**Compensation procedure in case of accessing medical services outside the Regina Maria Network**

For any medical service covered by insurance and called "insured event(s)", accessed by the Insurant/ Dependent person outside the Regina Maria Healthcare Network, the Insurer will pay to the Insurant/ Dependent person the due compensation based on the documents made available by the Insurant/ Dependent person, provided that the medical services fall within the limits and coverage specified in the insurance contract.

**This procedure is also applicable to services covered by insurance, performed within the Regina Maria Network, by physicians with full payment and paid by the Insurant/Dependent person.**

**1**. For the avoidance of any confusion, the reimbursement of costs of outpatient services is limited to the medical services in the annexes specified as being included (100%) within the Regina Maria Network; the following are not subject to reimbursement:

- dentistry services
- medical services falling in the category of "Special Services":, Central Bank of Stem Cells, One Day check-up
- services with copayment

For emergency services: the following are elligible for reimbursement:

- emergency medicine checkups
- checkups for medical specialties covered by insurance
- laboratory analyses covered by insurance and performed in the emergency room
- ambulance service; to avoid any confusion, all medically required services that the Insurant will benefit from by requesting the ambulance will be considered covered within the same medical case.

The services related to Emergency Medicine that are not specified above and that were performed in emergency rooms/emergency receiving units or any similar locations are not subject to reimbursement (even if those services are included in the basic package).

**2.** Before accessing outside the Regina Maria Healthcare Network any medical service covered by the insurance, the Insurant/Dependent person must have a valid written medical recommendation from the physician for the medical service to be performed and to be appointed at the healthcare unit where the medical service is to be performed. The medical recommendation must be issued prior to performing the recommended services. Exceptions to these cases are checkups with a general/specialist physician/pediatrician/continuous hospitalization and surgical intervention and covers in the annual screening, for which there should be no written recommendation from a physician.

**3.** In case of outpatient medical services, the Insurant/Dependent person has the possibility to contact the Insurer's Call Center at the telephone number 021 9767 to notify the intention to access the medical service outside the Regina Maria Network and to provide the identification data and the medical service to be accessed;

Insurer's Call Center will provide the Insurant/Dependent person with the following:

- assistance regarding the coverage included in the Insurance Contract;
- the maximum level of the amount to be reimbursed by the Insurer for the medical service to be accessed outside the Regina Maria Healthcare Network and which will be represented by:
- for ambulance: 90% of the paid value, but not more than 250 lei/case
- for the remaining covered services:
    - for the services performed at Regina Maria own locations: 100% of the cost paid for the medical service, but not more than 1,000 Lei / medical service.
    - for the services performed outside the Regina Maria own locations: 90% of the cost paid for the medical service, but not more than 1,000 Lei / medical service.

- the list of documents required for establishing the compensation file and the settlement of the equivalent value of medical services by the Insurer;
- information concerning the MG Dental network and the contact data of locations.

**4**. For hospitalization and surgical interventions it is required to notify Groupama through the Call Center (021 9767) / e-mail / mail for pre-authorization or within 5 calendar days since discharge, if during this time it was not possible to notify through the Call Center, because of the health status and then within 14 working days since the date of the event the documents for the completion of the file must be submitted.
The Call Center will provide the Insurant/Dependent person with the following information:

- assistance regarding the coverage included in the Insurance Contract;
- Insurer's consent/refusal for the coverage by insurance of the hospitalization/intervention after analyzing the medical documentation by the Insurer's physician;
- the maximum level of the amount to be reimbursed by the Insurer for hospitalization/surgical intervention outside the Regina Maria Healthcare Network, according to the insurance policy;
- the list of documents required for establishing the compensation file and the settlement of the equivalent value of medical services by the Insurer, according to art. 5.

**5.** The documents required for the payment of compensation by the Insurer, in case of accessing the medical services outside the Regina Maria Healthcare Network, are those provided in art. 5.1 and 5.2.

**5. 1**. For outpatient medical services (including pregnancy monitoring):

- The form for announcing the insured event - Groupama standardized, provided in Annex 14;
- Identity document – copy;

- For checkups (initial checkups/examinations/interpretation of analyses or similar services): valid medical report or valid medical letter issued following the checkup
- For the remaining medical services (other than checkups: investigations, blood analyses, etc.): valid medical recommendation in physical format. If the medical report or medical letter issued following the checkup contains medical recommendations for various investigations/laboratory analyses required to identify the conditions, only the medical report is enough. If the medical report or medical letter does not contain medical recommendations for various investigations/laboratory analyses required to identify the conditions, the medical report will be required together with the medical recommendation issued by the examining physician.
- Copies of the results of paraclinical investigations: laboratory analyses, ultrasounds, imaging investigations, etc
- Other medical documents, issued as the case may be by the Medical services provider – copy;
- Payment documents, which highlight the expenses incurred, and which must include the name of the treated person, the date of performing the services, the provided medical services, the value of each performed medical service: tax receipt +/- invoice, issued by the Medical services provider where the medical service was performed) - copy. Note: the tax receipts in which the correct names of medical services and the broken down costs of each performed and paid medical service will not appear will not be accepted as valid payment documents; for the avoidance of any confusion, the payment documents that register service packages (such as: checkup + ultrasound, subscription ..., package ...) are not considered valid.
- Other documents required by the Insurer, to certify the occurrence of the insured risk, in order to determine the legality of the payment and the level of the insurance indemnity.

For accessing outside the network the following will be reimbursed:

- for ambulance: 90% of the paid value, but not more than 250 lei/case
- for the remaining covered services:
    - for the services performed at Regina Maria own locations: 100% of the cost paid for the medical service, but not more than 1,000 Lei / medical service.
    - for the services performed outside the Regina Maria own locations: 90% of the cost paid for the medical service, but not more than 1,000 Lei / medical service.

The compensation term since the submission of the last document is 15 days.

**For the medical recommendation (referral note) to be valid** it must contain the following information:

- medical facility that has issued the recommendation;

- insurant's/dependent person's first and last name;
- diagnosis (certain or presumptive);
- investigation/s recommended by the physician (to show the medical need for those investigations);
- stamp and signature of the physician issuing the recommendation;
- date of issuance.

**For the medical report (medical letter) issued following the checkup to be valid** it must contain the following information:

- medical facility that has issued the medical report;
- insurant's/dependent person's first and last name;
- elements of the checkup: reasons for showing up/symptoms, personal pathological history, history of the disease, objective clinical examination, diagnosis, investigation(s) recommended by the examining physician;
- stamp and signature of the physician issuing the medical report;
- date of issuance;

**5.2.** For inpatient hospitalization /surgical interventions:

- Request for compensation –Groupama standardized form, provided in Annex 11 - copy;
- in case of an accident the following can be requested: report concluded by the competent authorities or any documents that may show the circumstances of the accident, certificate of toxicological analysis, alcoholemia, etc. - copy;
- Identity document - copy;
- Medical documents including the diagnosis (medical certificate/ discharge note/medical sheet, etc.) - copy;
- Payment documents to show the incurred expenses and to include the name of the treated person, the date and the diagnosis, the value of performed medical services, for hospitalization in a state hospital it is not applicable, except for the expenses not settled by the HIH - original;

Other medical documents, issued as the case may be by the Medical services provider – copy.

**6.** The payment of the insurance indemnity will be made in lei, in the Insurant's/Beneficiary's bank account specified in the Request for compensation, opened at a bank on the territory of Romania.

**7.** If the documentation sent to the Insurer is incomplete and the Insurant/Dependent person has not provided the information requested by the Insurer by telephone or email, the Insurer will contact the Insurant/Dependent person in order to obtain additional documents.

**8.** The payment of the insurance indemnity, in case of insured events produced outside the Healthcare Network, will be made within up to 15 working days since the date of submitting the last document requested by the Insurer to establish exactly the circumstances and causes of occurrence of the insured risk.

**9.** If the Insurant/Dependent person does not comply with the compensation procedure in case of accessing medical services outside the Healthcare Network, the Insurer may refuse to pay the insurance indemnity, if for this reason it could not establish the responsibilities incumbent on it according to the Insurance Contract.

The documents for opening the compensation file should be submitted scanned by email, at the address: **documente@groupama.ro .**