Special Conditions of the Fee-for-Service Coverage of Generali Company Care Health Insurance (GCC-SZOF/2019)

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These special conditions set out the standard terms and conditions for the **fee-for-service insurance covers available under Generali Company Care Health Insurance policies** offered by Generali Biztosító Zrt. (hereinafter: insurance company), provided that the policy has been concluded by reference to these special conditions.

In the case of matters **not regulated by the special policy conditions, the insurance shall be governed by the General Terms and Conditions of Generali Company Care Health Insurance (GCC-ÁSZF/02019)** (hereinafter: general conditions).

I. Insured event

I.1. The insurance covers medical or health services delivered to the insured during the coverage period applicable to him/her, to treat his/her injuries suffered in an accident, or his/her illness, or abnormal condition unprecedented relative to the commencement of the insurance coverage. For the purposes of this clause, illness, abnormal conditions and accidents shall be unprecedented relative to the commencement of the insurance coverage if they are not in any way connected to the insured's illness, abnormal condition or accident which existed or which was diagnosed or treated before the commencement of the insurance coverage, nor with a previously established permanent health impairment.

The insurance covers acute and elective health care services, as well as emergency medical attention which are not otherwise covered or may not be covered under the national social security scheme.

I.2. If medical underwriting has been completed before the insured was added to the insurance coverage, and during that the insured informed the insurance company about an existing or diagnosed illness, or his/her accident or medical abnormality, or a confirmed disability (health impairment), and the insurance company has not applied an exclusion to such a case, all health care and medical services which are required in relation to them shall be regarded as insured events.

1.3. **The insurance shall only cover medical or healthcare services received by the insured**

a) if these have been arranged by, known to, or approved by the insurance company or the medical management service provider appointed by the insurance company, and

b) the medical service provider satisfies the criteria set out in the general and special conditions.

I.4. The date of the insured event is the first day when medical care and/or health care services are received. Medical or health care services required for the treatment of the same trauma(s), medical condition(s) or illness(es), if they are received on the same day or within the framework of the same medical treatment, belonging to the same service category shall be treated as a single insured event.

II. Insurance benefit

II.1. The insurance company's obligation to settle an insurance claim means the obligation to reimburse the costs of medical, health care and other services specified in the benefit packages specified in Schedule No 1 of the general conditions of the insurance policy and detailed in this clause, subject to the provisions set out in the general and special conditions. The insured persons may receive the covered health care services included in benefit package applicable to them under the insurance policy after they call Generali Medi24 (hotline) where they are provided medical management services over the telephone.

II.2. Generali Medi24

II.2.1. Generali Medi 24 offers the insured persons medical advice 24 hours a day, while also arranging the health care treatment as required. Conversations shall be recorded and preserved by the medical management service provider in due observation of current Hungarian regulations.

II.2.2. **The medical management service provider shall give information in the following subjects and shall provide the following services via the Generali Medi24 hotline:**

a) arrangement of health care services in certain cases, and advising about the contact information about the medical service provider,
b) contact information and opening hours of out-of-hours emergency, medical or dental services and pharmacies,
c) prevention, health preservation and healthy lifestyle,
d) general medical advice over the phone, by a physician in the following subject matters:
   – information about medical conditions,
   – explanation of medical terms, hospital discharge summaries,
   – explanation of lab results and the related conclusions,
   – explanation of medical procedures.

II.2.3. Advice received through the medical hotline shall by no means substitute a personal medical consultation with a physician, a medical examination, or any other health care service.

II.2.4. The medical management service provider shall only be liable for the information it provides through the medical hotline; how such information or advice is used shall be the sole responsibility of the recipient party; therefore, neither the insurance company nor the medical management service provider shall be held liable in this respect.

II.3. Annual preventive screening test (health checkup)

It is not mandatory but recommended to have the screening test. Clinical diseases detected during and as a result of the screening examinations which require medical attention shall be further examined within the framework of health care treatments. A preventive screening program may be attended once in each policy period, and its content is different depending on the selected benefit package, containing the following components.

II.3.1. **Start Package**

It does not include screening tests.

II.3.2. **Standard Package**

– General medical examination (taking the patient's medical history, physicals, blood pressure, weight and height measurement);
– resting 12-lead ECG;
– blood test: complete blood count, erythrocyte sedimentation rate, creatinine, blood glucose, blood cholesterol (LDL, HDL), triglyceride, GOT, GGT, GPT;
– at the age of 40 and above: for men PSA;
– complete urinalysis + sediment;
– at the age of 50 and above: fecal immuno-blood test.

II.3.3. **Premium Package**

– General medical examination (taking the patient's medical history, physicals, blood pressure, weight and height measurement);
– resting 12-lead ECG;
– blood test: complete blood count, erythrocyte sedimentation rate, creatinine, blood glucose, blood cholesterol (LDL, HDL), triglyceride, GOT, GGT, GPT;

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- at the age of 40 and above: for men PSA;
- complete urinalysis + sediment;
- at the age of 50 and above: fecal immuno-blood test.
- standard ophthalmic exam;
- chest x-ray;
- for ladies: gynaecological examination (cytology, vaginal ultrasonography, clinical breast exam);
- for men: urology.

II.3.4. **Exclusive Package**

- General medical examination (taking the patient's medical history, physicals, blood pressure, weight and height measurement);
- resting 12-lead ECG;
- blood test: complete blood count, erythrocyte sedimentation rate, creatinine, blood glucose, blood cholesterol (LDL, HDL), triglyceride, GOT, GGT, GPT, HbAlc, C-reactive protein);
- at the age of 40 and above: for men PSA;
- complete urinalysis + sediment;
- at the age of 50 and above: fecal immuno-blood test.
- standard ophthalmic exam;
- chest x-ray;
- for ladies: gynaecological examination (cytology, vaginal ultrasonography, clinical breast exam);
- for gents: urology.
- pelvic and abdominal ultrasound;
- at the age of 40 and above: cardiology exam with cardiac ultrasound.

II.4. Services offered in primary care

Basic outpatient care: physician appointments, tests, treatments in the following specialities: internal medicine, otorhinolaryngology, ophthalmology, gynaecology, urology, dermatology, radiology (using Basic diagnostic tools as specified for Basic Specialities).

Basic laboratory: blood test, urinalysis, stool analysis, bacteriological fecal test, standard laboratory tests, coagulation test, sedimentation test (We), thyroid function tests TSH, FT3, FT4, screening for prostate cancer (PSA), screening tests related to various infections (except for sexually transmitted diseases / STD-tests), verification of pregnancy, gynaecological cytology test.

Basic diagnostics: ECG (resting, exercise, ABPM, 24-hour Holter), abdominal, cardiac, mammary, etc. ultrasound, X-ray (including enterography), mammography, screening audiometry, arteriography, dermatoscopy (naevus tests, examination of dermatological changes by magnifying devices), Doppler (vascular ultrasound tests), central bone density test, X-ray test with contrast medium (deglutition test by X-ray), perimetry, allergy tests (Epicutan test, depending on age: cutireaction (Prick test) or allergy test by blood sampling).

II.5. Services offered in extended care

When the Standard, Premium and Exclusive Packages are selected, the services offered in basic care are complemented by standard treatments approved and financed by the National Health Fund (OEP) and generally offered by medical service providers in Hungary supported by medical protocols, for example:

Extended outpatient care: cardiology, angiology, neurology, orthopedics, rheumatology (with electrotherapy and physical therapy), pulmonology, allergology, oncology, gastro-enterology, endocrinology, diabetology, dietetics, proctology, infectology, radiology (using instruments specified for the related basic or extended care diagnostics),

Extended laboratory: basic laboratory supplemented by the following laboratory tests: haematology, serology, immunology test, PCR, hormone test, screening for tumorous diseases (tumour and cancer markers), HIV test, STD test to screen for sexually transmitted diseases, toxicology tests and genetic tests.

Extended diagnostics: aspiration cytology, biopsy, detection of allergenes by blood sampling, endoscopic-reflective tests (including anoscopy, rectoscopy, gastroscopy, colonoscopy), cystoscopy, MRI, CT, Cardio-CT, PET CT, tests for electric activities in muscles, nerves and the brain (EEG, ENG, EMG), angiography, enterography (intestinal test by contrast agent, scintigraphy (isotopic imaging test), joint punction, spirometry (respiratory function test).

II.6. Reimbursement of the costs outpatient specialist appointment arranged by the insured

When the Standard, Premium and Exclusive benefit packages are selected, the insured may claim once in each policy period the reimbursement of the costs of one specialist appointment arranged by the insured at his/her own discretion as well as the costs of a related medical test (e.g.: cytology) – falling within the scope of Basic outpatient care – up to HUF 16 000. The procedure applied to the reimbursement of the cost of the treatment shall be the same as that of the reimbursement of prepaid medical bills (refer to Clause III.4).

The insurance only pays out, however, if the insured has notified the insurance company in advance about his/her intention to schedule a specialist appointment, its most probable date and the medical specialty concerned, by calling Generali Medi24.

II.7. Administering flu vaccination and the reimbursement of the vaccine cost

The insured may claim once in each policy period the reimbursement of the prepaid cost of the seasonal flu vaccination, including the vaccine price and the cost of administering the vaccine.

II.8. Physiotherapy

It may be claimed at the number of occasions per policy period specified in the benefit package, in medically justified acute cases.

II.9. House call

In medically justified acute cases, primary basic care for adults. The insurance company provides information through Generali Medi24 about which settlements the house call service is currently available.

II.10. Patient transport

If the insured becomes immobile (e.g. lying position is required due to thrombosis, or extremely prostrate physical condition), ambulance service is arranged by the Generali Medi24. Patient transport shall not involve immediate availability: the personnel of Generali Medi24 shall make arrangements for the service with a 24-hour deadline from the time of being informed of the required service, taking into consideration e.g. the scheduled time of the examination. The insurance company shall reimburse the cost of patient transport if it is required for resorting to the medical and health services arranged by the medical management service provider and qualified to be insured events under the general and special conditions.

II.11. Ambulatory surgery

Within the meaning of the definition set out in Clause 5 of Chapter VII of the general terms and conditions.

II.12. One-day surgery

Within the meaning of the definition set out in Clause 5 of Chapter VII of the general terms and conditions.

II.13. Inpatient care in a hospital at V.I.P./advanced level

Including acute and hospital care services which may be scheduled (tests, procedures, surgeries and treatments), performed for other than aesthetic, preventive or rehabilitation purposes, at an institution recognized as a hospital and not included in chronic care cases. **The insurance only pays out a maximum of HUF 4 000 000 for inpatient care (tests, interventions, surgeries, treatments, advanced care) in respect of any one insured in any one policy period.**

When urgent or emergency medical treatment is necessary as a result of an accident or trauma, the insurance only covers hospital lodging charges and the costs of medical services which are not otherwise covered and paid for under the national health insurance scheme.

It is the medical management service provider that is entitled to determine on the basis of health care standards which medical facility providing inpatient treatment should be selected for the service provision. Depending on the features of the medical facility, assignment may be to VIP / advanced private (single-bed) or semi-private (two-bed) rooms.

Description of advanced/VIP hospital and lodging service
- purpose-made, matrix-type one or two bed rooms with high quality furnishings and air-conditioning, bathroom included,
- discrete, high-standard treatment and nursing care, perfect hygiene,
- patient attendance by nurse or physician from admission to accommodation and for in-hospital test appointments (laboratory, X-ray),
- a'la carte catering, dietary if requested,
- nurse call system,
- fridge, television.

Acute and elective care may only be received under the insurance coverage if it is by referral from the medical management service provider, i.e. the insured must obtain a prior approval, since elective care may only be covered if the legal ground is determined and the suitable medical facility is selected by the medical management service provider. The medical management service provider may condition the approval to a preliminary specialist examination. The arrangement of the service will be commenced once the approval is granted.

III. Claiming insurance benefits

III.1. General rules

III.1.1. Services and benefits covered under the insurance may be claimed through the medical management service provider by calling the Generali Medi24 direct line.

III.1.2. **Services which have been delivered under the management of the medical management service provider are not required to be notified to the insurance company; their costs are directly paid by the insurance company to the service provider.**

III.1.3. **The medical management service provider and the insurance company will exercise discretion to make arrangements for and reimburse the costs of medical or health care services** covered under the insurance.

III.1.4. The insurance pays out the insurance benefit or procures for the arrangement of the services if all the following conditions are met:
a) the healthcare service to be delivered to the insured should be medically required and reasonable, and should be necessary to restore or preserve the insured's health, or for the insured to recover from an illness; or to avoid any health impairment,
b) the medical treatment shall be recommended by an authorized party in the cases and in the manner specified in current Hungarian legislation and medical protocols,
c) the insured should receive such medical or health service in a manner known to and managed by the medical management service provider or approved by the medical management service provider,
d) the claimed service should be covered under the insurance pursuant to the general conditions and these special conditions.

III.2. Delivery of medical services

III.2.1. **The insured is required to follow the procedure described herein to be delivered medical and health care services:**
a) The insured must contact the medical management service provider by calling Generali Medi24, a 24-hour direct line. In an urgent care case, the insured must make the call without delay, subject to the provisions set out in Clauses III.2.2 and III.2.3.
b) The medical management service provider will verify the validity of the insurance coverage based on the insured personal data.
c) Once the insured has described the complaints or requests, the operator of the medical management service provider will inform him/her about the recommended medical service, its date and place. In certain cases the medical management service provider will call the insured back with the exact date and place of the medical treatment. **The medical management service provider will offer a physician appointment within a timeframe of 48 hours for acute care, and within a timeframe of 14 days for elective care.**
d) The insured must attend the appointment scheduled by the medical management service provider in the designated medical facility. If the insured is not able to attend the scheduled appointment in the designated medical facility, it shall be communicated to the medical management service provider at least 24 hours before the scheduled appointment by calling Generali Medi24. Failing that, the insurance company may require the insured to settle the medical bill for the scheduled but not cancelled treatment/tests.
e) The insured is required to present a photo ID at the assigned medical facility so that the insured can be identified before receiving medical care.
The insurance company reserves the right to refuse to provide healthcare services if the insured cannot be identified, unless the insured's life is in danger or the case concerned is an emergency.

III.2.2. **In cases requiring urgent care in Hungary, the insured must call the ambulance service at the emergency phone number 104, or must attend an emergency out-of-hours service as no diagnosis or medical indications may be given, no treatment can be performed over the phone; the same applies to proper medical treatment, or prescription of any medication or durable medical equipment.**

If so advised by the medical management service provider on the basis of the symptoms described by the insured over the phone, the insured must promptly call an ambulance or go to an emergency unit.

III.2.3. **Cases requiring urgent care** (including urgent care after a trauma) must be reported by the insured or any other party on the insured's behalf to the medical management service provider through Generali Medi24 before the insured is provided such healthcare service, provided that this is made possible by the insured's medical conditions and/or the circumstances, but within 48 hours of hospitalization at the latest.

If also consented to by the party delivering the service, the costs of the medical service covered shall be paid to the medical facility by the insurance company directly or through the medical management service provider, thus relieving the insured – partly or entirely, depending on the insurance coverage – from the burdens of their prepayment obligation and reporting claims for benefits.

III.3. Limitations to services

III.3.1. **If a requested service is not covered under the insurance policy, the medical management service provider will refuse to arrange for such a service.**

III.3.2. **When an insurance claim is not legally grounded or only partly grounded on the basis of the insurance policy and as a result the insurance company is not or only partly required to pay an insurance benefit, the insured will be required to pay the costs of the medical services which the insured received and is not covered under this insurance, to the provider of the medical services or to the party which has issued the invoice.**

III.3.3. The insurance company will not be responsible for the professional quality of the medical and health services delivered to the insured, and it is not required to indemnify the insured for any damage suffered during a medical service or to pay a grievance fee; it shall be the responsibility of the healthcare service provider.

III.4. Treatments prepaid by the insured

III.4.1. **In urgent cases which are not covered or may not be covered under the national social security scheme,** and the medical management service provider has been notified of and approved the provision of the medical and health care services, but they were not provided in a contracted medical facility, **the insured is required to prepay the costs of such medical and health care services to the medical facility,** unless the medical facility and the insurance company jointly decide not to require prepayment.

If the insured has prepaid the costs of a service, the insurance company will only reimburse the costs afterwards if an insurance claim for the reimbursement of costs is notified to the insurance company in accordance with Clauses III.4.2 and III.4.3 of these special conditions, and the event underlying the insurance claim is covered under the insurance policy.

III.4.2. **In urgent care cases if the costs of medical and health care services are paid by the insured or any other person (but not the medical management service provider) on behalf of the insured, the following procedure must be followed when filling the insurance claim:**

The insurance claim, together with all the necessary information, shall be notified to the insurance company within 15 days after the last day when medical and health services are provided to the insured. The medical documentation produced in relation to the event shall be attached to the claim, and it shall be allowed that the claim as well as the information reported be verified.

III.4.3. **Documents required for the reimbursement of prepaid costs of medical or health services**

a) a duly completed standard insurance claim form supplied by the insurance company.
b) the **original invoice issued to the name of the insured,** specifying the delivered medical or health service, which shall be requested from the provider of the medical or health service no later than on the last day of the provision of the services.
c) a copy of all medical documents related to the insured event (e.g.: outpatient records, hospital discharge summary, examination records, nursing and hospital care documentation, test findings, laboratory records, images made during diagnostic or histology tests, prescriptions, referrals, etc.) including all precedence medical documentation and the documents produced during the first medical treatment.

IV. Cases when the insurance company is relieved from benefit payment, events excluded from insurance coverage

Under the present insurance, the insurance company will be relieved of payment of the insurance benefit in the cases defined in Chapter V. of the general conditions, and the insurance will not cover the cases defined in Chapter VI. of the general conditions.