MEDICA EXELENTA

VOLUNTARY HEALTH INSURANCE USER MANUAL

Read these the User Manual carefully.
Knowing the rights and obligations of the insured person is essential for taking full advantage of the insurance plan.

GENERALI

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GENERAL INFORMATION

Where is the insurance valid?

Insurance covers the costs of treatment on the territory of the Republic of Serbia.

How can you become eligible?

According to the relevant regulations, only persons with a registered place of residence/temporary residence in the Republic of Serbia are eligible for this insurance.

After the policy comes into force, a new person can be enrolled only if, after the start of the policy, they have become eligible for insurance under that policy, i.e., if they have:

1.1. entered into employment or another contractual relationship with the policyholder;

1.2. met the enrollment requirements (e.g., have become eligible for the voluntary health insurance through promotion);

1.3. become the policyholder's member, student, beneficiary, or has another direct relationship with them;

1.4. obtained the status of a family member (by birth, marriage, or cohabitation).

Exclusion of the insured from the insurance plan before the end of the insurance period is possible when the insured loses the status based on which they became eligible for insurance (e.g., termination of employment or contractual relationship, termination of membership, divorce of end of cohabitation) and in other cases set out in the general terms and conditions.

The insurer may ask the policyholder for additional documentation as a proof of insurability, or grounds for exclusion (npr. a statement certified by a public notary indicating the beginning or termination of a common-law marriage).

How to use this insurance plan?

This insurance is valid:

- at the in-network clinics (healthcare facilities that have a health services contract with the insurer) and
- at out-of-network clinics
- When it comes to prescription drugs in outpatient conditions covered by insurance, you take the medicine in any pharmacy in the Republic of Serbia, pay on the spot and subsequently get a refund from the insurer, based on a standard procedure.

At the clinics within the network, you don't pay for the healthcare services. They are paid by Generali Osiguranje Srbija directly to the clinic. Prior to using the service at a clinic within the network, you must identify yourself with a voluntary health insurance card (smart card) and an ID card.

At the clinics outside the network, you pay the bill yourself and subsequently submit the reimbursement request to the insurance company (the procedure is explained below).

If you wish to use the services of clinics outside the network, inquire about the prices first (reasonable and customary expenses) by calling Medic Call Center.

Generali Osiguranje Srbija shall cover only the reasonable and customary expenses of treatments.

How is the insured's share in the costs incurred (copayment) calculated?

Copayment is the insured person's share in the price paid for each service rendered. The contracted limits and sums insured are reduced by the amount paid by the insurer.

An example for treatment with an annual limit of €300 and a copayment of 20%:

- The treatment costs €30, of which the insured pays €6 on the spot, and the insurer reimburses €24.
- If they use the out-of-network service, the insured will submit a €30 receipt, and they will be refunded the amount of €24.
- The limit is reduced by €24.

Assistance by phone

Medic Call Center 011 / 222 0 575

Medical assistance and medical professionals are at your service 24/7, 365 days a year. Assistance includes:

- information on coverage and the use of insurance;
- help selecting the best service according to your needs;
- mediation between the medical censors and the insured in the medical treatment authorization procedure;
- scheduling appointments, referral to a physician, providing names, phone numbers and addresses of medical institutions, outpatient care centers, on-call clinics, pharmacies, etc.

If, in the process of claim payment, it is established that there are facts different from those available to the Medic Call Center at the time the appointment for the health service was made, the insurer shall reserve the right not to pay the costs incurred if the amount exceeds the sum insured / limit or if the service is not in line with the coverage.

All conversations are recorded to ensure a quality service.

Calling the Medic Call Center is not mandatory, except when you wish to make an appointment at public medical facilities within our network, when a pre-authorization of medical treatments is required, and when making annual physical exam appointments.

In addition to the possibility of obtaining information and scheduling an exam by calling the phone number, you have the option to do the same online, via email infomedic@generali.rs..

What do you need to do?

You need to:

- be informed of the coverages agreed on your behalf, and not accept a service to be charged to the insurance company, if not included in your coverage.

- be familiar with the contracted insurance terms and conditions set out in the insurance policy, this User Manual, and the insurance Terms and Conditions.

Detailed rights and obligations are set out in the insurance terms and conditions (link on the last page of this User Manual).

REIMBURSEMENT AND TREATMENT PRE-AUTHORIZATION

You can get reimbursement of expenses in one of these three ways of your choice:

- ✓ online, at the Customer portal

If you don't have the Customer Portal account, please register here.

* In case you don't have a security code for Portal registration, call the Generali contact center at **011 222 0 555** or send us an email at **kontakt@generali.rs** .

✓ by emailing the documentation to:
prijava.pzo@generali.rs (for email claim filing instructions use the following LINK)

✓ by mail to our address:

Generali Osiguranje Srbija, Španskih boraca 3, 11070 Novi Beograd
"Direkcija za obradu šteta PZO"

What is required for reimbursement?

✓ Voluntary Health Insurance Reimbursement Claim Form - link.

Please fill out the form carefully and enter all the requested details (the fastest form of communication if documentation is not complete is by e-mail, which you have to provide). Claim payment is often needlessly delayed due to insurance officer's inability to contact the insured.

All documents may be submitted as a photocopy, originals are not required:

✓ Fiscal receipt for services rendered

✓ Medical records - stamped and signed by the physician who provided the service

For medical exam, an examination report containing the diagnosis has to be provided;
For all other services (diagnostics, therapies, medication, glasses, glass), the following is required;
For all other services (diagnostics, therapies, medication, glasses, glass) the following is required:

1. Referral or a previous medical report showing medical reason for the service being reimbursed.
2. Report on the service rendered, confirming that a service was provided to the insured. Depending on the case, the report may include:
   - for lab and other diagnostic procedures – the result, with name and stamp of the facility (x-ray images are not required)
   - for recurring treatments, especially those paid for a set of services (therapies, injections, acupuncture, etc.) – the report stating the number and type of services rendered and a time when they have been performed.
   - for dental care – dentist's report stating the number of the treated tooth and the service performed. More expensive interventions (crowns, bridges, castable abutments) require a video/photograph before and after the procedure.
   - for vision correction – referral for glasses/contact lenses

When is the treatment pre-authorization required?

Except in cases of emergency, medical services must be pre-authorized:

✓ when it is known in advance that the costs will exceed €300;
✓ in case of planned inpatient care; or one-time reimbursement instead of inpatient care;
✓ in case of childbirth; or one-time reimbursement instead of childbirth
✓ in case of all planned or scheduled surgical and other procedures, or one-time reimbursement instead of surgical procedure
✓ for prenatal diagnostics;
✓ for the supply of medicines and medical and technical aids;
✓ for the removal of changes on the skin.

To get authorization, please call the Medic Call Center, at least 14 days before the service is rendered.

You send a filled-out Medical Treatment Authorization Form (attached) to the insurer, along with the relevant medical records, which will be returned to you after the treatment is approved, signed by the medical censor.

Within the Generali Network, the clinic will do this for you, and outside the Generali Network, you have to prepare the request on your own, and follow all the steps for treatment authorization.

In the event that a cost was incurred and the pre-authorization process has not been initiated, and the service is part of the medical services that need to be pre-authorized, the insurer reimburses the Insured up to the amount of reasonable and customary costs.
The insured may opt for payment of one-time reimbursement instead of coverage of treatment costs only BEFORE the service is rendered. Accordingly, a one-time reimbursement cannot be claimed even for services that were provided as an emergency.

When the insured opts for a one-time reimbursement, the insurer shall not cover the cost od medically justified treatment based on which the payment of reimbursement is requested, nor other costs connected to this treatment, including preparations for surgery or childbirth and post-op care.

NOTE:
Making an appointment via Medic Call Center is not considered authorization unless the complete procedure stated above has been carried out.

COVERAGES

COVERAGES	**Outpatient care Inpatient care Surgical procedures**	**Up to EUR 10.000**
	Healthcare for pregnant women and newborns	**Up to EUR 2.500**
	Medicine	**Up to EUR 300**
	Vision correction	**Up to EUR 200**
	Dental care	**Up to EUR 250**
	Annual physical exam	**Agreed plan**

Outpatient care*

	Agreed cost sharing percentage - Copayment	**0%**
	Special notes	**Limits**
Exam by a licensed physician (exam, follow-up or consultation, including an online	Medical exams by neuropsychiatrists, psychiatrists, psychologists, special education and rehabilitation specialists and other doctors, due to mental health issues, are covered solely within the scope of "Mental Health Services", if	Up to the coverage limit

consultation)	stipulated in the policy.	
Lab tests and analyses		Up to the coverage limit
Diagnostic procedures		Up to the coverage limit
Medical transport		Up to the coverage limit
Therapies (cost of medicine not covered):	- - therapy with medicines, injections, inhalation and infusion, - oculomotor exercises - occupational therapy, - other special education and rehabilitation therapies.	Up to the coverage limit (exclusion: orthokine, PRP and related treatments, hyperbaric chamber and MTT tinnitus)
Physical and kinesitherapy and speech therapy	Conducted exclusively by a qualified therapist or chiropractor, speech pathologist or speech therapist, respectively.	up to €20
Emergency dental treatment, due to an accident		up to €500
Home care	Immediately after inpatient care in case the insured is temporarily or permanently immobile	up to €500
Mental health services	Implies psychotherapy, consults with a psychiatrist, neuropsychiatrist, psychologist, speech therapist or, if necessary, another specialist	up to €300
Alternative and complementary medicine	Conducted in accordance with the legislation regulating this area and with the terms of insurance – by calling MCC, the insured will receive the necessary information about the use options	up to €150
Medical and technical aids	Prosthetics, orthotics, special types of aids and sanitary appliances, visual aids, hearing aids and other aids (except those specified in more detail in the Special Terms and Conditions)	up to €300
Reproductive health exam	Procedures and interventions conducted for examining sterility, causes for miscarriage and preparations for pregnancy	up to € 250
Primary outpatient procedures	Primary wound treatment, dressing and stitching, primary treatment of burns, removal of sutures with bandaging, removal of ticks and other foreign bodies from the skin, ear, nose and throat, plaster casts, joint fixation and immobilization, irrigation of the ear and nose, aspiration of nasal secretions, vaginal irrigation, nasal tamponade, applying gauze with medicine, abscess incision, therapeutic puncture of joint and connective tissue, orthopedic repositioning of luxations and fractures without anesthesia)	Up to the coverage limit within the defined scope - surgical procedures are excluded

** Pre-existing conditions are covered, except illnesses under Article 6, paragraph 7 of the Special Terms and Conditions*

House calls are only covered if needed and approved by the Medic Call Center.

Physical therapy at home only if the Insured is immobile due to a fracture of lower limbs, spinal injury or cerebrovascular insult (stroke).

The following costs are excluded:

- all types of massages not prescribed by a doctor as part of physical therapy (e.g., relaxation and aesthetic massage), exercise therapy (except kinesiotherapy and oculomotor exercises), rehabilitation therapy lasting more than a month and ambient therapy are excluded;
- orthopedic shoes, orthopedic insoles, or other aids for deformed, weak, overstressed, unstable and lowered feet, tarsalgia or metatarsalgia;
- all the costs incurred in spa conditions except for exams, diagnostic procedures and therapies;
- all other exclusions set out in Article 28 of the Special Terms and Conditions.

Inpatient care *

	Agreed cost sharing percentage - Copayment	0%
	Special notes	**Limits**
Inpatient care (without surgical procedures)	- accommodation, - medically permitted diet, - exams by licensed physicians - medical staff fees, - laboratory and diagnostic procedures, - therapy, - medicines and medical supplies, blood and blood products, - medical and technical aids, - treatment provided in the emergency room - parental escort for children under of age 18.	Up to the coverage limit (exclusion: right to single bedroom at personal request)
Chemotherapy and radiotherapy		up to €2,000
Emergency dental treatment, due to an accident		up to €500
A single payment instead of coverage of costs of inpatient care	Single payment is paid to the insured only if the service is covered by insurance and if the insured, instead of covering the costs of inpatient care, opted for the one-time payment option and started the authorization process. **In cases where the insured has not started the authorization process before going to the hospital, he is not entitled to a one-time compensation payment.**	EUR 45 per day spent in a hospital, and maximum 10 days during the insurance year period

** Pre-existing conditions are not covered*

Under these Special Terms and Conditions, inpatient care doesn't include staying in inpatient facilities such as: rehab facilities, mental hospitals, inpatient healthcare facilities specializing in rehabilitation, hydro-clinics, sanatoriums, nursing homes for the sick, nursing homes for the elderly, health retreats, resorts, weight loss and recovery centers.

Surgical and other procedures *

	Agreed cost sharing percentage - Copayment	0%
	Special notes	**Limits**
Surgical and other procedures	Costs of surgical and other procedures (including blood and blood components for transfusion, medical and technical ads, and implants needed to perform the procedure, medicines, medical supplies used during the procedure),	up to €5,000
Implants for performing the procedure		up to €1,500
A single payment instead of coverage of costs of treatment for surgical procedures	Single payment is paid to the insured only if the service is covered by insurance and if the insured, instead of covering the costs of treatment for surgical procedure, opted for the one-time payment option and started the authorization process. **In cases where the insured has not started the authorization process before the surgical procedure is performed, he is not entitled to a one-time compensation payment.**	up to 65% of the authorized amount under the Terms and Conditions if the surgical procedure is performed in the Republic of Serbia or 100% of the authorized amount if the surgical procedure is performed abroad (authorized amount as the amount of treatment costs to cover surgical and other procedures approved by the insurer for treatment in the Republic of Serbia)

** Pre-existing conditions are excluded*

The costs of preoperative patient preparation, intensive and postoperative care are paid from the "Outpatient care" or "Inpatient care" coverage (if contracted by the policy)

The following are excluded from the Surgical and Other Procedures coverage:

- radial keratotomy or any other surgical procedure for vision correction (including laser treatments);
- sex reassignment surgery;
- organ and tissue transplant surgery;
- nasal septum surgery for persons over the age of 18;
- removal of genital warts if the sample was not sent for HP analysis or HPV typing;
- removal of moles, lipomas, atheromas, fibromas, warts, capillaries, cherry angiomas, keratoses of similar widespread skin lesions which, according to the medical censor, do not pose a risk to the patient's health. Coverage is limited to cases of emergency and medically indicated cases where a skin change might be injured or PH analysis for suspected malignancy is requested;
- circumcision, if not medically indicated;
- gastric balloon insertion.

Healthcare for pregnant women and newborns		up to €2.500
	Agreed cost sharing percentage - Copayment	**0%**
	Special notes	**Limits**
Healthcare for pregnant women	- Pelvic exams, - lab tests, - CTG, - Progesterone and tocolytics therapy and other medications for the prevention of preterm birth, - Biochemical screening for chromosomal aberrations, One full routine pelvic exam up to six months after childbirth.	Up to the coverage limit
Hospital stay due to high-risk pregnancy		Up to the coverage limit
Prenatal vitamins	Medicinal products that represent a combination of vitamins and minerals that are used exclusively during pregnancy and are intended for the proper development of the fetus. If the doctor prescribes individual minerals and vitamins for general use, only those that are registered as medicine will be covered, i.e. those that are in the National Register of Medicines.	up to €50
Ultrasound exams		7 exams up to €50 per exam
Additional fetal ultrasound exams in high-risk pregnancy		1 exam up to €50
Expert ultrasound		1 exam up to €70
Fetal echocardiography		1 exam
Additional fetal echocardiography in case of shown anomalies		1 exam
Invasive and non-invasive prenatal diagnostics	Invasive prenatal diagnostics like amniocentesis, chorionic villus biopsy, cordocentesis, etc. And non-invasive, which involves testing on a mother's sample, for example the Nifty test	Up to the coverage limit (limit: 1 non-invasive up to €500)
One follow-up exam and related laboratory and diagnostics procedures in the event of miscarriage or abortion		up to €70
Childbirth	Epidural anesthesia, medically indicated caesarean section, suite accommodation, father's presence during childbirth, doctor, medical technicians, anesthesiologist. Caesarean section is covered only if it is medically indicated.	up to €2,000

One-off compensation instead of childbirth coverage	Single payment is paid to the insured only if the service is covered by insurance and if the insured, instead of covering the costs of childbirth, opted for the one-time payment option and started the authorization process. **In cases where the insured has not started the authorization process before the surgical procedure is performed, he is not entitled to a one-time compensation payment.**	up to €750 per childbirth
Health care of newborns in the first month of life	Treatment of health disorders in newborns, but not the exams and other services that are conducted routinely in the first month of life	up to €500
Home care for one month after childbirth		up to €100

The limits of this coverage apply to an individual pregnancy, not the year of insurance. If the policy expires during pregnancy and is renewed under the same terms and conditions, the remaining limit under the previous policy will be paid as part of the next policy.

If the policy is renewed with different coverage during pregnancy, the following applies:

- if the current policy covers childbirth, and the policy during which the pregnancy occurred does not - childbirth is covered
- if the current policy does not include childbirth, but the policy during which the pregnancy occurred does - the childbirth is not covered
- all other limits are calculated according to the new policy, minus the benefits paid under the previous policy for the same pregnancy.

Apart from medicine used for progesterone and tocolytic therapy, other drugs related to pregnancy are covered only if the "Medicine" coverage is included.

The costs of treatment of other health issues that are a consequence of pregnancy, i.e. costs of medical treatments that would not be indicated if the insured were not pregnant, are also paid from this coverage.

All limits related to the newborn can be used from the other parent's policy if this coverage is contracted and if the pregnancy occurred during the father's insurance period.

* Insurance shall not cover the costs if the pregnancy took place before the start of the insurance period

It is considered that the pregnancy occurred before the start of insurance if the selected authorized gynecologist determined the date of delivery before the expiration of the period of 9 months from the day when the pregnant woman was first included in the insurance.

Excluded from the insurance are antenatal classes (preparations for childbirth) and hospital accommodation for companions during hospitalization for childbirth or pregnancy maintenance.

ADDITIONAL COVERAGE

Coverages	Special notes	Limits	Copayment
Prescription medicine		Up to €300	0%

The insurance does not cover: biological, immunological, medicines from blood and blood plasma, medicines for advanced therapy, while traditional and homeopathic medicines are exclusively covered by "Traditional medicine" coverage, if contracted; medical cosmetics; all medical devices (including syringes, needles and bandages) that are not listed as covered by medical devices coverage; dietary supplements except: probiotics with antibiotic therapy during therapy, iron preparations for anemia (with a doctor's report that the insured has a negative reaction to the preparation registered as a medicine), eye preparations (artificial tears) in case of a diagnosis of dry eye or conjunctivitis.

Vitamin preparations prescribed by a doctor will be covered only if they are registered as a medicine.

Medicines used for hospital treatment are not subject to the prescription medicine limit. They are used from basic coverage (inpatient care), up to the coverage limit for inpatient care.

Vision correction	Eye exam Frames Glasses and contact lenses	Up to the coverage limit Up to €75 Up to €125	0%

With continuous insurance, you have the right to change the frame and glass only in case of change of diopter. If there is no change in diopter, you are entitled to change frames and glasses two years after the last one purchased.

If the diopter changes during the insurance period, the insurer can approve the purchase of additional glasses within the agreed limit.

Contact lenses in the amount that corresponds to medical needs.

Loss or damage of the aid does not entitle the insured to purchase new ones at the cost of the insurance. Sunglasses, accessories for glasses, glasses and lenses without diopters are excluded from the insurance.

Dental care	Preventive treatment Basic restorative treatment Larger restorative treatment Orthodontic treatment (up to 35 years of age) Periodontal descaling – annually Periodontal surgery Oral surgery	**Up to €250** Insurance does not cover: • cosmetics treatments • artificial teeth • ceramic restorations on dental implants • dental implants • fixed prostheses • multi-surface seals -veneers and all associated costs	20%

Cosmetic and aesthetic dental treatments, artificial teeth, dental implants, ceramic restorations on dental implants, fixed prostheses, veneers with all associated costs, teeth whitening, and all other dental aids are excluded from the insurance.

For policyholders who join the insurance after the start of the policy, the limit for dentistry is reduced proportionally to the duration of the insurance. Example of a limit for an insured included 90 days after the start of a policy with a limit of 250: 250/365*90=61.65.

Annual physical exam	One annual visit in accordance with the contracted plan Additional routine exams as indicated by the doctor (vaccinations excluded)	Agreed plan Up to €100	0%

The physical exam plan is available in one of the several in-network clinics that have the capacity to perform a physical exam. You must make a physical exam appointment through the Medic Call Center by calling 011/ 222 0 575.

ANNUAL PHYSICAL EXAM

WOMEN	MEN
✓ Lab tests (CBC, SE, blood sugar, urea, creatinine, cholesterol, LDL, HDL, triglycerides, AST, ALT, AP, complete urine test)	✓ Lab tests (CBC, SE, blood sugar, cholesterol, LDL, HDL, triglycerides, urea, creatinine, ALT, AST, complete urine test, PSA in men over 40.)
✓ Exam by an internist, including ECG	✓ Exam by an internist, including ECG
✓ Pelvic exam, gynecological US exam, breast US, PAP test, colposcopy, VS	✓ Exam by a urologist with ultrasound
✓ Abdomen and pelvis ultrasound	✓ Abdominal ultrasound
✓ Exam by a dermatologist and dermoscopy	✓ Exam by a dermatologist and dermoscopy
✓ Exam by a physiatrist	✓ Exam by a physiatrist
✓ Thyroid gland ultrasound	✓ Doppler of blood vessels of the neck
✓ Final exam and conclusion	✓ Ultrasound of the abdominal aorta
	✓ Final exam and conclusion

You can find an updated list of clinics where you can use the above content of the annual physical exam on the following link: GOS 3 (cloud.microsoft) *or on our website www.generali.rs in the section: "Legal entities. Health and Accident. Medica Exelenta. Additional Coverage: Annual Physical Exam."* ***The list of clinics is subject to change over the course of the insurance period.***

There is a possibility of changing the agreed content of the physical exam for those who:
have had a Covid-19 infection, suspect that they were infected with a Covid-19 infection, or want to replace the physical exam contracted by the company with a post-Covid 19 physical exam.

Note: During the insurance policy duration, the insured has the right to use one contracted physical exam plan (standard contracted or post-Covid 19 physical exam) – but does not have the right to both. The insurance does not cover the treatment of conditions that arise as a result of a prolonged infection with Covid 19, regardless of the existence of indications/instructions for further treatment.

ANNUAL PHYSICAL EXAM – POST COVID 19

WOMEN	MEN
✓ Lab tests (CBC, sedimentation, glucose, ALT, AST, urea, creatinine, LDH, CRP, D-dimer)	✓ Lab tests (CBC, sedimentation, glucose, ALT, AST, urea, creatinine, LDH, CRP, D-dimer)
✓ Exam by an internist, including ECG	✓ Exam by an internist, including ECG
✓ Pulse oximetry	✓ Pulse oximetry
✓ Heart ultrasound	✓ Heart ultrasound
✓ Abdominal ultrasound	✓ Abdominal ultrasound

The listed contents of a physical exam can be used in the following health institutions from the network of clinics:

- ✓ VIZIM health centers – Novi Beograd, Novi Sad
- ✓ Egzakta Medica – Belgrade, Novi Sad, Čačak and Kragujevac
- ✓ Humano – Niš

ANNUAL PHYSICAL EXAM FOR CHILDREN:

A two-year plan in line with the preventive healthcare visits calendar for babies.
The plan has no restrictions in terms of limit and number and it includes:

- In the first month of life – one physical exam.
- In the first year of life – one physical exam; three hip ultrasounds;

three exams by a pediatrician before the vaccination and vaccine administration (cost of vaccine not included); two complete blood counts and urine tests.

- In the second year of life – one physical exam; one exam before the vaccination and vaccine administration (cost of vaccine not included)

The "Healthy Child“ plan is available in any in-network or out-of-network clinic.

From 2 to 6

- Pediatric exam
- Lab tests
- ORL exam
- Eye exam
- Exam by a physiatrist
- Exam by a special education and rehabilitation specialist
- Dental exam

From 6 to 18

- Pediatric exam
- Lab tests
- Eye exam
- Exam by a physiatrist
- Exam by a dermatologist
- Dental exam

The listed contents of an annual physical exam is provided by the following in-network healthcare providers:

- ✓ VIZIM HELTH CENTER
- ✓ MEDI GROUP health centers

An exception is the scope of the "Healthy Child" physical exam, where it is allowed to use the contracted scope according to the child's age at the in-network and out-of-network clinics up to the amount of reasonable and customary fees.

Making the annual physical exam appointment by calling the Medic Call Center at 011/ 222 0 575 is mandatory.

IMPORTANT FOR USING THE ANNUAL PHYSICAL EXAM SERVICE:
At your request, the insurer will enable partial use of this coverage for a single medical examination/diagnostic procedure from the list above for which there is no indication. The service can only be provided at the facilities that have been contracted to carry out an annual physical exam.

By using one partial service it is considered that you have fully used the Annual Physical Exam coverage.

Vaccines that are not mandatory according to the national immunization program can be covered as part of the physical exam, as well as certain diagnostic procedures aimed at investigating family history. Examination of family history must be indicated by a licensed physician.

ADDITIONAL BENEFOTS

NEW! Online Consultation service

In an effort to provide you with additional security and comfort when using our services, we have a new benefit for all our insured persons - Online Consultation with a doctor about the diagnosis.

In order to use the Online Consultation services with a doctor, you need to call the Medic Call Center at this number: 011/ 222 0 575 (press 3). After checking the coverage and the insurance terms and conditions, the Medic Call Center will provide you with all the information regarding the Online Consultation process and direct you to the relevant Internet platform.

You will receive the Online Consultation platform instructions by email.

Online Consultation service includes:

- ✓ interpretation of lab tests and diagnostic test results
- ✓ consultation on the continuation of therapy prescribed by a specialist
- ✓ referral to additional diagnostics and further treatment
- ✓ second opinion
- ✓ nutritional advice, only for the diagnosis of diabetes and cancer, if in accordance with the Terms and Conditions
- ✓ consultations and treatment by a psychiatrist, if this coverage is included
- ✓ reproductive health exam (analysis of previous findings, medical history and referral to further treatment or diagnostics), if this coverage is included
- ✓ consultations with doctors regarding family history, if this coverage is included

Discount “For the Loved Ones”

Insureds' family members, who are not enrolled in the plan, can have a 20% discount on certain medical services in the following healthcare facilities:

- ✓ VIZIM HEALTH CENTER – BEOGRAD, CENTAR
- ✓ VIZIM HEALTH CENTER – NOVI BEOGRAD
- ✓ VIZIM HEALTH CENTER – NOVI SAD
- ✓ "BELMEDIC” healthcare facilities

”

You may register your family members via this link: Discount “For the Loved Ones” – Application Form (at each policy renewal, you need to resend an application “For the Loved Ones”).

Benefit Program - My Benefits

For our insureds we provide discounts for services, treatments and activities carried out by our partners, which help maintain a healthy lifestyle. List of partners in our Loyalty Network (click on the link).

Customer Portal

If you don't have an account, you need to follow these steps:

1. In order to use the portal services, you must register, and in order to register, you must first leave your contact details on our webpage: https://www.generali.rs/fizicka_lica/zdravlje_i_nezgoda.3638.html

When you enter the required information, we will immediately send you a portal activation code to your e-mail. You will need this code to create an account. A security code for minors is generated and sent to the e-mail address of the parent employed by the policyholder. If family members are adults, their e-mail addresses must be provided.

2. After that, you can create an account by clicking on the following link.

On this link, using the code you received, you create an account on our portal by first entering your Personal number (JMBG), then click on the "I already have a security code" button, filling in all the required data in the fields that will open and finally clicking on the "create account" button.

Parents/guardians open separate accounts for underage insured persons. Spouses open accounts separately.

Our contact center is available and can provide assistance anytime: 011/222-555

Moje zdr@vlje – mobile app

Part of the mobile app of Generali Osiguranje Srbija which allows for:

- ✓ Insured identification – “Moja E Kartica” (My E-Card)
- ✓ Making an appointment
- ✓ Access to the loyalty program for Health Insurance clients – “My Benefits”
- ✓ Access to the web Portal for monitoring the status of the policy – „Proveri stanje polise“ (“Check Policy Status”)

QR CODE for app download:

GET IT ON Google Play

Download on the App Store

ADDITIONAL INFORMATION

What is covered?

This insurance covers reasonable, customary fees for a medically justified treatment of a health disorder caused by illness or accident during the period of insurance.

What are reasonable and customary fees?

Reasonable and customary fees are the costs of a medical treatment not exceeding the negotiated price for the same or similar medical treatment within the Network, at the time the insured event occurs. These apply to out-of-network services. All amounts above the reasonable and customary fees shall be paid by the Insured.
Call the Medic Call Center to find out what is the amount of reasonable and customary fees.

What is a medically justified treatment (indication)?

- ✓ The insurance covers the costs of a medically justified treatment (recommended by a medical professional) of health disorders (due to illness or accident) of the insured person, which is provided for in the insurance policy.
- ✓ Insureds can use the services of general practitioners and all specialists whenever they have any health issues.
- ✓ You don't need a referral to see a doctor, including a specialist. For any further treatment, analysis, diagnostics, medicines, glasses, etc., you need a written report from the doctor in which they recommend a treatment (referral) (Referrals from both public and private healthcare facilities are accepted).

The costs of treatment requested by the Insured, based on the doctor's oral instructions or without the actual need (e.g., new glasses if the prescription (diopter) has not changed) will not be covered.

Healthcare service, medical product, medical supplies, and medicine (if prescription drugs coverage is included) are considered medically necessary (justified) if:

- if they are necessary for the diagnosis, treatment and management of a disease or injury of the Insured, if they meet their medical needs in scope, dosage, and duration, and are in compliance with the policy;
- they are necessary for healthcare for pregnant women or for prevention of an onset or early detection of a disease during annual physical exam (if such coverage is stipulated);
- they are negotiated in accordance with these Special Terms and Conditions and set out in the policy;
- they have been prescribed by a licensed physician and if there is a clear medical indication;
- their primary purpose is not personal comfort of the patient, family, physician or another healthcare provider;
- they are not a part of related to the patient's educational or professional training;
- they are not experimental or in the research phase;
- they are in accordance with widely accepted professional standards of medical practice in the country where the coverage is in force and don't exceed - in scope, duration or intensity - the level of protection required to provide safe and adequate medical treatment according to the professional judgment of the insurer's medical censor or to good clinical practice guidelines (procedures must address the symptoms of a disease and be required based on the current clinical presentation).

What is a pre-existing condition and what it means under the voluntary health insurance?

A pre-existing condition is any health condition resulting from a chronic illness or injury that occurred before the first enrollment.
The insurer's medical censor may determine the pre-existing condition based on diagnosis or indication for treatment, or based on etiology and pathophysiology of an illness (cause and mechanism of the onset of illness), the onset of symptoms and signs of an ailment listed in the medical records.

"Inpatient care" and "Surgical and Other Procedures" are excluded from coverage in case of a pre-existing condition, whereas outpatient services may be used according to the agreed coverage.

The costs of treatment of the following pre-existing conditions are completely excluded, for all coverages: psychosis, chronic diabetes with complications, Alzheimer's disease, post-stroke condition with functional disorders, liver cirrhosis, brain tumors with neurological deficits, chronic renal failure (hemodialysis), malignancies in all organs, multiple sclerosis, motor neuron disease, paralysis/paraplegia, Parkinson's disease, muscular dystrophy, presenile dementia, rheumatoid arthritis, unless stipulated otherwise.

What is the difference between the outpatient and the inpatient care?

Inpatient care is a medically justified treatment in a hospital where the Insured occupies a bed for the purpose of treatment, for more than 24 hours.
Outpatient care is a medically justified treatment an Insured undergoes at a healthcare facility without spending consecutive 24 hours in that facility (doesn't stay overnight, i.e. doesn't occupy a hospital bed).

What is excluded from the coverage?

General and special exclusions from the insurance coverage are described in detail in the Terms and Conditions enclosed with this User Manual.

Before using the services, please read the Voluntary Health Insurance General Terms and Conditions and the Group Voluntary Health Insurance Special Terms and Conditions, especially:

- all the exclusions listed in the explanation of coverage;
- Article 28 General Exclusions and Limitations of the insurer's Liability
- Article 6.7 Exclusions of the insurer's Liability

Termination of insurance

Insurance of all insured persons and the sub-insured shall be terminated whenever the employment with the policyholder ceases. Please discontinue further use of insurance upon termination of employment.

Privacy Notice

GENERALI OSIGURANJE SRBIJA a.d.o. (hereinafter: the Company) collects personal data from the policyholders/insureds at the time of conclusion of the insurance contract, or from third parties with whom it cooperates (brokers and agents);

Purpose of processing, legal basis, and retention period

The Company processes the policyholder's/Insured's personal data and information on Insured's health status in order to conclude an insurance contract, pursuant to the Health Insurance Act.
Without collecting and processing Insured's personal data the Company cannot execute the contract. The data processed for this purpose are retained, in compliance with the law, throughout the insurance contract period, and for a period of 10 years after the expiry of the insurance contract.

Data access and portability

The Company may share personal data with third parties with whom it has entered into a business cooperation agreement, with the reinsurer or co-insurer in order to meet contractual obligations, members of the Generali Group and third parties who must have access to such data, under the law (the National Bank of Serbia and other authorities, external auditors, courts, etc.).
The transfer of data to another country, to the reinsurers and members of the Generali Group is carried out providing an adequate level of personal data protection, in accordance with Article 64 of the Law on Personal Data Protection.

Data processing rights

The Insured has all the legal rights regarding personal data processing: the right to access, rectify and erase personal data, the right to restrict data processing, to object, and to transfer the data.
If they believe that the personal data processing was carried out against the Law on Personal Data Protection, the Insured has the right to file a complaint to the Commissioner for information of public importance and personal data protection.

Contact

If you have any questions about your rights related to personal data processing, or if you have information or concerns about data breach, please contact us:

- Contact center: 011 222 0 555
- E-mail: dpo@generali.rs
- Address: GENERALI OSIGURANJE SRBIJA a.d.o., Španskih boraca 3, 11070 Novi Beograd.

“The English version of this document is for information only;
In case of discrepancies original Serbian version shall prevail.”

ANNEXES

- ANNEX 1. Medical Treatment Authorization Form
- ANNEX 2. Voluntary Health Insurance Reimbursement Claim Form
- ANNEX 3. Generali Osiguranje Srbija Network of Clinics
- ANNEX 4: Voluntary Health Insurance General Terms and Conditions
- ANNEX 5: Group Voluntary Health Insurance Special Terms and Conditions

CONTACT

Generali Osiguranje Srbija a.d.o.
Španskih boraca 3, 11070 Novi Beograd
011/ 222 0 555
kontakt@generali.rs