Health plans 2022 – 2023

Payment Procedures for non-dental cover

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

Insurance policies: payment procedure

This document explains the payment procedures adopted by the Insurance Company for certain coverage contained in the Conditions of Insurance (healthcare policies), hereinafter referred to as the "COI". It aims to provide Policyholders with clarification regarding the applicability of certain policy coverage.

GENERAL MATTERS

URGENT PROCEDURE

The COI only provide for this in the event of hospitalisation. However, to ensure better benefits for Policyholders, it is applied to all types of services if the medical prescription states the urgency of the requested service.

ACCIDENT AND INJURY

To supplement what has already been stated in the COI, **Replacement public medical facility** means a facility that is part of the Local Emergency System (such as first aid points and the out-of-hours emergency care service).
In addition, in the event of a **road traffic accident** - at the same time as the first request for reimbursement concerning healthcare services that became necessary as a consequence of the same - the Policyholder must send the Italian **"CID" Form** (direct indemnity agreement), if they have it (but this may also be sent at a later time) or the **accident report** sent to their Company or to that of the third party responsible for the accident.

EXCESS/DEDUCTIBLE

Unless otherwise specified in the specific guarantees, the excess or deductible amount applies per EVENT.
If the service involves a course of treatment (e.g. physiotherapy), the course of treatment shall be considered as the event.
The course of treatment should be understood as the total number of sessions prescribed/performed for each type of therapy required per anatomical site.
FOR EXAMPLE:
Service: 10 Tecar therapy sessions + 10 massage therapy sessions + 10 rehabilitation sessions for both wrists.
This amounts to 6 courses (3 types of physiotherapy x 2 wrists), and the excess is applied to each course.

TELEMEDICINE (all the medical and computer techniques that enable treatment of a patient at a distance or, more generally, the provision of health services at a distance)

Specialist consultations performed by means of telemedicine are treated in the same way as in-person specialist consultations, with application of the relevant legislation in terms of applicable schemes (direct or indirect form), maximum limits, deductibles and excess.

INHERITANCE OF DAILY ALLOWANCE

To provide greater benefits than those provided for in the COI, the daily allowance is heritable.

PRE-EXISTING DISEASES

The policy covers: illnesses (including chronic and relapsing diseases), malformations and pathological conditions, which have given rise to treatment, examinations and diagnoses before the cover start date.

HOSPITALISATIONS

HOSPITALISATIONS PAID FOR IN FULL BY THE ITALIAN NATIONAL HEALTH SERVICE (NHS) WITH HOSPITALITY SURCHARGE - DAILY ALLOWANCE

"**Hospitality surcharge**" means the additional daily expenses paid by the Policyholder to take advantage of additional services during their hospitalisation under the Italian National Health Service, such as a private room, a single room with bathroom, a room with a television and the option of an additional bed.

If the Policyholder submits a claim for the hospitality surcharge, the hospitalisation will be managed and settled as a private hospitalisation: therefore, the hospitality surcharge and any expenses incurred pre- and post-hospitalisation will be subject to the deductibles/excess required for private hospitalisation. In this case, therefore, payment of the substitute indemnity (daily allowance), for hospitalisations fully paid for under the NHS, shall not be made.

OUTPATIENT PROCEDURES FOR ENDOPROSTHESIS

This primarily concerns cataract surgery, which is mainly performed on an outpatient basis, during which an artificial lens (endoprosthesis) may be inserted.

In the event of surgery on an in-patient or day-hospital basis, the costs of the surgical equipment are also covered, including endoprostheses. Although it has not been included in the paragraph on outpatient procedures, this provision also applies to these.

DAY SERVICE

Day Service is an alternative model of care to the outpatient model, performed at healthcare institutions. It does not involve hospitalisation, not even during the day. Its aim is to manage clinical cases whose solution requires the provision of multiple, multidisciplinary clinical and instrumental tests and investigations, including those of a complex nature.

The day service is NOT equivalent to the day hospital. As such, it is not eligible for coverage. Individual services performed during the Day Service may be reimbursed if they fall under the relevant policy cover (out-of-hospital services).

PRE- AND POST-HOSPITALISATION SERVICES

Pre- and post-hospitalisation services are subject to excess/deductibles, where applicable, if the latter have not been fully absorbed by the main event, i.e. the hospitalisation, including in a day hospital, or outpatient procedure.

FOR EXAMPLE:

Indirect outpatient procedure - deductible: 10%, minimum €750

cost of the procedure	€500
excess applied	€500
residual excess not applied	€250

post-procedure services	€300
residual excess not applied	€250
amount paid	€50

PRE- AND POST-SERVICES RELATING TO DIRECT PROCEDURES WITH CEILINGS

There is no excess for direct procedures with ceilings. Therefore, the related pre- and post-services (both direct and indirect) are not subject to excess.

REIMBURSEMENT IN THE CASE OF SEVERAL CONCURRENT PROCEDURES WITH A CEILING OR ORDINARY PROCEDURES AT THE SAME TIME AS PROCEDURES WITH CEILINGS

If hospitalisation involves more than one of the surgical procedures set out in the Table "List of Surgical Procedures with Ceilings" in the COI, the Company shall pay the indemnity at 100% up to the capped amount established for the main procedure (as defined by the surgeon) and at 70% up to the capped amounts established for the secondary operations, without prejudice to the application of any deductibles or excess.
Below are a few examples.

Examples:

1) Procedure with ceiling performed on a reimbursement basis: ceiling €14,000
Cost of the procedure €10,000.00
Deductible 10% min. €1,750.00 per hospitalisation
Authorised service €10,000.00 of which €8,250.00 paid for by the Company and €1,750.00 by the Policyholder

2) Procedure with ceiling performed on a reimbursement basis: ceiling €14,000
Cost of the procedure €17,000.00
Deductible 10% min. €1,750.00 per hospitalisation
Service reimbursed €14,000.00 (since, after subtracting the deductible, the reimbursed amount would have been higher than the ceiling).

3) First procedure with ceiling performed on a reimbursement basis: ceiling €14,000
Second procedure with ceiling performed on a reimbursement basis: ceiling €14,000
Cost of the main procedure €17,000.00
Cost of the secondary procedure €10,000.00
Deductible 10% min. €1,750.00 per hospitalisation (calculated on the full amount) **€24,300.00**
Reimbursed service €14,000.00 for the first procedure, €7,000.00 for the second

4) First procedure with ceiling performed on a reimbursement basis: ceiling €14,000
Second procedure with ceiling performed on a reimbursement basis: ceiling €14,000
Cost of the main procedure €10,000.00
Cost of the secondary procedure €17,000.00
Deductible 10% min. €1,750.00 per hospitalisation (calculated on the full amount) = **€24,300.00**
Reimbursed service €10,000.00 for the first procedure, €11,900.00 for the second

5) First ordinary procedure performed on a reimbursement basis
Second procedure with ceiling performed on a reimbursement basis: ceiling €14,000
Cost of the main procedure €10,000.00
Cost of the secondary procedure €17,000.00
Service reimbursed €10,000.00 for the ordinary procedure, €14,000.00 for the procedure with ceiling (the 100% - 70% rule only applies in the case of 2 procedures with ceilings)

POST-HOSPITALISATION HOME PHYSIOTHERAPY

To offer greater benefits to Policyholders, post-hospitalisation home physiotherapy (both direct and indirect) is reimbursed in cases of documented impossibility to travel to a medical centre, certified by a prescription from a specialist.

OTHER OUT-OF-HOSPITAL SERVICES

HIGHLY SPECIALISED TREATMENTS AND DIAGNOSTICS

No other services other than those contained in the specific list in the COI are eligible for coverage.
Endoscopic diagnostic tests not explicitly included in the aforesaid list are eligible for coverage as part of the "routine diagnostics" cover, including when a biopsy is performed.
Procedures performed via endoscopy (for example polyp removal) are reimbursed in the context of "outpatient surgical procedures" only, under the terms provided for therein.

INFILTRATIONS, FOCUSED SHOCKWAVE THERAPY AND SCLEROSING THERAPY OR SCLEROTHERAPY

Infiltrations, focused shockwave therapy and sclerosing therapy or sclerotherapy are considered to be medical acts and are therefore paid for in accordance with the "Specialist consultations" cover. Therefore, for the purposes of reimbursement, the Policyholder must indicate the doctor that performed the service.
Only the service provided by the doctor is eligible for coverage, and not any medicinal products used.
For the above services, an excess is applied per course of treatment.

REHABILITATIVE LASER THERAPY FOR ACUTE CONDITIONS

To offer greater benefit to Policyholders, the excess for direct services is applied per course of treatment.

NON-INVASIVE PRENATAL GENETIC TESTING OF FOETAL DNA

Notwithstanding the provisions of the COI, for the sake of clarification, cover is granted in the following cases:
- suspected foetal malformation;
- if the insured mother has a condition that prevents more invasive tests.

In the absence of any existing or suspected conditions, the indication “screening for chromosomal abnormalities” shall in any case be accepted, where supported by objective evidence of potential risk: the medical history of the parents must therefore be provided, which must be consistent with the test requested.

SHOCKWAVE THERAPY

Please note that:
- RADIAL Shockwave Therapy is eligible for coverage under PHYSIOTHERAPY cover, and it is not necessary to indicate the name of the doctor performing it;
- FOCUSED Shockwave Therapy is eligible for coverage under SPECIALIST CONSULTATION cover as a medical act, and the name of the doctor performing it must be indicated.

Excess and deductibles apply to Shockwave Therapy per course of treatment.

CANCER TREATMENTS AND FOLLOW-UP

The CANCER TREATMENTS cover may be used for ONGOING cancer (including recurrence).
For specialist cancer follow-up visits - which are provided for in the COI for up to 10 years from the date of onset of the disease - a valid 048 exemption code is required or, failing this, medical documentation showing the date on which the cancer was first diagnosed (e.g. histology examination report).
The same documentation is required in the case of diagnostic testing for cancer follow-up. These tests are eligible for coverage under “Highly specialised treatments and diagnostics” and “Routine diagnostics”.

PHYSIOTHERAPY SERVICES

Maintenance physiotherapy services are covered, as long as they are related to the diseases provided for by the cover in question.
To supplement the provisions of the COI, below is a non-exhaustive list of examples of diseases for which physiotherapy services are eligible for coverage:

.

- **degenerative neurological and homeoplastic conditions:** multiple sclerosis, amyotrophic lateral sclerosis (ALS) and all chronic neurological conditions due to degenerative processes affecting the central nervous system (such as Parkinson’s disease, Huntington’s disease, Friedreich's ataxia);
- **neuromyopathic conditions**: mixed pathological conditions affecting the neuromuscular system (such as muscular dystrophy [Duchenne muscular dystrophy and Becker muscular dystrophy], myotonic dystrophy [Steinert disease] and spinal muscular atrophy).

SPEECH THERAPY

To offer greater benefit to the Policyholder, the following applies:
- speech therapy required as a result of mental illnesses is eligible for coverage;

- bills issued by duly qualified speech therapists are reimbursable;
- for direct services, the excess is applied per course of treatment.

LEARNING DISORDERS

To offer greater benefit to the Policyholder, the following applies:
- bills issued by duly qualified practitioners are reimbursable;
- for direct services, the excess is applied per course of treatment.

ADDITIONAL SERVICES (paediatric consultations)

All consultations performed by a paediatrician (specialist or primary care practitioner) as a result of a MEDICAL CONDITION (not for a check-up) are eligible for coverage. A medical prescription is therefore required, stating the diagnosis or suspected diagnosis or, in the case of an indirect consultation, the consultation report showing the diagnosis.

PSYCHOTHERAPY

A prescription for PSYCHOTHERAPY may be issued by a general practitioner/primary care paediatrician or by a medical specialist in any field.
The doctor issuing the prescription must not be the same as the one providing the service.
The service may only be provided and billed by a psychotherapist/psychoanalyst or medical specialist in the field (in other words, not by a psychologist who is not a psychotherapist or by other professionals such as neuro- and psychomotor therapists working with children and adolescents). In order to establish whether the service is eligible for coverage, the Company therefore reserves the right to check the specialisation of the professional and their listing on the register, if this information is not indicated in the documentation submitted by the Policyholder (e.g. on the bill).
Consultations, courses of sessions, psychotherapy, mental health interviews, the history-taking interview, etc., are eligible for coverage, provided that they are performed by the above-mentioned professional figures.
Any additional specialist consultations following the initial assessment of the condition are also included in the cover and relevant ceiling. However, specialist consultations must be performed by a specialist (e.g. by a psychiatrist/neuropsychiatrist) and not by psychologist who is also a psychotherapist (as this professional is not a doctor). The bill submitted by the Policyholder must include the wording “specialist consultation”.

ACUPUNCTURE

Acupuncture services are eligible for coverage if prescribed by an ASL (local health authority) doctor or a specialist and carried out by a doctor qualified in acupuncture. The qualification to practise acupuncture must be proven by the documentation sent by the Policyholder (e.g. on the bill); otherwise, the Company reserves the right to request the acupuncture diploma.

ADDITIONAL SERVICES

MEDICALLY ASSISTED REPRODUCTION

To supplement the COI, please note that the following are eligible for coverage:

- medical and surgical services in relation to medically assisted reproduction (e.g. oocyte retrieval, homologous or heterologous, of level I – simple insemination– and levels II and III – FIVET, GIFT, and ICSI. As a general rule, all medical and surgical services related to the operational phase of medically assisted reproduction are considered eligible for coverage);

POSTPARTUM CARE

Within six months of childbirth, occurring during the insurance period, it is possible to have a lower limb check-up (angiology/vascular surgery consultation) to determine the presence of any pathological changes in the superficial and deep venous system of the lower limbs. Diagnostic assessments are not eligible for coverage.

PREVENTIVE SERVICES

PAEDIATRIC CHECK-UP

Without prejudice to the COI, no medical prescription is required.

NUTRITIONAL CHECK-UP + DIET

If the service is provided partly directly (e.g. nutritional consultation) and partly indirectly (e.g. diet), the conditions provided for in the COI shall apply for the type of scheme used.