Special Conditions of the Fee-for-Service Coverage of Generali Private Care Health Insurance (GPC-SZOF/2017_EN)

Generali Biztosító Zrt. • Mailing address: 7602 Pécs, PO Box 888 • Customer Service Direct Line: +36 1 452 3333 • generali.hu

These special conditions set out the standard terms and conditions for the **fee-for-service insurance coverage available under Generali Private 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 Private Care Health Insurance (GPC-ÁSZF/2017_EN)** (hereinafter: general conditions).

I. Insured Event

I.1. The insurance covers medical or health care 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, provided that such treatment is medically reasonable and necessary. 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 if it is not otherwise covered or may not be covered under the national social security scheme.

1.2. Any medical or health care service received by the insured during the coverage period in connection with a trauma, illness or medical condition which existed or which was diagnosed or treated before the commencement of the insurance coverage, or in connection with a previously determined permanent impairment shall only be covered under this insurance as an insured event if

a) the insurance company has been made aware of the injury, illness, medical condition, trauma, or health impairment in the course of the underwriting procedure or in any other demonstrable way before the execution of the insurance policy, or
b) this condition has been declared to the insurance company by the insured in the statements completed for the underwriting procedure in compliance with the insured's disclosure obligation,

and the insurance company did not exclude claims connected with the above from the coverage, but approved the risk.

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

a) **if these have been arranged by, known to, or approved by the insurance company or the medical management company appointed by the insurance company, and**
b) **if these have been provided by a medical service provider which satisfies the criteria set out in the general conditions (Clause VII.5.) and in these 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. The 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 included in the Insurance Plans listed in Schedule No 1 of the general conditions of the insurance policy and described 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 Insurance Plan selected under the insurance policy after they call Generali Medi24 (direct line) 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, 7 days a week, 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 Company shall give information in the following subject matters and shall provide the following services via the Generali Medi24 Direct Line:**

a) arrangement of health care services in certain cases, and advising about the contact information about the medical service provider,
b) contact data and duty service hours of emergency, medical, dental care 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 direct line 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 company shall only be liable for the information it provides through the medical direct line; 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 and subject to the respective rules. A preventive screening program may be attended once in each policy period, and its content may vary under different Insurance Plans, as described in the following.

II.3.1. Start and Plus Insurance Plans

These plans do not include screening tests.

II.3.2. Complex Insurance Plan

- 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;
- for gents at the age of 40 and above: PSA;
- complete urinalysis + sediment;
- at the age of 50 and above: fecal immuno-blood test;

Nysz.: 19970

- for ladies: gynaecological examination (cytology, vaginal ultrasonography, clinical breast exam).

II.3.3. Exclusive Insurance Plan

- 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, HbA1c, C-reactive protein);
- for gents at the age of 40 and above: PSA;
- complete urinalysis + sediment;
- at the age of 50 and above: fecal immuno-blood test;
- standard ophthalmic exam;
- chest x-ray;
- pelvic and abdominal ultrasound;
- for ladies: gynaecological examination (cytology, vaginal ultrasonography, clinical breast exam);
- for gents: urology;
- at the age of 40 and above: cardiology exam with cardiac ultrasound.

II.4. Covered Services in Basic 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: basic blood test: blood glucose, Na, Cl, K, uric acid, KN, creatinine, total bilirubin, direct bilirubin, blood panel, serum ferritin, transferrin, cholesterol, HDL cholesterol, triglyceride, GOT, GPT, gamma GT, alk. phosph., se.amylase, lipase, CRP, blood cotting test-INR, erythrocyte sedimentation rate (We), of thyroid function tests: TSH, FT3, FT4, screening for prostate cancer (PSA); general urinalysis and sediment, urine culture; fecal occult blood test; basic infection tests: fecal bacteriology (Salmonella, dysentery, etc.), ova and parasite (O&P) exam (protozoa and helminths), throat culture, but the insurance does not cover tests related to sexually transmitted diseases (STD); confirmation of pregnancy, gynecologic cytology.

Basic diagnostics: ECG (at repose, under load, ABPM, 24-hour Holter), abdominal, cardiac, mammary 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).

Under the Start Insurance Plan, only laboratory and diagnostic tests ordered in outpatient care provided under this insurance are covered. Specialists may only order laboratory and diagnostic tests which are required for a direct diagnosis.

II.5. Covered Services in Extended Care

When the Plus, Complex and Exclusive Insurance Plans 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).

Only laboratory and diagnostic tests ordered in outpatient care provided under this insurance are covered.

II.6. 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.7. Physiotherapy

It may be claimed in acute cases when medically reasonable and necessary, on as many occasions in any one policy period as specified in the selected Insurance Plan.

II.8. House Call

Primary basic care for adults offered in acute cases if medically reasonable and necessary. For information about towns and cities where the house call service is currently available, please call Generali Medi24 Direct Line.

A House Call shall not substitute Emergency Care. The service is offered with deadlines applicable to acute care cases.

II.9. 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.10. Ambulatory Surgery

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

II.11. One-day Surgery

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

II.12. Inpatient Care in a hospital at V.I.P./advanced level

Including only 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 licensed as a hospital and not included in chronic care cases.

The insurance only covers medical bills totaling up to HUF 4 000 000 for inpatient care (tests, procedures, 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 (for instance the medical bills of emergency treatment of persons with no valid social security insurance in Hungary).

It is the medical management company 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

- specially designed, matrix-type one or two bed rooms with 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. The medical management company may require a preliminary specialist examination for granting its approval. The arrangement of the service will be commenced once the approval is granted.

III. Eligibility to Covered Services

III.1. General Provisions

III.1.1. Services covered under the insurance may be requested through the medical management company by calling the Generali Medi24 Direct Line.

III.1.2. **Services which have been delivered under the management of the medical management company 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 company 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 company procures for the arrangement of the services and covers medical and health care services if all the following conditions are met:**

a) **the health care service to be delivered to the insured should be medically reasonable and necessary, and should be required 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 based on indications, in the cases and in the manner specified in current Hungarian legislation and medical protocols,**
c) the insured should receive such medical or health care service in a manner known to and managed by the medical management company or approved by the medical management company,
d) the requested service must be covered under the insurance pursuant to the general conditions and these special conditions.

III.2. Delivery of Medical and Health Care 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 company by calling Generali Medi24, a 24-hour Medical Direct Line. In urgent cases, 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 company will verify the eligibility to the service (validity of the insurance coverage).
c) Once the insured has described the complaints or requests, the operator of the medical management company will inform him/her about the recommended medical service, its date and place. In certain cases the medical management company will call the insured back with the exact date and place of the medical treatment. **The medical management company will offer a physician appointment within a timeframe of 2 working days for acute care, and within a timeframe of 10 working days for elective care, if it is medically reasonable and necessary.**
d) The insured must attend the appointment scheduled by the medical management company 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 company 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 medical facility so that he/she can be identified before receiving medical care.

The insurance company reserves the right to refuse to provide health care services if the insured cannot be identified, unless the insured's life is in danger or the case 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 company 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, or it is medically not reasonable and necessary, 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. **If the insurance premium of the policy is not paid at the time of the insured event, but the policy is not yet terminated in accordance with Clause III.3 of the general terms and conditions, the insurance company will arrange for the requested services if the associated medical costs are prepaid by the insured.**

III.4.2. **In urgent cases which are not covered or may not be covered under the national social security scheme,** and the medical management company has been notified of and approved the provision of the medical and health care services, **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.4.3 and III.4.4 of these special conditions, and the event underlying the insurance claim is covered under the insurance policy.

III.4.3. **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 filing 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.4.4. **Documents required for the reimbursement of prepaid costs of medical or health care services**

a) a duly completed standard insurance claim form provided 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 care documentation, test findings, laboratory records, images made during diagnostic or histology tests, prescriptions, referrals, etc.) including all related precedence medical documentation and the documents produced during the first medical treatment.

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

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

The effective date of these special conditions shall be: April 1, 2017.