance, unless otherwise agreed.

7.3. Insurance is concluded for a period of at least one (1) year and is prolonged upon the expiration of the insurance period for an equal period for which it was concluded, whereby the prolongation is tacit. The insurer may revoke the prolongation with a written notice that must be submitted to us at least sixty (60) days before the expiration of the current insurance year. If insurance is revoked within the stated deadline, the contract is terminated with the expiration of the current insurance year.

7.4. We are also entitled to revoke the insurance prolongation, if we discontinue providing such insurance, if the insurer or the insured person acts in violation of the contract or if circumstances arise that prevent us from maintaining the contract in effect. In this case, we will notify you at least sixty (60) days before the expiration of the current insurance year. The contract is terminated with the expiration of the current insurance year.

7.5. Insurance is prolonged and may last no longer than until the end of the insurance year in which you reach 75 years of age.

7.6. Insurance for an individual insured person terminates prematurely on the date of the insured person's death, on the date of termination of the employee's employment relationship, unless otherwise agreed, or by termination of the contract.
If the employee's insurance terminates prematurely, insurance for family members also ceases simultaneously.

7.7. Assistance services such as chat or video consultation with a doctor cannot be prolonged under these terms, if the contracting partner significantly changes the terms of cooperation or terminates cooperation with us. We will notify you in writing at least three (3) months before the expiration of the insurance year regarding this matter. In such instance, the stated assistance service will be terminated with the expiration of the current insurance year.

8. What are the provisions on insurance coverage?

8.1. If you have paid the first premium before the start of the insurance, assistance services and insurance coverage for insured events that are the result of an accident will be provided starting from the insurance commencement date. For insurance cases resulting from newly-acquired illnesses or conditions, as well as for insured events resulting from existing health conditions, insurance coverage begins after the waiting period.

8.2. If the first premium is not paid before the start of the insurance, insurance coverage for assistance services and insured events resulting from accidents begins from the date when the first premium is paid, provided that all other overdue premiums are also paid by that time. For insured events resulting from newly-acquired illnesses or conditions, insurance coverage begins after the agreed waiting period, calculated from the day of the first premium payment, provided that all other overdue premiums are also paid by that time.

8.3. If the entire annual sum insured has been utilized within the insurance year, insurance coverage will be reinstated at the beginning of the next insurance year.

8.4. Coverage for Surgical procedures for an individual insured person ceases if the agreed total sum insured specified in the policy has been paid out after all insurance claims.

INSURANCE IN DETAIL

9. What is covered by insurance?

The insurance provides you with assistance services and other medical services in accordance with the concluded contract. The range of all possible coverages is briefly presented in the table below, with detailed descriptions provided in the following sections. Coverages are also listed in your policy.

Assistance services	
Information	In the assistance centre, you can obtain the following information: • Regarding insurance and the extent of coverage • About the terms and methods of invoking rights under the insurance • About medical service providers covered by the insurance • General information about our insurances, and more.
Verification and confirmation of your claim eligibility	In the assistance centre, the eligibility of your claim to medical services is verified and confirmed in accordance with the concluded contract.
Assistance during the use of medical services	To ensure you promptly access the necessary medical services, the assistance centre takes care of: • Organizing the required medical service • Providing all necessary information for quick and easy claim of medical services • Arranging payment or reimbursement of medical service costs according to the terms.
Chat or video consult with a doctor	During the insurance period, you will have access to chat or video consultation with a doctor through various chat platforms 24 hours a day, every day of the year.
Specialist medical services	
Medical services on the primary level	The coverage ensures quick access to a general/family medicine doctor and gynaecologist.
Specialist medical services	The coverage ensures you quick access to: • Specialist outpatient services • Diagnostic examinations • Second specialist opinion for you and your family members.
Rehabilitation	The coverage entails: physiotherapy, occupational therapy and speech therapy as a continuation of specialist treatment or surgical procedure.
Dental accident	The coverage entails dental services that are necessary due to the effects of an accident.
Medications	The coverage ensures payment of costs for medications prescribed on a white prescription by a specialist doctor.
Specialist outpatient surgical procedures	The coverage ensures payment of costs for specialist outpatient procedures.
Prevention	The coverage ensures the organization and coverage of costs of the selected preventive medical services.
Surgical procedures	
Surgical procedures due to effects of an illness or accident	If you require a surgical procedure due to illness or accident, we cover the costs of self-funded surgical procedures up to the agreed sum insured.
Package Plus	If we organize a surgical procedure for you abroad, we pay the corresponding insurance indemnity, which you can use to cover additional expenses incurred due to travelling abroad.
Second opinion	
Second opinion	The coverage ensures obtaining a second medical opinion and consultation visit with our contracted doctor.

10. What is included in assistance services?

10.1. **Information:** by calling our assistance centre at the phone number 080 20 60, you can obtain information about insurance, medical service providers and the terms and methods of asserting rights under the insurance. We also provide general information related to our insurances and other matters.

10.2. **Verification and confirmation of claim eligibility:**
Based on the information and documentation you provide to us, we will verify your insurance and discuss with you the organization of the service with our selected provider.

10.3. **Assistance in utilizing medical services:**
Once we verify and confirm the eligibility of your claim, we will organize the medical service for you. Upon agreement with you, we will arrange everything necessary for quick and easy access to the medical service you require.

10.4. **Chat or video consultation with a doctor:**
If you need advice from a doctor for non-urgent health issues, you can utilize chat or video consultation with a doctor through various chat platforms 24 hours a day, every day of the year. Chat with a doctor is intended for providing general health information and does not replace a medical diagnosis or treatment. It is not intended for addressing urgent medical cases or life-threatening health conditions. The assistance service is provided by our contracted partner in accordance with point 15 of these terms.

11. What is included in specialist medical services insurance?

11.1. Insurance for specialist medical services can be taken out as standalone coverage. Optional coverages (optional) can also be added to the insurance. If the insured person requires specialist services or other medical services specified in this chapter due to illness or accident, we will cover the costs incurred, up to the maximum sum insured specified in the contract. We will organize the agreed medical service unless otherwise agreed beforehand. The service can also be arranged in the form of a telephone or video consultation. Areas of specialization where such services are available are published on our website.

11.2. With the insurance, you will have easy and quick access and coverage for the following medical services:

- **Medical services at the primary level,** including consultations with a general/family medicine doctor and one (1) visit per insurance year to a gynaecologist specialist.
- **Specialist outpatient services,** including services necessary for diagnosing and treating newly-acquired illnesses, conditions or injuries. These services include specialist examination, basic tests and measurements (imaging, functional, laboratory such as EKG, X-ray, EMG, ultrasound, spirometry, etc.) and simple associated outpatient procedures that can be performed during the specialist examination (e.g. application of blockade, puncture, removal of suspicious or cancerous skin changes or growths, etc.). The utilization of specialist outpatient services in each insurance year is limited to a maximum of two (2) visits for a rheumatologist and a maximum of three (3) visits for a psychiatrist/psychologist.
- **Complex diagnostic examinations** include services that usually follow specialist examinations and are typically necessary for diagnosing newly-acquired illnesses, conditions or injuries. These may include magnetic resonance imaging (MRI, MRA), computed tomography scans (CT, CTA), positron emission tomography (PET), ultrasound-guided biopsy of internal organs, arthrography, endoscopic ultrasound, gastroscopy, colonoscopy and the possible collection of tissue for histopathological examination.
- **A second specialist opinion,** provided once a year, grants access to re-specialist treatment within our network of contracted providers for the insured person and their immediate family members (spouse or cohabiting partner and their children).
-

11.3. **Rehabilitation**
Medical services under this coverage are provided for the consequences of accidents or illnesses, as agreed in the contract. This includes physiotherapy, occupational therapy and speech therapy services that represent a continuation of specialist treatment or surgical procedure and are necessary for the treatment of newly-acquired illnesses, conditions or injuries.

The costs of physiotherapy are covered for conditions after surgery, bone fractures, partial or complete joint dislocation or partial or complete tears of muscles, tendons and/or ligaments, which must be confirmed by appropriate imaging diagnostics (e.g. ultrasound, MRI).

Rehabilitation can be utilized for up to one (1) year after a newly-acquired illness, condition or injury, or the one-year period begins after you are medically fit to undergo physiotherapy, except in cases of nerve injuries, where this period is two (2) years.

Occupational therapy is part of rehabilitation aimed at improving the insured person's function, independence and safety. It is provided on an outpatient basis, either at the service provider's premises or at the individual's home. It includes

cognitive and motor activities, training in the use of medical devices, etc.
Speech therapy is part of rehabilitation aimed at improving speech disorders caused by injury or illness that occurred during the validity of the policy, such as stroke or head injury. It includes activities aimed at improving cognitive and social communication, breathing exercises and exercises to strengthen mouth muscles for easier speech, feeding and swallowing.

Coverage for Rehabilitation may be automatically included in the insurance or chosen as an option.

11.4. **Dental accident**
The coverage includes the costs of dental services incurred as a result of dental treatment (treatment, replacement, conservative and prosthetic care) due to an accident. Intentional biting of a hard object resulting in the breaking or loss of dental tissue, filling material or a tooth is not considered an accident.

Coverage may be included in the insurance as an option.

11.5. **Medications**
This includes coverage for the costs of medications prescribed on a white prescription by a specialist doctor, up to the annual sum insured. Medications must be prescribed in accordance with the diagnosis, medical doctrine and healthcare guidelines, as stated in the medical documentation. In the insurance year, only the costs of the first issuance of medication for a newly-acquired illness are covered in the quantity necessary for the treatment of the newly-acquired illness, but for a maximum of thirty (30) days. The medication must be prescribed on a white prescription according to the instructions applicable in compulsory health insurance and dispensed at a pharmacy. Excluded are medications for which a specific prescribing regimen is determined, except for medications that can be prescribed by a specialist doctor.

Coverage may be automatically included in the insurance or chosen as an option.

11.6. **Specialist outpatient surgical procedures**
The coverage includes self-paying diagnostic and/or therapeutic specialist outpatient procedures within day care up to the agreed sum insured. The procedure is a continuation of specialist treatment or complex diagnostic examination and is necessary for establishing a diagnosis or treating a newly-acquired illness or accident.

If you undergo a specialist outpatient procedure in the public healthcare system and it requires subsequent rehabilitation, we cover the rehabilitation costs within this insurance, after the procedure in the public system, up to the agreed sum insured.

Coverage may be included in the insurance as an option.

11.7. **Prevention**
The coverage provides you with one of the preventive medical services from the list published on our website. You are entitled to utilize this service for the first time after two (2) years of continuous insurance coverage and then every two (2) years, provided that all overdue premiums have been paid. The service must be used within one (1) year of obtaining the entitlement and cannot be transferred to another person.

Coverage may be included in the insurance as an option.

12. What is included in surgical procedures insurance?

You can take out insurance for surgical procedures as standalone coverage, which includes coverage for self-paying surgical procedures due to the consequences of an accident or illness, up to the agreed sum insured. The procedure is a continuation of specialist treatment or complex diagnostic examination and is necessary for establishing a diagnosis or treating a newly-acquired accident or illness.

As a surgical procedure, it is considered an operative procedure (of manual and instrumental nature), usually performed by a qualified surgeon, in the presence of an anaesthesiologist, in accordance with current medical standards. The procedure must be medically necessary, proposed by a doctor as appropriate treatment for the diagnosis of the disease, condition or injury. All experimental or research procedures are excluded. Only surgical procedures performed in the EU (unless otherwise agreed) and in healthcare facilities with appropriate permits for their healthcare activities are considered.

We will organize the surgical procedure for you unless otherwise agreed beforehand.

The insurance includes Package Plus which entails assistance in the organization of an surgical procedure abroad and the payment of the sum insured with which you will be able to cover the costs of the services accompanying the surgical procedure abroad (e.g. costs of transportation, accommodation, medications, etc.). The sum insured amounts to 20% of the insurance indemnity for the performed surgical procedure and is paid to you.

If you undergo a surgical procedure in the public healthcare system and it requires subsequent rehabilitation, we cover the rehabilitation costs within this insurance, after the procedure in the public system, up to the agreed sum insured.

13. What is included in Second opinion insurance?

It is an optional coverage that in accordance with these terms covers obtaining a second medical opinion for the insured person in case of a medically established need for surgical intervention or the onset of a serious illness, as defined in the third paragraph of this point. The opinion includes comments on the diagnosed illness, comments on the treatment process and any recommendations for further treatment. The insured person receives the opinion in written form in the Slovenian language. The purpose of the opinion is to verify the adequacy of the planned or performed surgical procedure or to dispel doubts in the case of treatment for a serious illness.

If the insured person is entitled to obtain a second opinion, they may also arrange for one consultative visit with our contracted physician, who will provide the insured person with additional explanations. We organize the consultative visit; otherwise, we have no obligation to pay for it.

The insured person can claim a second opinion in the event of a medically established need for a surgical procedure that has been or will be performed, or if the insured was first diagnosed with malignant cancer, stroke or heart attack during the insurance coverage, in accordance with this point. The insured person can claim a second opinion for a specific surgical procedure or illness only once during the term of the insurance policy.

The diagnosis of malignant cancer, according to these terms, signifies the presence of progressive uncontrolled growth and spread of malignant cells with invasion into healthy tissues. Cancer must be confirmed with a histopathological report. Coverage includes leukaemia, malignant lymphoma including skin lymphomas, Hodgkin's disease, malignant bone tumours and sarcoma.

The diagnosis of a heart attack, in accordance with these terms, signifies a reliable diagnosis of necrosis (tissue death) of a part of the heart muscle due to insufficient blood supply to the relevant area of the heart. The diagnosis must be confirmed by a characteristic change in the levels of markers specific to a heart attack (such as Troponin I, Troponin T, CK-MB), with at least one marker exceeding the upper limit of normal values by 99%. Additionally, at least one of the following criteria must be met: typical central chest pain suggestive of a heart attack or recent changes in the electrocardiogram (EKG) consistent with a heart attack (ST elevation or depression, T-wave inversion, pathological Q-wave, left bundle branch block).

The diagnosis of a stroke, in accordance with these terms, involves the necrosis of a part of the brain tissue due to inadequate blood supply or haemorrhage, resulting in neurological deficit as a consequence of the stroke.

The second opinion is prepared solely based on the acquired medical documentation and does not include medical examinations, tests or potential treatments. If the opinion cannot be prepared due to incomplete medical documentation or if as a result, the opinion is incomplete in content, we do not assume responsibility for it.

The opinions are carried out by subcontractors of our assistance partners, who are recognized healthcare institutions domestically and abroad. The list of these institutions is constantly updated and published on our website. The responsibility for the content of the opinion lies with the individual subcontractor who prepared the opinion. The responsibility for the organizational execution is undertaken by our assistance partners.

The insurance company is not liable for the content of the opinion.

OUR OBLIGATIONS AND YOUR RIGHTS

14. What are our obligations?

14.1. We undertake to fulfil all obligations specified in the contract upon the occurrence of each insured event.

14.2. We will organize the agreed medical services for you and guide you through the process of claiming them. The costs of the provided services, as defined in our contract, will be settled directly with the contracted service provider or with you, if agreed upon in advance.

15. How can you invoke your insurance rights?

15.1. If you require medical assistance, please call our assistance centre at the telephone number 080 20 60 or fill out the assistance case application online at www.vzajemna.si. We will verify the eligibility of your claim, for which we will need a referral indicating that you require medical services (e.g. a referral from a doctor, a specialist's report, etc.). If you do not have a referral, we can arrange for a (video) consultation with our contracted physician, who will issue a referral if further treatment is necessary.

15.2. We may also request additional documentation if needed to ascertain relevant circumstances related to resolving the claim. You also authorize us to obtain any other necessary information and explanations (e.g. from your personal physician, etc.) to establish the circumstances related to the insured event. Any additional costs incurred in this regard will be your responsibility. If important circumstances regarding the resolution of your claim cannot be determined within fifteen (15) days of receiving the claim, we will not organize services under the insurance or cover costs under the insurance, and we will close the insurance case.

15.3. After verifying the eligibility of your claim, we will discuss with you the choice of medical service provider and the date of service provision. The process for organizing medical services typically proceeds quickly, within no more than three (3) working days for specialist medical services and a maximum of fifteen (15) working days for surgical procedures.

15.4. You can cancel or propose a change to the appointment date up to two (2) working days before the scheduled appointment. Cancellation is possible due to unforeseen extraordinary circumstances, for which you must notify us, and we may request appropriate documentation from you. If you fail to attend the scheduled appointment without timely notification and we incur costs as a result, the service will be deemed to have been provided, and your available sum insured will be accordingly reduced.

15.5. If you agree with us in advance, you can arrange the medical service yourself. In this case, we will reimburse the costs or pay the sum insured based on the medical documentation you provide, up to the maximum amount specified in the pricelist published on our website. Information about prices is also available in our assistance centre.

15.6. If we find that all current obligations from the insurance, i.e. premium payments, have not been settled when making a claim, we will settle our obligations with payment or fulfil them after all obligations have been settled.

15.7. The medical service provider is fully responsible for its quality execution, so any compensation liability on our part related to medical services performed in accordance with the rights under the contract is expressly excluded.

15.8. If we organize a medical service for you through our assistance partner (especially in the case of organizing services abroad), you will be informed about and accept its terms of business beforehand.

15.9. If you need medical advice, you will be able to connect with a doctor through various chat platforms. Before the first chat or video consultation with a doctor, you will confirm the terms of use of our contractual partner's service. The contractual partner is fully responsible for the quality execution of the service, so any compensation liability on our part related to the execution of this service is expressly excluded.

16. What are the limitations of our obligations?

16.1. You will be able to claim the agreed medical services after the waiting period has expired. The waiting period is determined as follows:
- The waiting period applies to newly-acquired illnesses and conditions, namely 3 (three) months from the start of the insurance.
- With respect to all existing illnesses and medical conditions that you had before the commencement of insurance, or illnesses and conditions that occurred during the three-month waiting period upon conclusion, a 24-month waiting period shall apply which commences from the date when insurance commenced
- In the event of injuries resulting from accidents occurring after the start date of the insurance or in the case of chat or video consultations with the contracted general or family medicine physician, there is no waiting period.

16.2. With respect to illnesses and conditions listed in the second paragraph of point 16.1, you must have had the insurance valid for at least 24 months, during which you have not been treated for these illnesses and conditions before you can claim rights from the insurance for them. If you are treated during this period, the waiting period for existing conditions shall start from the completion of the last treatment.

16.3. When a newly-acquired illness, condition or injury becomes recurring, or when a newly-acquired illness or condition is diagnosed as chronic, we, as a rule, no longer have an obligation of covering specialist medical services related to this illness, condition or injury.

16.4. If the insured person takes out insurance within 30 days after the expiration of collective or individual insurance, there is no waiting period for newly-acquired illnesses and conditions for the same extent of coverage under the new insurance contract.

16.5. The organization of medical services according to these terms is provided for services available on a self-payment basis.

17. What is excluded from coverage?

17.1. The insurance does not cover the cost of treatment:
- For chronic illnesses that occurred or that were diagnosed before the insurance came into effect or during the waiting period, except when using the chat service or video consult with a doctor on the primary level
- In ANY intense and urgent activities, ANY preventive examinations, unless agreed otherwise
- Obesity, androgenic baldness, sleep disorders and snoring and erectile dysfunction
- ANY sexually transmitted diseases, HIV infections
- Related to pregnancy, birth, miscarriage, infertility, procedures for the prevention of impregnation, etc.
- Refractive eye disorders (treatment of short-sightedness, far-sightedness, astigmatism) unless they are the result of an accident
- Visual acuity due to old age - presbyopia, hypertensive and diabetic retinopathy, cataracts due to old age
- Hearing difficulties related to hearing impairment, except for those that are the result of an inflammation or accident
- Speech therapy treatment that is not a part of the speech therapy covered in accordance with these terms
- ANY type of dental services (including maxillofacial and oral surgery), unless it is agreed with this contract
- Arthroscopy unless a coverage of specialist outpatient procedures and/or insurance of surgical procedures is agreed with the contract
- Medical services to be performed on the already surgically treated or damaged parts of the locomotor system (such as (partially) removed meniscus, reconstruction of cross bridge or procedure done on cartilage, prior procedures on rotator cuff, prior surgery on the backbone (discus hernia, stenosis), prior surgery on hips, prior procedures on carpal tunnels, etc.)
- Kinesiological treatments
- Congenital anomalies and changes resulting therefrom
- Removal of non-suspect skin growth or changes such as birthmarks, warts, keratosis, atheroma, telangiectasia, etc.
- Related to any pre-existing changes in the digestive tract
- In the event of varicose veins or venous insufficiency within the first two years of coverage
- Cancerous diseases
- Transplantations, impairments and complications during or after surgical procedures
- Medical services due to aesthetic reasons or gender change
- Genetic testing, organ, tissue, bone marrow, stem cell donation and associated treatment
- With stem cells, blood products, hyaluronic acid, etc.
- Kidney failure, including dialysis
- Effects of osteoporosis, except for the first insured event based hereupon
- Geriatric conditions or degenerative neurological conditions (all types of dementia),
- Occupational illnesses
- Any health effects resulting from the effects of alcohol, drugs, medications or psychoactive substances and treatment of all types of addictions

17.2. The insurance does not cover the cost of:
- Medical opinions for determining work capacity or degree of disability
- Services that are not professionally recognized medical methods in the Republic of Slovenia or are experimental, complementary or alternative in nature, unless otherwise agreed by contract (for example, osteopathy, biotherapy, bioresonance, craniosacral therapy, visceral therapy, acupressure, etc.)
- Activities of clinical microbiology, pathology, except in the case of laboratory tests within the insured event
- Repeated follow-up examinations for the same cause, except for the first follow-up examination
- Accompanying person, travel and telephone expenses, accommodation and meals
- Medical devices
- Home care nursing
- Emergency transport
- Biological drugs and special purpose foods
- Dental prosthetic devices and replacements, unless otherwise agreed in the contract.

17.3. From the insurance, our obligations are also excluded when illness, condition or injury occurs due to or in connection with:
- Engaging in professional sports activities (during active participation in competitions, events or training sessions organized by sports associations or clubs), unless otherwise specified by contract
- War or war-like events, sabotage, terrorist acts, riots, rebellion, revolution, etc.
- Epidemics, pandemics, environmental pollution, radioactive contamination, direct or indirect effects of nuclear energy and natural disasters
- Preparation, attempt or commission of a criminal offence, as well as escape after such an act
- Physical altercation, except in the case of proven self-defence, which you are obligated to prove yourself

- Self-harm or attempted suicide
- Operating vehicles, aircraft, vessels and machinery without legally required permits.

17.4. Additionally excluded for insured persons up to 18 years of age are:
- Conditions originating from the perinatal period
- All types of illnesses and congenital anomalies of the respiratory system, airways, throat, ears, mouth, nose and nasal cavities
- Intestinal infectious diseases and zoonoses
- Developmental issues in children (such as dyslexia, autism, learning difficulties, short stature and attention deficit hyperactivity disorder).

17.5. Our obligations are also excluded in case of:
- Irresponsible behaviour or failure to act, and if you do not follow the instructions of the treating physician
- Determination that you provided us with untrue information or in case of concealment, fraud, forgery or abuse on your part.

17.6. If Dental accident coverage is agreed upon, our obligation towards dental care coverage is excluded for:
- Missing teeth prior to the conclusion of the insurance
- Dental materials made of gold alloys or other precious metals
- Dental services related to periodontal or orthodontic specialist treatments, except for dental services for implant placement
- Cosmetic dental services that are not medically justified and aimed at improving the appearance of the dentition, such as external and internal tooth whitening, making aesthetic fillings, crowns or (direct and indirect) veneers
- Services of alternative, complementary, experimental or laser treatment
- Dental services related to conditions, injuries or diseases resulting from excessive alcohol consumption or other psychoactive substances
- Obtaining a second opinion
- Providing emergency medical assistance
- Medications not used in the implementation of dental services and pain relievers not medically justified.

PREMIUM

18. How is the premium amount determined?

18.1. The insurance premium is determined in accordance with our valid premium pricelist. The premium depends on the number of persons that accede to collective insurance and their age structure. The amount of the premium may also depend on other factors, such as the health condition of the insured persons, the share of included persons, past insured events. The premium is unified for all employees and their family members.

19. How should you pay us the premium?

19.1. The premium is paid in accordance with the payment dynamic that is stipulated in the contract (annually, semi-annually, quarterly, monthly). The premium is to be paid in advance, namely by the last day of the month prior to the period to which the premium relates. The first premium falls due upon the conclusion of the contract unless we agreed otherwise.

19.2. If you paid the premium through a bank or another organization for payment transactions, it is deemed paid on the date when you submitted an order for the payment to the bank or another organization for payment transactions. In the event of default, we may charge you statutory default interest and costs.

19.3. In addition to the agreed premium, you are also obliged to pay all contributions and taxes that are prescribed or that the legislator will prescribe during the contract.

19.4. If the premium is not paid by its due date, we may request payment from you. If you still will not pay the premium, we will request payment from you again with a registered letter. If the premium will not be paid even within the deadline that we determine in the registered letter, we may withdraw from the contract upon the expiration of said deadline.

19.5. You are obliged to pay the premium until the expiration or termination of insurance. If the contract termination occurs in accordance with these terms, we are entitled to the premium until the end of the month in which the contract is terminated.

19.6. If the employment contract of the insured person that is included in collective insurance is terminated, we are entitled to the insurance premium by the end of the month in which the termination of the employment contract occurred. The same shall apply in relation to the termination of insurance for family members.

20. Can the contract be changed throughout its duration?

20.1. During the duration of the insurance, we reserve the right to change the terms, premium amount or the amount of annual insurance coverage.

20.2. If changes occur, we will inform you in an appropriate manner at least one (1) month before the changes take effect, with the changes becoming effective at the beginning of the new insurance year. If you do not agree with the changes, you have the right to cancel the contract in writing within thirty (30) days of the notification, with the termination taking effect at the end of the current insurance year. If you do not cancel the contract, we will assume that you agree to the changes.

20.3. During the insurance period, you can request a change in the method of premium payment. The change typically takes effect on the first day of the following month.

21. What information do we require from you during insurance?

21.1. During the duration of the insurance, you must inform us of any changes that are important for the performance of the contract (e.g. changes in personal data, change of residential address etc.) within eight (8) days of said change. You must also provide us with appropriate proof of the change. All our mutual communication is conducted in written or electronic form.

21.2. In the case of mutual communication by registered mail, if you fail to collect the shipment, it is considered that you, as the recipient, have received it, on the day we sent the shipment by registered mail. Therefore, in accordance with this agreement, legal consequences arise even if you do not collect the registered mail.

OTHER

22. Personal data

22.1. All important information regarding the processing of your personal data for the purpose of the conclusion and performance of insurance and other purposes for which we process your personal data, as well as information about your rights related to personal data protection, is gathered in Vzajemna's Privacy Policy, available at www.vzajemna.si/politika-zasebnosti. For fast and accurate communication, it is particularly important that we have your up-to-date personal and contact information (name, surname, address, email address, phone number). Therefore, we kindly ask you to notify us of any changes in writing to Vzajemna zdravstvena zavarovalnica, Vošnjakova ulica 2, 1000 Ljubljana, or via email at info@vzajemna.si.

22.2. When using assistance services, we will exchange your contact personal data with one of our contracted medical service providers for the purpose of scheduling or booking an appointment. For the purpose of carrying out medical services within the framework of handling insurance cases, we may exchange your personal data, including health data, with medical service providers based on the concluded contract and the insurance legislation.

22.3. Upon the conclusion of the insurance, we will provide our contractual partner with your personal data (especially name, telephone number, email address, year of birth, gender, policy number) for the purpose of identification and using the chat or video consultation service with a doctor. You will receive a link from the contractual partner through which you can use the chat or video consultation service with a doctor. For the purpose of monitoring the performance of the service, the contractual partner will inform us about the number of uses. You will be informed in detail about the processing of personal data for the purpose of providing the service before the first use of the service.

22.4. When providing data and documentation related to your health condition, please follow the recommendations for a secure method of transmission to protect your personal data, as outlined on our website.

23. Complaint procedure

23.1. In case of a dispute regarding the contract, the dispute can be resolved through an out-of-court procedure by filing a complaint. You can submit a complaint orally or in writing at our business unit, through the website www.vzajemna.si or via email at info@vzajemna.si.

23.2. Your complaint will be handled by our competent body in accordance with the regulations governing the internal complaint procedure. The internal complaint procedure is organized in two stages. The decision of the complaint committee at the second stage is final.

23.3. If you disagree with the decision of the complaint committee at the second stage or if the insurance company does not decide on the complaint within thirty (30) days of receipt, you can continue the out-of-court dispute resolution process at the Mediation Centre of the Slovenian Insurance Association, located at Železna cesta 14, 1001 Ljubljana, telephone: 01/300 93 81, email: irps@zav-zdruzenje.si, website: www.zav-zdruzenje.si.

24. Final provisions

24.1. The relations between the insurance company, insured person, insurer, beneficiary and other persons that are not regulated by these terms shall be governed by the provisions of the law of the Republic of Slovenia that regulates contractual obligations.

24.2. In the event of a dispute, a court in the Republic of Slovenia shall hold jurisdiction, namely the locally competent court in Ljubljana.

24.3. The applicable statute of Vzajemna is available for consult at Vzajemna headquarters and conclusion spots of business units and website www.vzajemna.si where consult of its changes will be provided as well.

24.4. The report on solvency and financial state of the insurance company is published on www.vzajemna.si.

24.5. The supervision over the insurance company is under the auspice of the Insurance Supervision Agency, Trg republike 3, Ljubljana.

24.6. These terms shall apply as of 1 April 2024.