HEALTHCARE SERVICES GUIDE

DIRECT ASSISTANCE SYSTEM
REFUND/INDIRECT SYSTEM, MIXED SYSTEM

Uni.C.A.
PER IL PERSONALE E LE AZIENDE DEL GRUPPO UniCredit

GENERALI welion

FOREWORD

This guide is a tool for the correct **understanding** and **use** of the **Healthcare Plan**. Under no circumstances may it replace the Insurance Contract of which it only highlights the main features. The Insurance Contract therefore remains the only valid tool for complete and exhaustive reference.

Available to the beneficiaries

For more information about the healthcare plan, you can call the Dedicated Line **800 590 590** within Italy or **+39 0282 951 111** from abroad, **Monday to Sunday from 7 a.m. to 8 p.m. CET**.

See the list of affiliated facilities, affiliated doctors and affiliated services:
https://www.generali.it/strutture-convenzionate/strutture-mediche

Access to the Reserved Area is possible after authentication for:
- carrying out the pre-activation as described in the following paragraphs
- completing the reimbursement request

Access methods:

1

the **Welfare portal** > Uni.C.A. > GENERALI (2024-25)

2

from the **APP** active from 1 March 2024 (subject to registration/login)

3

from the **web page** active from 1 March 2024 (subject to registration/login)

Registration is valid for methods 2 and 3

INDEX

INTRODUCTION

You can access the healthcare services offered by Uni.C.A. through Generali/Welion as illustrated below:

a) direct healthcare: the Beneficiaries have the right to access the healthcare services provided by the affiliated facilities belonging to the Healthcare Network made available by UNI.C.A. through Generali Italia, which provides for the direct payment to the affiliated facilities of the amount due for the medical and hospital services received, provided that they are indemnifiable under the terms of the policy. The Beneficiary therefore does not have to advance any amount, except for any deductibles and/or uncovered amount that he/she may have to pay and/or uncovered amount that he/she may have to pay for services that are not indemnifiable under the policy.

b) reimbursable/indirect healthcare: reimbursement of expenses incurred for services received from healthcare facilities freely chosen by the Beneficiaries and not included in the healthcare network made available by the Insurance Company (except in the event of access to the network without having contacted the Operations Centre in advance), within the limits set out in their Healthcare Plan.
In the indirect system, the Beneficiary must advance the amount to which a deductible will then be applied depending on the plan. Reimbursement healthcare also applies to healthcare costs incurred abroad.

c) mixed healthcare: the patient will be able to benefit from a mixed form of payment of expenses in the case of services at healthcare institutions (public and private) affiliated with the Company and surgeons (also under the intramoenia system) and teams and/or services not affiliated with the Company. The Company pays directly to the affiliated healthcare institution the expense component indemnifiable under the terms of the policy relating to the affiliated healthcare institution (direct assistance), except for the application of coinsurance/deductibles provided for in the policy for the direct form.
The insured party bears the cost component relating to doctors not affiliated with the Company him/herself, subsequently requesting reimbursement from the same. The expenses indemnifiable under the terms of the policy are reimbursed to the insured party subject to the application of overdrafts/deductibles indicated in the policy for the indirect form, which remain at his/her expense

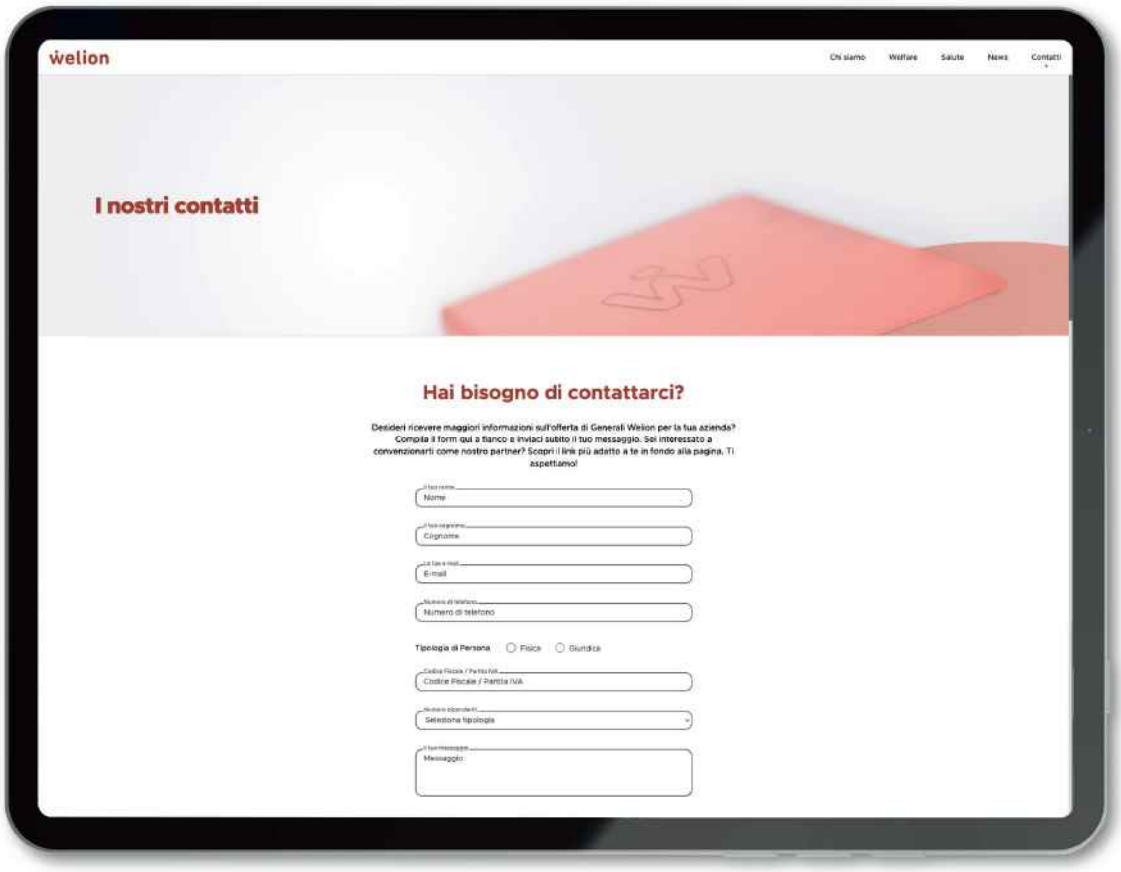
"Healthcare Network" means **the set of healthcare facilities** (Hospitals, Nursing Homes and Diagnostic Centres) and professionals affiliated with Generali Italia, to which the Insured Party may be referred by the Operation Centre to benefit from healthcare services covered by the policy.

The list of affiliated healthcare facilities is available on the **Generali Italia website www.generali.it** under **"Strutture Convenzionate"** [Affiliated Facilities] and is periodically updated.

In fact, the Healthcare Network is also subject to changes during the insurance year. The Facilities Affiliation office constantly updates its Database, providing Insured Parties with up-to-date information through the Operation Centre.

Do you want to affiliate a facility that is not part of the Network?

A Healthcare Facility can apply to the Generali Welion Network in a few simple clicks! Simply tell the applicant healthcare facility to visit our website Welion.it and click on the CONTACTS section (here is the link: **https://www.welion.it/Contatti**). Once there, simply go to the bottom of the page and choose the most suitable form according to the type of facility (HEALTHCARE or DENTAL). Our doctors will be affiliated through the Facilities. It is not possible to directly affiliate individual doctors.



By clicking on "**CLICCA QUI E COMPILA IL FORM**" [CLICK HERE AND FILL OUT THE FORM], a screen will appear with important information to fill out before your request can be processed.

As soon as the form is filled out, the Generali Welion Facilities Affiliation office will be notified and will evaluate the application, providing timely feedback in case of mutual interest.

01. HEALTHCARE SERVICES UNDER DIRECT CARE SYSTEM

Direct care

In order to receive services under the direct care system, the Beneficiary must first be authorised. Authorisation is obtained by contacting the Generali Welion Operations Centre via:

- dedicated freephone number
- web portal

Hospitalisations and surgeries

If the Insured Party needs to receive a healthcare service at an affiliated facility, he/she must contact the Operation Centre at least 5 working days before the date of the service, in order to verify the affiliation of the chosen facility and the medical team and to assess the insurance of adequacy of the service. In order to complete the administrative checks required for the authorisation of the file in time, it is not advisable to communicate the request for direct payment to the Operations Center close to the limit communicated above, but with reasonable advance notice.

How to access and submit a request online

- The Beneficiary accesses the Direct Request for Authorisation section
- selects the year in which the service was performed
- selects the Beneficiary for whom a health service is being requested, by clicking on the name of said person
- selects the service to which the request authorisation refers. The service is also searchable using the search engine
- if there is more than one policy, selects the relevant policy
- uploads the medical documents and fills in the relevant information fields (facility, affiliated doctor, etc.)
- inserts any notes supplementing the request
- displays a summary page where he/she can edit what was entered, before sending
- enters the date of the service booked at the previously selected health facility.

Necessary documentation

The Beneficiary must attach:

- prescription or medical certificate stating the hospital service to be provided
- diagnosis or presumed diagnosis
- immediate and past medical history, presenting the medical certificate certifying the onset of the pathology
- medical examination reports (Emergency Room report, in the case of an accident, as this must be objectively documented)
- signed power of attorney and privacy form if making the request for an adult family member

At the first request (direct or indirect system) on each Insured Party, it is required to provide consent to privacy. In the case of consent for another adult Insured Party, it is necessary to attach the signed power of attorney and privacy document made available during the application process and in the Documents section.

How to access and submit a request via FREEPHONE NUMBER

The Operations Centre can be reached at the Dedicated Line **800 590 590** within Italy or **+39 0282 951 111** from abroad, Monday to Sunday from 7 a.m. to 8 p.m. CET.

In order to guarantee the direct coverage of expenses and carry out the related paperwork in favour of the Insured Party, it is necessary to communicate:

- name and surname of the person providing the service
- policyholder
- mobile telephone number - for sending text confirmation - of the person performing the service
- healthcare facility where the service will be carried out
- service date
- medical team name

The Insured Party is required to send the medical prescription by e-mail to ricoveri.it@generali.com with the following information:

- information about the service to be performed
- diagnosis
- immediate and past medical history presenting a medical certificate certifying the onset of the pathology
- instrumental examination reports

The prior request of the Insured Party, the forwarding of the required documentation and the subsequent confirmation by the Operation Centre **are essential conditions for direct payment**.

Timeframe for authorisation and confirmation

Upon receipt of the medical certificate, the Operations Centre, after assessing the medical-insurance congruity of the service, shall authorise the affiliated facility to provide the service within the following 2 working days and shall notify the Insured Party of the positive outcome of his/her case.

In the facility

At the time of the service at an affiliated facility, the Insured Party must sign the appropriate "letter of commitment", a document that reaffirms the reciprocal obligations between the affiliated facility and the Insured Party, supplemented with fulfilments of the obligations under EU Regulation 2016/679 and under current data protection legislation.

The affiliated healthcare facility shall send the originals of the invoices and a copy of the reports for the payment of services directly to Generali Italia, in compliance with the agreements in place with the healthcare facilities.

Considering that direct payment is a method provided for by the policy, any non-authorisation of the service by the Operation Centre shall not prejudice the possibility of the claim being reimbursed by Generali Italia.

It is reiterated that the Insured Party shall be entitled to direct payment of the expenses invoiced by the professionals and by the affiliated facilities only to the extent authorised by the Operation Centre.

Pre- and post-hospitalisation services

With regard to pre-hospitalisation services, the Insured Party may request the activation of Direct Assistance only if the hospitalisation is authorised by the Operation Centre; with regard to post-hospitalisation services, the Insured Party may request the activation of Direct Assistance by sending the letter of discharge.

Cases of special urgency

If the Insured Party requires a particularly urgent direct service, he or she must contact the Operations Centre at least on the previous working day. In the event of urgent hospitalisations at a time other than that indicated, the Beneficiary is asked to contact the Operation Centre on the first available working day.

Preventive opinions

The Patient can make a request for preventive opinions only for oncological treatments with a well-defined clinical picture and with documentation to support the diagnosis.

It is specified that:
- The opinion is only possible if the clinical documentation is sufficient for the evaluating doctor
- There are opinions that cannot be expressed in the absence of medical records
- An opinion is an indication and not a certainty
- The opinions evaluate the known scope. Anything that emerges, for example, on admission and is unknown, is not part of the preventive opinion

The request for a preventive opinion can be submitted via Cassa Uni.C.A. to the email address **unicacomunicazioni@unicredit.eu**

Specialist examinations, diagnostic tests and out-patient services

If the Insured Party needs to receive an out of hospital service at an affiliated facility, the Operation Centre must be activated at least 2 working days before the date of the service, in order to verify the affiliation of the chosen facility and of the doctor in case of specialist examinations. In order to complete the administrative checks required for the authorisation of the file in time, it is not advisable to communicate the request for direct payment to the Operations Center close to the limit communicated above, but with reasonable advance notice.

How to access and submit a request online

- **The Beneficiary** accesses the Direct Request for Authorisation section
- selects the Beneficiary for whom a health service is being requested, by clicking on the name of said person
- selects the service to which the request authorisation refers. There is a search bar to facilitate the selection of the Beneficiary
- The Beneficiary **uploads documents** related to the request for health care (see section below)
- accesses a screen where it is possible to set the search criteria for the health facility at which to receive the service as well as the affiliated doctor
- enters the date of the service booked at the previously selected health facility

Necessary documentation

The Beneficiary **must attach**:
- medical certificate indicating the request for the service with diagnosis or presumed diagnosis. In the case of dental procedures, this data is not necessary.
- the signed power of attorney and privacy document if making the request for an adult family member.

How to access and submit a request via FREEPHONE NUMBER

The Operations Centre can be reached at the Dedicated Line **800 590 590** within Italy or **+39 0282 951 111** from abroad, Monday to Sunday from 7 a.m. to 8 p.m. CET.

In order to guarantee the direct coverage of expenses and carry out the related paperwork in favour of the Insured Party, it is necessary to communicate:
- name and surname of the person providing the service
- policyholder
- mobile telephone number - for sending text confirmation - of the person performing the service
- healthcare facility where the service will be carried out

- date of service
- diagnosis or presumed diagnosis reported on the medical certificate indicating the request for the service. In the case of dental services, this data is not necessary
- name of the doctor

Necessary documentation

At the time of initiating the telephone request, the Insured Party must be in possession of a medical prescription or medical certificate indicating the request for the service with diagnosis or presumed diagnosis (to be delivered subsequently to the facility). In the case of dental services, this data is not necessary.

The prior request of the Insured Party, the forwarding of the required documentation and the subsequent confirmation by the Operation Centre **are essential conditions for direct payment**.

Timeframe for authorisation and confirmation

Upon successful verification of the affiliation, the healthcare facility and - in the event of a specialist examination - the specialist doctor, the Operation Centre, having assessed the medical-insurance adequacy of the service, authorises the affiliated facility within the following 2 working days to perform the service in compliance with the Insurance Conditions (with evidence of any expenses not covered by the policy).
If the authorisation is denied, the Operation Centre will notify both the healthcare facility and the Beneficiary.
The Beneficiary must notify the Operations Centre in advance of any changes and/or additions to the authorised service so that, once the administrative and technical/medical checks have been carried out, the authorisation can be issued.

In the facility

Upon acceptance at the clinic, the Insured Party must sign the “letter of commitment” (a document that sets out the reciprocal obligations between the Insured Party and the affiliated healthcare facility) in relation to the service and with reference to the Conditions of Insurance, and deliver the prescription communicated by telephone to the Operation Centre.
If there is a discrepancy between the prescription communicated by telephone when requesting authorisation from the Operations Centre and the medical documentation handed in at the facility at the time of the service, Generali reserves the right not to authorise the assumption of responsibility/repay the insured party for any services not provided for in the coverage.

The affiliated healthcare facility shall send a copy of the invoices and the medical request for payment of the service directly to Generali Italia in compliance with the agreements in place with the healthcare facilities.

Considering that direct payment is a method provided for by the policy, any non-authorisation of the service by the Operation Centre shall not prejudice the possibility of the claim being reimbursed by Generali Italia.

02. HEALTHCARE SERVICES UNDER REIMBURSEMENT/INDIRECT CARE SYSTEM

Generali Italia shall refund the expenses once the treatment has been completed, directly to the Insured Party, upon submission of photocopies of the relevant receipts, bills, invoices and receipts duly received.
For expenses incurred abroad, reimbursements are made in Italy, in the currency that is legal tender in Italy, at the average exchange rate for the week in which the expense was incurred by the Insured Party and based on official exchange rates. Any documentation drawn up in a language other than Italian, English, French or German must be accompanied by a translation into Italian or English.
For indemnities related to days of hospitalisation, Generali Italia shall make the payment to the Insured Party, upon submission of the supporting documents (complete medical record and medical documentation) certifying the duration and reasons for the hospitalisation.

How to access and submit a request online

- The Beneficiary accesses the Indirect Request for Authorisation section
- selects the year in which the service was performed
- selects the Beneficiary for whom a health service is being requested, by clicking on the name of said person
- selects the service to which the request authorisation refers. The service is also searchable using the search engine
- if there is more than one policy, selects the relevant policy
- uploads the invoice and fills in the relevant information fields (facility, amount, etc.)
- uploads medical documents
- inserts any notes supplementing the request
- displays a summary page where he/she can edit what was entered, before sending

Necessary documentation

In the event of hospitalisation or request for a daily hospitalisation allowance, the Beneficiary must enclose the following:

- medical records and/or letter of discharge
- invoice for the operation/recovery incurred

In the case of a request for reimbursement for out-of-hospital services, the Beneficiary must enclose the following:

- medical certificate indicating the request for the service with diagnosis or presumed diagnosis
- invoice for service rendered

In both cases, the Beneficiary must attach the power of attorney and the privacy document if making the request for an adult family member., available during the request process and in the “Documenti e modulistica” (Documents and forms) section.
At the first request (direct or indirect system) on each Insured Party, it is required to provide consent to privacy and automated processing. The latter is not compulsory.
Welion, together with the Smart Process Automation division of Generali Italia, has developed an innovative system that automates the settlement processes of health claims for the most standard practices, a first in the Italian market.
Based on artificial intelligence and OCR technology, the system verifies the data according to standardised rules and allows claims to be settled in a very short time, with a significant advantage for the customer and the network of healthcare facilities.
For further details, please refer to the Generali privacy policy in the “Documenti e modulistica” (Documents and forms) section of the personal area.

Dental care from Accident

In the event of dental care due to an accident, said care must be congruent with the injuries sustained and the accident must be objectively proven with appropriate supporting documentation (emergency room report, OTP, X-rays and photographs).

Lenses and glasses

The Insured Party may take advantage of discounted rates for the purchase of lenses and glasses if he/she goes to facilities affiliated with Generali Welion.
To access the discounted rates as a customer of Generali Italia, the Beneficiary must submit the “Associated Facilities Certificate” document in the appropriate documents and forms section. The expense incurred may be the subject of a request for reimbursement if it falls under the health plan executed with application of the deductibles applied to “out-of-network” services.
If the “Lenses” supplementary plan is subscribed to, the deductibles for “in-network” benefits apply. The document “Affiliated Facilities certificate” is available in the reserved area of documents and forms.

Time frames

The settlement system will automatically perform all checks regarding the contribution and eligibility rules defined by the entity before allowing the Welion operator to complete the settlement process. The company guarantees a processing time of 10 working days for the reimbursement request following the submission of complete documentation.

03. HEALTHCARE SERVICES UNDER MIXED SYSTEM

The patient will be able to benefit from a mixed form of payment of expenses in the case of services at healthcare institutions (public and private) affiliated with the Company and surgeons (also under the intramoenia system) and teams and/or services not affiliated with the Company.

The Company pays directly to the affiliated healthcare institution the expense component indemnifiable under the terms of the policy relating to the affiliated healthcare institution (direct assistance), except for the application of coinsurance/deductibles provided for in the policy for the direct form (please refer to the process referred to in point 01 **"Healthcare services under direct assistance"**).

The insured person bears the cost component relating to doctors and/or services not affiliated with the Company him/herself, subsequently requesting reimbursement from the same. The expenses indemnifiable under the terms of the policy are reimbursed to the insured party subject to the application of overdrafts/deductibles indicated in the policy for the indirect form, which remain at his/her expense (please refer to the process referred to in point 02 "**Healthcare services under the indirect assistance system**").

04. TRACKING THE CASE/FILE

By accessing the section of the requests placed using the main menu, it is possible to have a view of all requests previously made by the user.

You can search by entering keywords in the specific field. Previews of the requests contain a progress status divided by colour and are immediately visible. The Head of the Family Unit using the system will receive an e-mail when the submitted file changes its status.

Request for supplementary information

If one or more documents are missing, the user will receive an e-mail with a request for supplementing the documents provided.
In this case, the tracking will show the indicator on "Supplementary information Request", and the user can complete the information or upload documents directly by clicking on the respective button.
In case of doubt, additional notes of clarification may be sent to the settling agent. All uploaded documents are always displayed in the appropriate section: they can be consulted and shared.

Processing the request

If the status of the request is "Processing", it means that the file is being handled by the Health Claims area.
It is possible to check all sent documents and any previously entered information: however, only in this status will it not be possible to send additional notes about the file. The user will be able to access the "Documents" section, where all previously uploaded documents will be shown: it will also be possible to consult and share them.

Request Authorised

Once the investigation has been completed and the request authorised, the status "Authorised" will be displayed for the user. In the event of a request for reimbursement, the details of the transfer and the amount paid will be included. Clicking on "See Details" in the tracking screen on an authorised payment will open a pop-up with all settlement or authorisation data. All uploaded documents are always displayed in the appropriate section: they can be consulted and shared.

Request Cancelled

If the user cancels his or her direct request, the system saves the entry “Cancelled”. In this way, the system cancels, stores and displays the status update while keeping the file visible for evidence without proceeding to the reimbursement process.
It is only possible to cancel the request in the case of a direct service, and only in the “sent” state or in the “supplemental information request” status. All uploaded documents are always displayed in the appropriate section: they can be consulted and shared.

Support

The user may always send notes to the settling agent to receive information on the case, except if the reimbursement or direct payment is already being processed.
Should the user be unable to send notes, the system returns a default message instructing the user to contact the freephone number in the policy for further information.

The following is also available in the reserved area:

- A request **Archive section** where you can view all requests made and, if necessary, supplement missing documentation
- A **Maximum amounts** section where you can view the expected and incurred limits, available for the family unit or individual insured party
- A **Documents** section where the following can be viewed:
  - the services reconciliation table
  - policy documents
  - the power of attorney and privacy form for insured adult persons
  - Affiliated Facilities certificate - this is the form, which can be downloaded from the Document section of the FE reserved area, certifying that the beneficiary is covered and that he/she is entitled to take advantage of the affiliated rates at facilities in the network, if he/she presents him/herself as a solvent (without authorisation for direct payment)
  - certificate of foreign cover
  - tax certificates

05. ACCESS TO THE HEALTH NETWORK AT DISCOUNTED RATES

In the case of services not covered by the Policy or if the Insured Party does not activate the Operation Centre, but nevertheless uses an affiliated clinical centre or dental office and pays his/her own expenses, he/she shall be entitled to the application of the affiliation tariffs, being recognised as a Generali Italia Insured Party through the document "Affiliated Facilities certificate".

The expense incurred may be the subject of a request for refund if it falls within the health plan executed with application of the deductibles applied to "out-of-network" services.

The document "**Affiliated Facilities certificate**" is available in the area reserved for documents and forms.

06. DOCUMENTS AND FORMS

The insured party will be able to access the personal area and the “documents and forms” section.

The section contains useful documentation regarding the policy, including:

- **The power of attorney and privacy document**
- The foreign coverage certificate, **useful in the event of services abroad**
- **Tax certificates**, divided by year. It is possible to view certifications for past years by clicking on the ‘change year’ button
- **Services reconciliation table**, useful for checking which service items to select during the online request for direct payment/reimbursement.

All documents can be downloaded by clicking on the download button to the right of the document name.

ẇelion [da Generali Italia] s. f. - / uè • li • on / è la prima società di welfare integrato; dalla ***salute*** ai ***flexible benefit***, un mondo di servizi innovativi e semplici da fruire per dare più valore alle famiglie, ai lavoratori e alle imprese.
Sinonimo: eccellenza.
Nel contesto: *se dici welfare, dici Welion*.

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