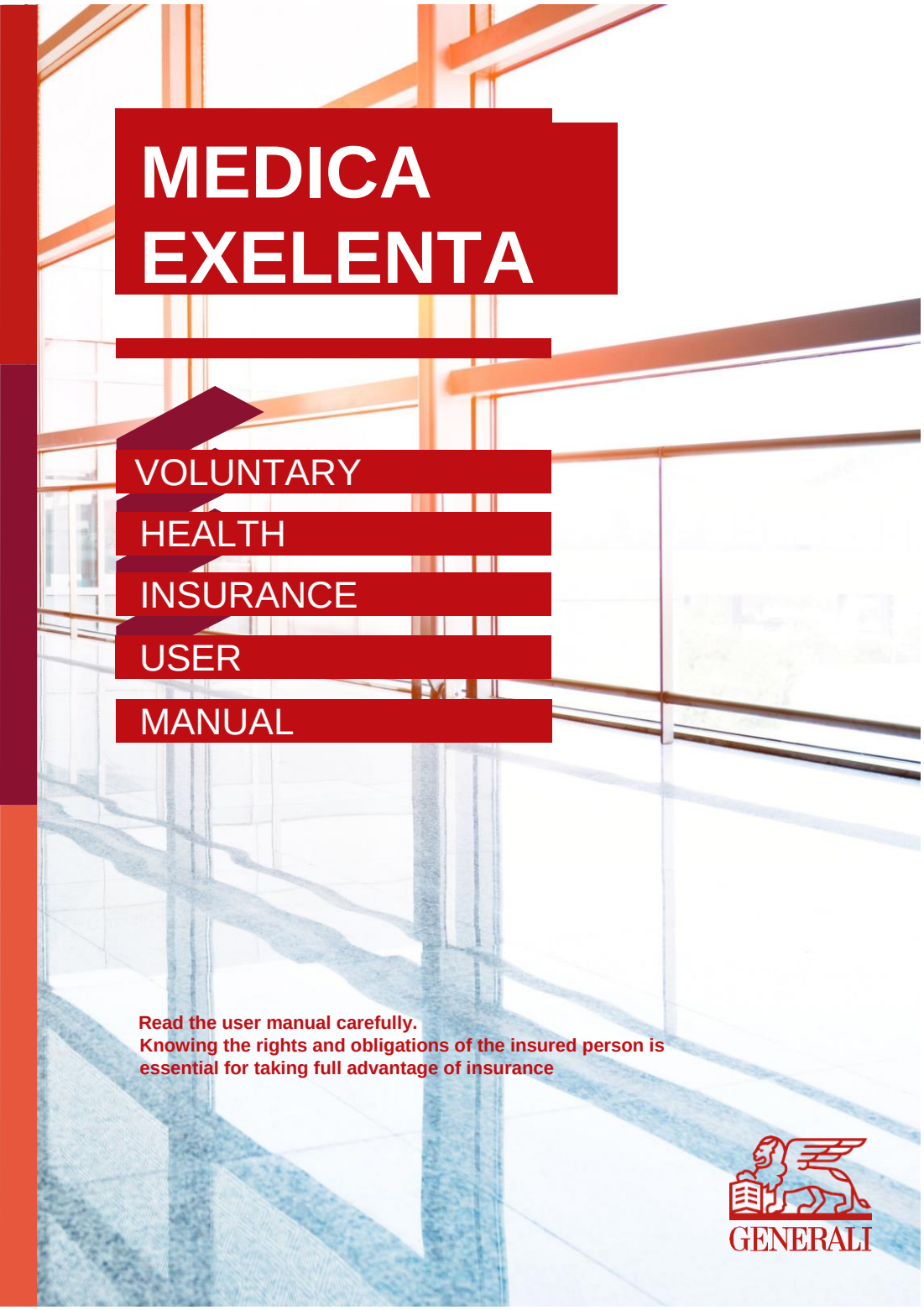

MEDICA EXELENTA

VOLUNTARY HEALTH INSURANCE USER MANUAL

Read the user manual carefully.
Knowing the rights and obligations of the insured person is essential for taking full advantage of insurance

GENERALI

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SUMMARY

Where is the insurance valid?

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

Eligibility

Only persons with registered residence/temporary residence in the Republic of Serbia are eligible for this insurance, in accordance with relevant regulations.

When the policy is in force, a new person can be enrolled only if they have become eligible for insurance under this policy after the commencement date, i.e. if:

1.1. they have entered into employment contract or another contract with the policyholder;

1.2. they have met the enrollment requirements (e.g. by becoming eligible for voluntary health insurance due to promotion);

1.3. they have become a member, participant, user of the policyholder's services or is in another direct relationship

Exclusion of an insured person from the insurance policy before the end of the insurance period is possible if the insured loses capacity of an insured person, based on which they became eligible for insurance (e.g. termination of employment contract or contractual relationship, cancellation of membership) and in other cases set out in the General Terms and Conditions.

The insurer may ask the policyholder to submit additional documents proving the grounds for enrollment or exclusion of the insured, according to the case in question.

How to use this insurance?

This insurance can be used:

- at the clinics within the network (medical institutions with which the insurer has an agreement on provision of healthcare services) and
- at the clinics outside the network
- for coverage of prescription drugs in outpatient conditions covered by insurance, you can take the drug at any pharmacy in the Republic of Serbia, pay on the spot and subsequently refund the amount from the insurer, following the 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 the Medic Call Center.

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

How to calculate insured’s share (copayment) in incurred expenses?

Copayment is the insured’s share in the price of each service received. The agreed limits and sums insured shall be reduced by the portion paid by the Insurer.

Example for treatment with annual limit of €300 and 20% copayment:

- Cost of the treatment is €30, of which the insured pays €6 at the spot, and the insurer shall reimburse €24.
- If they are using a service outside the Network, the insured will submit the bill for €30, and the amount of €24 will be reimbursed to them.
- The limit shall be reduced by the amount of €24.

Assistance by phone

Medic Call Center 011 / 222 0 575

Free 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 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 treatment centers, on-call clinics, pharmacies, etc.

If, in the process of reimbursement, facts different from those available to the Medic Call Center at the time of making an appointment are discovered, the insurer reserves the right not to assume the obligation to pay the expenses incurred if the amount exceeds the sum insured/limit or if the service is not consistent with the agreed coverage.

All calls are recorded for the purpose of control and providing 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 calling for information or for making an appointment, you can also send a request via email: infomedic@generali.rs

What do you need to do?

You need to:

- be informed about the covers agreed on your behalf and not accept a service to be charged to the insurance company, if not included in your coverage.
- know the insurance terms and conditions set forth in the insurance policy, this User Manual and insurance Terms and Conditions.

  Rights and obligations are specified in the insurance Terms and Conditions (link on the last page of this User Manual).

REIMBURSEMENT AND TREATMENT PRE-AUTHORIZATION

A request for reimbursement of expenses can be made in one of three ways:

- ✓ online, at the Customer Portal

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

* If you don't have the portal registration security code, please call the Generali contact center at this number: **011 222 0 555** or send us an email at: **kontakt@generali.rs**

- ✓ electronically, by sending the documents to the e-mail address: prijava.pzo@generali.rs (instructions for application via email, go to: LINK)
- ✓ by mail to our address:

Generali Osiguranje Srbija, Vladimira Popovića 8, 11070 Novi Beograd,
To: "Direkcija za obradu šteta PZO"

What is required for reimbursement?

- ✓ A completed Voluntary Health Insurance 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.

To get a medical exam, submit the doctor's report with a diagnosis indicated by a physician.
For all the other services (diagnostics, therapies, medicine, glasses) the following is required:

1. Referral or a doctor's previous report showing medical reason for the service being reimbursed.
2. Report on the service rendered, confirming that a service has been provided to the insured.

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 period of execution.
- for dental services – a dentist's report, with specified number of a treated tooth and the work done. For more expensive interventions (crowns, bridges, cast upgrades) a pre- and post-intervention dental x-ray image is required.
- for eye exam – referral for glasses/lenses

When is the treatment pre-authorization required?

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

- ✓ when you have been informed that the costs will exceed €300eur
- ✓ for planned inpatient treatment; or single indemnity instead of covering inpatient treatment costs
- ✓ for childbirth, or ne-time fee instead of coverage for childbirth
- ✓ for all planned or scheduled surgical and other procedures, or a single indemnity instead of covering treatment costs in surgical procedure
- ✓ for prenatal diagnostic
- ✓ for procurement of durable medical equipment
- ✓ for removal of changes in the skin

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

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

In 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 pre-authorization.

In the event that a cost was incurred and the pre-authorization process has not been initiated, and 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 expenses.

The insured may claim single indemnity instead of cost of treatment coverage only BEFORE the treatment is performed. Consequently, a single indemnity cannot be claimed even for services performed as an emergency.

When the insured chooses single indemnity, the insurer does not cover the cost of medically justified treatment, based on which the payment of indemnity was requested, nor other expenses related to that treatment, including preparation for surgery or childbirth and postoperative care.

NOTE:
Making an appointment through the Medic Call Center shall not be considered pre-authorization if the above procedure has not been carried out.

COVERAGE

COVERAGE	**Outpatient treatment Inpatient treatment Surgical procedures**	**Up to €10,000**
	Healthcare for pregnant women and newborns	**Up to €2,500**
	Drugs	**Up to €300**
	Optic services	**Up to €200**
	Dental services	**Up to €250**
	Annual physical exam	**Agreed plan**

Outpatient treatment *

	Copayment	0%
	Special notes	Restrictions/Limits
Examination by a licensed physician (examination, follow-up or consultation, including online consultation)	Examinations of neuropsychiatrists, psychiatrists, psychologists, speech pathologists and other physicians in the field of mental health are covered exclusively within the scope of "Mental Health Services" coverage if contracted by the policy.	Up to the coverage limit
Lab tests and analyses		Up to the coverage limit
Diagnostic procedures		Up to the coverage limit
Ambulance transport		Up to the coverage limit
Therapy treatments (without the cost of drugs):	- therapy with drugs, injections, inhalation and infusion, - oculomotor exercises, - occupational therapy, - other rehabilitation therapies	Up to the coverage limit (exclusion: Ortokin, PRP and related treatments, hyperbaric chamber and MTT tinnitus therapy)
Physical and kinesiotherapy and speech therapy	It can be provided only by qualified therapists or chiropractors, or a speech therapist or special education specialist.	Up to €200
Emergency dental treatment, accident-related		Up to €500
Home nursing care	Immediately after inpatient treatment or treatment in case the insured is temporarily or permanently immobile	Up to €500
Mental health services	It involves psychotherapy, consultation with a psychiatrist, neuropsychiatrist, psychologist, special education specialist or, if necessary, a physician of other specialty	Up to €300
Alternative and complementary medicine	It is implemented in accordance with the legal regulations governing this area and the terms of insurance - by calling MCC the insured will receive the necessary information about the options	Up to €150
Medical-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
Fertility tests	Procedures and interventions performed to test sterility, causes of miscarriages, and preparation for pregnancy	Up to €250
Primary outpatient interventions	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,	Up to the coverage limit according to defined scope – surgical procedures are not included

	ear, nose and throat, plaster casts, fixation and immobilization of the joint, irrigation of the ear and nose, aspiration of nasal secretions, vaginal irrigation, nasal tamponade, applying gauze with drug, abscess incision, therapeutic puncture of joint and connective tissue, orthopedic repositioning of luxations and fractures without anesthesia)	

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

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

Physical therapy at home only if the insured person is immobile due to fracture of the lower limbs, spinal injury or cerebrovascular stroke.

Insurance doesn't cover:

- any type of massage not prescribed by the physician as part of physical therapy (e.g., relaxation and aesthetic massage), exercise therapy (except kinesiotherapy and oculomotor exercises), rehabilitation therapy lasting more than one month and ambient therapy;
- orthopedic shoes, orthopedic inserts or other aids for deformed, weak, overstressed, unstable lowered feet, tarsalgia or metatarsalgia;
- any costs incurred in spa conditions except for exams, diagnostic procedures and therapies.
- any other exclusions defined in Article 28 of the Special Terms and Conditions

Inpatient treatment *

	Copayment	0%
	Special notes	**Restrictions/Limits**
Inpatient treatment (without surgical procedures)	- accommodation, - medically permitted diet - exams by certified 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 18 years of age	Up to the coverage limit (single-bedroom upon personal request is not included)
Chemotherapy and radiotherapy		Up to €2,000
Emergency dental treatment, accident-related		Up to €500
A single indemnity instead of covering inpatient treatment costs	The single indemnity is paid to the insured only if the service is covered by insurance and if the insured, instead of covering the costs of hospital treatment, opted for the option of paying a single indemnity and started the authorization process. **In cases when the insured did not initiate the authorization process before going to the hospital, he is not entitled to a single**	€45 per day spent at the hospital, and no more than 10 days during the insurance year

	indemnity.	

** Pre-existing conditions are excluded*

In terms of these conditions, inpatient treatment does not include the accommodation of insured persons in inpatient care facilities such as: rehabilitation centers, mental hospitals, inpatient hospitals specialized in rehabilitation, hydroclinics, sanatoria, hospice care homes, nursing homes, spas, rest, weight loss and recovery centers.

Surgical and other procedures *

	Copayment	0%
	Special notes	**Restrictions/Limits**
Surgical and other procedures	Costs of surgical and other procedures (including blood and blood components for transfusion, medical supplies and implants needed to perform the procedure, drugs, medical supplies used during the procedure),	Up to €5,000
Implants for performing the procedure		Up to €1,500
A single indemnity instead of covering treatment costs in	The single indemnity benefit 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 surgery, opted for the option of paying a single indemnity benefit and started the authorization process. **In cases when the insured did not initiate the authorization process before the performed surgical intervention, he is not entitled to the payment of a single indemnity.**	Up to 65% of authorized amount in accordance with Terms and Conditions if the surgical procedure is performed in the Republic of Serbia or 100% of authorized amount if the surgical procedure is performed abroad (authorized amount as the amount of treatment costs for coverage of surgical and other procedures approved by the insured 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 treatment" or "Inpatient treatment" coverage (if stipulated under the policy)

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

- radial keratotomy or any other surgical procedure for vision correction (including laser treatments);
- sex change surgical procedure;
- surgical procedures for organ and tissue transplantation;
- nasal septum surgery for persons over 18 years of age;
- removal of genital warts if the sample was not sent for HP analysis or HPV typing;
- removal of birthmarks, lipomas, atheroma, fibromas, warts, capillaries, cherry angiomas, keratoses of similar widespread skin lesions which, in the opinion of the censor physicians, do not endanger the health of the patient.

  Coverage is limited to emergency cases and medically indicated cases where change might be injured or PH analysis for suspected malignancy is requested.
- circumcision, if not medically indicated;
- insertion of a gastric balloon.

Healthcare for pregnant women and newborns		Up to €2,500
	Copayment	0%
	Special notes	Restrictions/Limits
Healthcare for pregnant women	- examination by a gynecologist, - lab tests, - CTG, - progesterone and tocolytic therapy and other medicines to prevent preterm birth, - biochemical screening for chromosomal aberrations, - a complete routine pelvic exam, up to 6 months after childbirth.	Up to the coverage limit
Staying at the hospital for pregnancy maintenance		Up to the coverage limit
Prenatal vitamins	Medical devices that represent a combination of vitamins and minerals used only during pregnancy, for proper development of the fetus. If the doctor prescribes minerals and vitamins for general use, only those that are registered as medicine i.e. are listed in the National Medicines Registry (NRL) will be covered,	Up to €50
Ultrasound and Doppler exam		7 exams up to €50 per exam
Additional ultrasound exam with high-risk pregnancy		1 exam up to €50
Expert ultrasound		1 exam up to €70
Fetal echocardiography		1 imaging
Additional fetal echocardiography in the event of shown anomalies		1 imaging
Invasive and non-invasive prenatal diagnostics	Invasive prenatal diagnosis such as amniocentesis, chorionic biopsy, chordocynthesis, etc. And the non-invasive which involves testing on the mother's blood sample, e.g. the Nifty test	Up to the coverage limit (restriction: 1 non-invasive – up to €500)
One follow-up exam and related lab and diagnostics procedures in case of miscarriage or termination of pregnancy for medical reasons		Up to €70
Childbirth	Epidural anesthesia, medically indicated caesarean section, suite accommodation, father's presence at childbirth, physician, medical technicians, anesthesiologist. Caesarean section is only covered if	Up to €2,000

	medically indicated.	
Single indemnity instead of coverage for childbirth	The single indemnity is paid to the insured only if the service is covered by insurance and if the insured, instead of covering the birth, opted for the option of paying a single indemnity and started the authorization process. **In cases when the insured has not initiated the authorization process before the birth, they are not entitled to the payment of a single indemnity.**	Up to €750 per childbirth
Health care for babies in the first month of the child's life	Treatment of newborn's health disorders but not check-ups and other services routinely performed within the first month of life.	Up to €500
Home nursing care in the first month of the child's life		Up to €100

The limits of this coverage apply to an individual pregnancy, not the year of insurance. If the limit for this coverage is not used within one year, the maximum liability of the insurer in the following insurance year continuously is equal to the remaining limit under the previous policy.

With the exception of drugs used for progesterone and tocolytic therapy, other pregnancy-related drugs are covered only if "Drugs" coverage is agreed.

This cover also covers the cost of treating other health issues that result from pregnancy, i.e. the cost of medical treatments that would not be indicated if the insured was not pregnant.

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

*Insurance does not cover pregnancies which occurred before the insurance period.

It is considered that the pregnancy occurred before the beginning of insurance if according to the insured person's preferred licensed gynecologist the estimated date of delivery would be before the expiry of the period of 9 months from the date the pregnant woman took out an insurance policy for the first time.

Classes for pregnant women (preparations for delivery) and hospital accommodation for the companion during hospitalization for childbirth or maintenance of pregnancy are excluded from insurance coverage.

ADDITIONAL COVERAGE

Coverage	Special notes	Restrictions/Limits	Copayment
Prescription drugs		Up to €300	0%

Insurance does not cover: biological, immunological, blood and plasma medicines, advanced therapy drugs, while traditional and homeopathic medicine are exclusively covered by "Traditional medicine" coverage, if contracted; medical cosmetics; all medical devices (including syringes, needles and bandages) not covered by medical aids coverage, as well as dietary supplements (except: probiotics with antibiotic

therapy and during the therapy, iron products for anemia (with a medical report showing that the insured person has a bad reaction to a registered product), eye drops (artificial tears) in case of dry eye or conjunctivitis diagnosis.

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

Medications used during hospital treatment are not subject to prescription drugs limit. They are used under the basic coverage (inpatient treatment), up to the coverage limit for inpatient treatment.

Eye exam	Exam by ophthalmologist Frames Glasses and lenses	Up to the coverage limit Up to €75 Up to €125	0%

With continuity insurance, you are entitled to change frames and glass only if your diopter value changes.
If the diopter value does not change, you will be entitled to change frames and glass two years after the last purchase.

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

Contact lenses in medically appropriate amount.

By losing or damaging aids, the insured does not gain the right to purchase new ones at the cost of insurance.
Insurance excludes sunglasses, accessories for glasses, glasses and lenses without diopter.

Dental services	Preventive exam Basic restorative treatment Major restorative treatment Orthodontics (up 35 years of age) Plaque removal – once annually Periodontal surgical procedures Oral surgical procedures	Up to €250 eur Insurance does not cover: - cosmetic treatments - artificial teeth - ceramic additions on to dental implants - dental implants - permanent retainers - fillings for multiple surfaces - facets and all related costs	20%

Insurance does not cover cosmetic and aesthetic teeth treatments, artificial teeth, dental implants, ceramic additions on dental implants, permanent retainers, veneers with all the related costs, teeth whitening and all other dental aids.

Annual physical exam	One exam per year according to the agreed plan Additional routine exams as indicated by a doctor and vaccinations	Agreed plan Up to €100	0%

You can use the contracted annual physical exam plan at one of several clinics within the network that have the capacity to perform the annual physical exam. The annual physical exam is always scheduled through Medic Call Center at 011/ 222 0 575.

CONTENT OF ANNUAL PHYSICAL EXAM

WOMEN	MEN
✓ Complete lab tests (CBC, SE, ŠUK, urea, creatinine, cholesterol, LDL, HDL, triglycerides, AST, ALT, AP and complete urine test)	✓ Lab tests (CBC, SE, ŠUK, cholesterol, LDL, HDL, triglycerides, urea, creatinine, ALT, AST, complete urine, PSA in men over 40)
✓ Exam by an internist, with ECG	✓ Exam by an internist, with ECG
✓ Pelvic exam, pelvic US, breast US, Pap test, colposcopy, VS	✓ Urological exam with US
✓ Abdominal and small pelvis US	✓ Abdominal US
✓ Dermatological exam and dermoscopy	✓ Dermatological exam and dermoscopy
✓ Exam by an ophthalmologist	✓ Exam by an ophthalmologist
✓ Thyroid gland US	✓ Neck blood vessels Doppler
✓ Final exam and conclusion	✓ Abdominal aorta US
	✓ Final exam and conclusion

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You can use the listed services as part of the annual physical exam in the following medical institutions within the network of clinics:

- ✓ DZ VIZIM
- ✓ AURORA
- ✓ EUROMEDIC

There is an option to change the content of annual physical exam for those who:
have recovered from Covid-19 infection, suspect they have been infected with Covid-19, or want to change the annual physical exam offered by the company for a post-Covid-19 physical exam.

Note: Over the course of insurance period the insured is entitled to one annual physical exam plan (standard plan that is contracted or a post-Covid-19 annual physical exam) – not both. Insurance does not cover the costs of treatment of conditions resulting from Covid-19 infection, regardless of possible indications/referrals for further treatment.

CONTENT OF ANNUAL PHYSICAL EXAM – POST-COVID-19

WOMEN	MEN
✓ Lab tests (CBC, glucose, ALT(SGPT), AST(SGOT), urea, creatinine, LDH, CRP, D-dimer)	✓ Lab tests (CBC, glucose, ALT(SGPT), AST(SGOT), urea, creatinine, LDH, CRP, D-dimer)
✓ Exam by an internist, with ECG	✓ Exam by an internist, with ECG
✓ Pulse oximetry	✓ Pulse oximetry
✓ Spirometry – based on clear criteria	✓ Spirometry – by clear criteria
✓ Heart ultrasound	✓ Heart ultrasound
✓ Abdominal US	✓ Abdominal US
✓ One-minute stress test with saturation and pulse measurement	✓ One-minute stress test with saturation and pulse measurement

You can use the listed services as part of the annual physical exam in the following medical institutions within the network of clinics:

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

An annual physical exam must be scheduled through the Medic Call Center at: 011/ 222 0 575.

IMPORTANT FOR USE OF ANNUAL PHYSICAL EXAM:

At your request the insurer shall enable partial use of this coverage for one single exam/diagnostic procedure from this list for which there is no indication. The given service can be used only in institutions contracted to conduct the annual physical exam.

By using one partial service, you will have used the entire Annual Physical Exam coverage.

As a part of the annual physical exam certain diagnostic procedures can be performed, in order to establish the family medical history. Examining the family medical history must be indicated by a licensed physician.

ADDITIONAL BENEFITS

NEW! Online Consultation service

In an effort to provide you with additional security and comfort when using our services, we are offering a new benefit to all our policyholders – Online Consultation services by a doctor regarding your diagnosis.

To use Online Consultation services, you need to call the Medic Call Center at the following number: 011/222 0 575 (key 3). After checking the coverage and the insurance terms and conditions, the Medic Call Center will provide you with all the information on how the online consultations are conducted and direct you to a relevant internet platform.

You will receive Online Consultation platform user instructions by email.

Online Consultation service includes:

- ✓ interpretation of laboratory and diagnostic test results
- ✓ consultation regarding the continuation of therapy prescribed by a medical specialist
- ✓ referral to additional diagnostic tests and continuation of treatment
- ✓ second medical opinion
- ✓ nutrition advice from a specialist, only for diabetes and cancer diagnoses, if in accordance with the terms and conditions
- ✓ psychiatric consultation and treatment, if you have the relevant cover
- ✓ reproductive health examination (analysis of previous results, medical history and referral for further treatment or diagnostic tests), if you have the relevant cover
- ✓ consultations with doctors regarding family history, if you have the relevant cover

Discount “for the loved ones”

Insureds' family members, who are not insured, can use some of these services with a 20% discount in the following medical facilities:

- ✓ DZ VIZIM – BEOGRAD, CENTAR
- ✓ DZ VIZIM – NOVI BEOGRAD
- ✓ DZ VIZIM – NOVI SAD
- ✓ “BELMEDIC” group health centers

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

We provide our insureds with 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

The Portal enables you to check your spending any time. To use the portal, you must register. Access the registration form on the following link.

If you are registering for the first time, you need a security code which you can get by calling General contact center at 011 222 555 or send us an email at: kontakt@generali.rs

You can also send us, through your employer, your email to which you will receive portal registration instructions along with the security code.

Security code for minors is generated and sent to the email of a parent employed by the policyholder, whereas the emails for all the adult family members are required.

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 the loyalty program for Health Insurance clients – “My Benefits”
- ✓ Access the WEB portal for monitoring the status of the policy – “Check Policy Status”

QR CODE for app download:

ADDITIONAL INFORMATION

What is covered?

The insurance covers reasonable, customary expenses of a medically indicated treatment for a health condition caused by a disease or accident during the insurance period.

What are the reasonable and customary expenses?

The costs of medical treatment which are not higher than the contracted service for the same or similar medical treatment within the network at the time the insured event occurs. They shall be applied to use of services outside the network of clinics. All the amounts above the reasonable and customary expenses shall be charged to the insured.

You can get the information about the amount of reasonable and customary expenses by calling the Medic Call Center.

What is medically justified treatment (indication)?

- ✓ Insurance covers the costs of medically justified treatment (recommended by a medical expert) of a health condition (due to illness or accident) of the insured person, provided by insurance policy.
- ✓ The insured may use the services of a general practitioner and all the specialists any time they experience health problems.
- ✓ A referral is not required for a doctor's appointment, including specialists. For any further treatment, analysis, diagnostics, drugs, glasses, etc., you must have a doctor's report (referral) in which the doctor recommends a treatment (referrals from both public and private medical institutions are accepted).

The costs of treatments the patient underwent at own initiative, based on doctor's verbal recommendation or without reason (e.g. new glasses with no diopter value change), will not be reimbursed.

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

- they are necessary for the diagnosis, treatment and follow-up exam of illness or injury of the insured, if they suit their clinical needs in scope, dosages and duration, and in accordance with the policy;
- they are necessary for healthcare of pregnant women or prevention of appearance or early discovery of illness during annual physical exam (if these coverages are agreed);
- they are contracted pursuant to these special terms and conditions and defined in the policy;
- they are prescribed by a licensed physician and if there is a clear medical indication for them;
- they are not primarily intended for personal comfort of the patient, family, physician or other provider of medical services;
- they are not part of education of professional training of patient and are not in relation with them;
- they are not experimental or in research stage;
- they are in accordance with widely accepted professional standards of medical practice in the country where coverage is valid, and they do not exceed the scope, duration or intensity level that is needed to provide safe, adequate and appropriate treatment according to expert assessment of the insurer's censor physician or according to the guidelines of good clinical practice (procedures performed must be in connection with symptoms of the illness and their performance must be justified with a valid clinical manifestation).

What is a pre-existing condition and how is it treated under the voluntary health insurance?

Pre-existing condition is any health condition resulting from a chronic illness or injury which took place before the insurance policy was taken out for the first time.
The insurer's censor physician can determine a pre-existing condition based on a diagnosis or indication for treatment, or based on etiology and pathophysiology of illness (cause and mechanism of illness occurrence), appearance of symptoms and signs of the disease stated in medical records.

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

The costs of treating the following pre-existing medical conditions are completely excluded from insurance: psychoses, chronic diabetes mellitus with complications, Alzheimer's disease, post-stroke condition with functional disorders, liver cirrhosis, brain tumors with neurologic deficits, chronic renal failure (hemodialysis), malignancies in all organs, multiple sclerosis, paralysis of motor neurons, paralysis/ paraplegia, Parkinson's disease, muscular dystrophy, presenile dementia, rheumatoid arthritis, unless otherwise agreed.

What is the difference between outpatient and inpatient treatment?

Inpatient treatment is a medically indicated treatment of the insured at a hospital where the insured person has a bed for treatment for a period longer than 24 hours.
Outpatient treatment is a medically indicated treatment provided to the insured person by the healthcare service provider, but the patient has not spent 24 consecutive hours at the facility (no overnight stay, i.e. no use of a hospital bed).

What is excluded from insurance?

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 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: Company) collects personal data of the policyholder/insured from the policyholder/insured at the conclusion of the insurance contract, or from third parties with whom they have business cooperation (insurance brokers and agents);

Purpose of Processing, Legal Basis and Retention Period

The Company shall process personal data of the policyholder/insured person, as well as data on the previous health status of the insured, for the purpose of concluding the insurance contract, in accordance with the Health Insurance Act.
Without collecting and processing policyholder/insured's personal data the Company cannot conclude 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 exchange all personal data with third parties with whom it has a business cooperation agreement, with reinsurers or co-insurers in order to fulfil the obligations arising from the insurance contract, with members of Generali Group and third parties who by law must have access to this information (National Bank of Serbia and other authorities, external auditors, courts, etc.).
The transfer of data to another country, namely to reinsurers and members of Generali Group, is carried out on the basis of appropriate level of protection of personal data, in accordance with Article 64 of the Law on Personal Data Protection.

Data Processing Rights

The insured has all legal rights regarding the processing of personal data, namely: the right to access, right to rectification, amendment and erasure of personal data, the right to restrict the data processing, to object and to transfer the data.
If they believe that the personal data processing was carried out contrary 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

For questions relating to the processing of personal data, or if you have any knowledge or suspicion of personal data breach, you may contact us via:

- contact center: 011 222 0 555
- e-mail: dpo@generali.rs
- mailing address: GENERALI OSIGURANJE SRBIJA a.d.o., Vladimira Popovića 8, 11070 Novi Beograd.

ANNEXES

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

CONTACT

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Vladimira Popovića 8,11070 Novi Beograd
011/ 222 0 555
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