Private Health Insurance Conditions
GENERALI Co-Protect

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GENERALI

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Definitions:

The following definitions are used in these Insurance Conditions:

Pre-existing disease (condition):	Any Illness, Accidental Injury or other medical condition of the Insured Person, diagnosed by a Physician prior to him/her being included in this Insurance, except for Acute Diseases that have fully healed.
Group Insurance:	Insurance granted to a certain number of people (at least 10), which meets the criteria of the Group definition.
Insured person:	Person designated by the Contractor, a member of the Group, whose health represents the object of the Insurance and who is granted the benefits included in the Insurance Contract.
Insurer:	Generali România Asigurare Reasigurare S.A.
Discharge summary:	A medical document issued by a Hospital accredited by the Ministry of Health that meets the definition of a Hospital stated in these Insurance Conditions and which contains: Insured Person's identification data, medical history, hospitalization period, medical procedures and examinations performed during the hospitalization period, medical evaluation (established diagnosis), treatment regimen administered, recommendations and treatments indicated at discharge, including the period of medical leave recommended (if any). The document must bear the date, signature and seal of the physician who examined the Insured Person.
Chronic illness:	Known medical or psychiatric condition, which has a long period of evolution or which presents frequent relapses, requiring repeated specialized medical care. This category includes the following diseases (the list is illustrative, not exhaustive): diabetes, chronic hepatitis, chronic pancreatitis, rheumatoid arthritis, heart failure etc. Other chronic diseases include other conditions favoured by excessive consumption of alcohol, toxic or narcotic substances, respectively smoking, as well as other conditions with similar characteristics in terms of clinical evolution.
Category of Insured:	Part of the eligible members, included in a subgroup according to criteria established by the Insurance Contractor and accepted by the Insurer.
Catering:	Supply, delivery and serving of cooked food through specialized companies.
Insurance application:	The form filled in and signed at its own responsibility by the Contractor, Intermediary (if applicable) and the Insurer, which contains the information necessary to conclude the Insurance, as well as the manifestation of the Contractor's will and consent regarding the conclusion of the Insurance Contract.
Contractual clauses:	Provisions mentioned in the Insurance Contract, which establish at least the rights and obligations of the Contracting parties.
Confidentiality of information:	The obligation not to disclose information related to the health status and treatment performed, in accordance with the legal provisions in force. In order to solve the claim files, the Insured Person empowers the Insurer, under the confidentiality of all data, at the conclusion date of the Insurance Policy, to undertake any kind of investigations, to request documents from the attending physicians and to obtain the results of the medical investigations carried out by it.
Insurance Contract:	The bilateral legal document by which the Contractor undertakes to pay the Insurance premiums to the Insurer in exchange for taking over the Insured Risk. The Insurance Contract is made up of the following documents: - The DNT Form; - Information document according to the legislation in force for the Generali Co-Protect Product (PID); - Insurance offer, GDPR informing and Issuing application (successive documents, one after the other); - The Insurance Policy and its annexes (if any); - These General Insurance Conditions; - Particular Insurance Conditions; - Health statements (if any) and other declarative acts (if any); - Any other documents requested by the Insurer for the smooth performance of the Insurance.
Contractor:	The legal person who concludes, on behalf of the Insured Person, the Insurance Contract with the Insurer and who bears the responsibility regarding the payment of the Insurance Premium.
Start date of the Insurance Contract:	The date from which the Insurer's liability starts, mentioned in the Insurance Policy, only if the Insurance Premium has been paid.
End date of the Insurance Contract:	The date when the Insurer's liability ends, mentioned in the Insurance Policy.

Claim statement: Request for payment of the claim covered by the Insurance Contract.

Diagnostics: The process of identifying a disease or bodily injury of the Insured Person, based on clinical data and on data obtained from paraclinical tests and recorded in a medical document bearing the signature and seal of a physician, with a valid free practice permit.

Settlement supporting documents: Documents issued by the healthcare provider to cover the cost of medical services performed to an Insured Person.

Event: The incident or series of incidents that produce the Insured Risk for which the Insurer will pay the Insurance Indemnity to the Insured Person, according to the Insurance Contract.

Exclusions: Specific circumstances or conditions mentioned in the Insurance Contract for which the Indemnity or Insured Sum is not granted.

Franchise: The part of the prejudice that remains with the Insured Person. The franchise is mentioned in the Insurance Policy/ additional documents and is expressed as a number of days of daily Indemnity. The achieved franchise is applied (only the period after the franchise was exceeded is covered).

Group: At least 10 (ten) members (natural persons) of the Contractor's personnel who perform activities for its benefit, based on an individual employment agreement, mandate, personnel leasing or services, and who meet the Insurer's eligibility criteria.

Insurance Indemnity/ Compensation: The amount of money payable by the Insurer, in case of an insured Risk, according to these Insurance Conditions. The Insurance Indemnity is payable only if the Insured Risk occurred within the Validity Period of the Policy.

Disease/ Illness: The organic or functional change in the normal state of health, diagnosed as such by a Physician, Contracted or manifesting for the first time in the Validity Period of the Insurance.

Disputes: Misunderstandings, divergences, differences of opinions between the parts of the Insurance Contract that can be the subject of a trial before the competent courts.

Physician: Graduate and BA of an authorized Faculty of Medicine, who holds a diploma issued by the authorities in the field and who professes based on a valid free practice permit.

Medicine: Substance or mixture of substances that have curative properties in case of illnesses, as well as any product that can be administered in order to establish a medical diagnosis or to restore, correct and modify the organic functions and can be found in the Nomenclature of medicinal products for human use in Romania, published by the National Agency for Medicines and Medical Devices (ANMDM).

Insurance offer: Document provided by the Insurer to the Contractor, which contains the information necessary for the conclusion of the Insurance, the Insured Risks offered, the Insured Sums, the Insured Period, as well as other important data related to the services offered by the Insurance, through which the Contractor expresses its consent regarding the conclusion of the Insurance Contract.

Insurance Contract Validity Period: The period of time between the Start date and the End date, when the Insurance Contract is in force.

Insurance Policy: Written document, issued by the Insurer, which proves the conclusion of the Insurance Contract. Any derogation from the Insurance Conditions is made by specific provisions in the Insurance Policy or by additional documents to the Insurance Policy.

Individual Insurance premium/ Single individual Insurance premium: Amount of money to be paid by the Contractor for an Insured Person, regardless of the time of inclusion in Insurance.

Total Insurance premium/ Insurance premium: Amount of money to be paid by the Contractor for all Insured in exchange for taking on the Insured Risk by the Insurer. The total Insurance premium will be paid in full at the terms and in the currency specified in the Insurance Contract.

Medical report: A medical document requested by the Insurer, necessary for the evaluation and establishment of the entitlement to the Insurance Indemnity, containing: Insured Person's identification data, medical history, symptomatology, result of the medical examination, procedures performed during examination and indicated medical recommendations/ examinations/ treatments, bearing the signature and seal of the physician who examined the Insured.

Recommendation/ prescription/ medical prescription: Medical document, issued by a Physician with the right to free practice issued by the Romanian College of Physicians, which contains the following mandatory information: identification data of the Insured Person, diagnosis, the Physician's recommendations, date, signature and seal of the Physician.

Private suite, in hotel regime: A private hospital unit, located inside a State hospital.

Insured Risk:	A possible, but uncertain future event, when the life or health of the Insured is exposed. The Insured Risks for which the Insurer grants claims are only those provided in the Insurance Policy.
Hospital:	A public or private medical unit with beds, whose operation is authorized by the Ministry of Health and which cumulatively fulfils the following conditions: - it provides continuous diagnosis and treatment services to the hospitalised patients, with the preparation of the General Clinical Observation Sheet (FOCG), according to the legal procedures in force; - it has adequate medical equipment, medical and auxiliary personnel accredited according to the legal regulations in force for the provision of specialized medical assistance, in accordance with the main diagnosis set at the patient's hospitalization.
Insured Sum:	The sum for which the Insurance has been concluded and to the extent of which the Insurer pays the Insurance Indemnity.
Emergency medical transportation/ Ambulance:	Patient's transportation to a hospital, using a vehicle specially fitted for providing emergency medical care.
Unassisted medical transportation:	Transportation of patients who are not in critical condition and who do not require special monitoring and medical care during transport, as set by current legislation.

General Insurance Conditions

Insurance Contract

The Insurance Contract is governed by the general and particular Insurance Conditions, the Contractual clauses, if they are expressly mentioned in the Insurance Policy, annexes, statements/ additional documents, the Insurance Application and other written agreements, signed by the parties, all being an integral part of the Contract.

The rigorous observance and compliance with the provisions of this Contract, insofar as it relates to the obligations of the Insured Person, as well as the assumption that the statements and answers in the Insurance Application are true, will be a condition that precedes any liability of the Insurer.

Contract form and proof

a) The Insurance Contract must be concluded in writing and cannot be proved by witnesses, even if there is a written proof of its beginning. If the Insurance documents have disappeared by force majeure or by chance, and there is no possibility of obtaining a duplicate, their existence and content can be proved by any proof.

b) The provisions of the preceding paragraph also apply to all subsequent amendments to the Insurance Contract.

c) The conclusion of the Insurance Contract is stated by the Insurance Policy issued and signed by the Insurer, as well as by the payment of the Insurance Premium.

d) The documents attesting the conclusion of an Insurance can be signed and certified by electronic means.

Art. 1 Object of the Insurance

1.1. Group Insurance "GENERALI Co-Protect" is an Insurance product that offers protection for the Risks specified in section 1.5. of this article, for Groups.

1.2. The "GENERALI Co-Protect" group Insurance does not represent a saving or capitalization plan and therefore has no surrender value and cannot be transformed into a Reduced Sum Insurance.

1.3. The "GENERALI Co-Protect" group Insurance is concluded for a period of one year/ less than one year, until 31st of December 2023. The group Insurance "GENERALI Co-Protect" is concluded exclusively in Lei.

1.4. The Insurance Contract is concluded with a list of names, for all eligible members of the Contractor's staff. Lists with these people will be updated by including new members of the Contractor's staff and excluding those which are no longer part of its staff.

1.5. The Risks Insured by these Insurance Conditions are:
   a) Daily Indemnity for Continued hospitalization as a result of Covid-19;
   b) Daily Indemnity for Continued hospitalization in Intensive Care Units as a result of Covid-19;
   c) Insurance for post-hospitalization expenses as a result of Covid-19, to cover basic needs.

Art. 2 Conclusion of the Insurance Contract and eligibility criteria

2.1. The Insurance Contract is concluded between the Insurer and a legal person registered in Romania, as a Contractor, for the benefit of the Insured. The Insured Person is a natural person, Romanian or foreign citizen, who has his/ her domicile/ residence/ right of residence in Romania. The Contractor has the obligation to inform the Insured about the Insured Risks, the exclusions from the Insurance, the Terms and Conditions of the Insurance Contract, as well as the Procedure in case of claim.

2.2. The Insurance Contract is concluded for all eligible members of the Group, with ages between 16 and 65 years (inclusive). For the purpose of these Insurance Conditions, the age in years at the date of inclusion in the Insurance is taken into account.

2.3. Under the conditions of section 2.2., an eligible member is considered:
   a. a member of the Group, active and present at the workplace at the start date of the Insurance;

b. a member of the Group, who is not active and present at the workplace at the start date of the Insurance is considered eligible at the date when the activity is resumed;

c. a person who becomes a member of the Group after the commencement date of the Insurance, is considered eligible from the moment of inclusion in the respective Group by the Insurer.

2.4. The Contractor has the right to ask the Insurer only once a month, by a notice sent to this effect, to include in the Insurance new employees, respectively to exclude employees who are no longer part of its staff. Inclusions and exclusions in/ from Insurance are done only with the consent of the Insurer and are operated by the Insurer once per month, starting with 00:00 of the day immediately following the day on which the Insurer received the notification of inclusion/ exclusion. Notification of new employees and/ or former employees shall be sent by the Contractor within a maximum of 30 days since date of employment, respectively termination of the contractual relations of work/ mandate/ provision of services/ staff leasing.

2.5. In the cases included in point 2.3 letter b) and c), the payment of the Individual Insurance Premium is made on the date agreed in the Addendum to the Insurance Contract.

2.6. At the time of the conclusion of the Insurance Contract and at each staff adjustment, unless the parties agree otherwise, the Contractor shall send to the Insurer the list of eligible members in electronic format, which shall include:

- name and surname;
- Personal Identification Number;
- the commencement date of the employment Contract/ collaborative relationships;
- the termination date of the employment Contract/ collaborative relationships;
- the category of benefits they fall into.

2.7. The Insurer issues a single Insurance Policy for all Insured, to which, as the case may be, attachments and/ or additional documents with the above-mentioned identification data of all Insured can be attached.

2.8. The Insurance coverage starts at 00.00 on the day immediately following the day on which the Contractor paid the Total Insurance Premium, but no earlier than the Start Date of the Insurance mentioned in the Insurance Policy, unless the parties have agreed otherwise.

2.9. A person who is excluded from Insurance can no longer be included in Insurance during the Insurance year.

2.10. During the Contract, the Insurer agrees to keep the Insured in Insurance during the period of temporary interruption of the normal activity at their place of work, provided the continuous payment of the Insurance Premiums (including during the interruption of the activity) in the following cases: holiday leave, vocational training leave, unpaid leave, maternity leave, leave for raising a child up to 2 years of age or, in the case of a child with a disability, up to the age of 3 years, technical unemployment.

Art. 3 Single Insurance Premium

3.1. The individual Insurance Premium is the same for all Group members, regardless of the period for which each Insured Person is effectively included in the Insurance.

3.2. The Insurance Premium must be paid by the due date specified in the Insurance Contract.

3.3. The obligation to pay the Insurance Premium for all Insured rests with the Contractor and is done by bank transfer, in the account indicated by the Insurer in the Insurance Contract.

3.4. In case the number of Insured has changed, the Single Individual Insurance Premium is calculated in full for each new person included, regardless of the Period Insured for that person, and is paid no later than 30 calendar days since the date of the change. In case of exclusion of some Insured from the Insurance, the premium for the period remaining until the End Date of the Insurance Contract, for those Insured, shall not be reimbursed to the Contractor.

Art. 4 Insurance Indemnity payment

4.1. The Insurer undertakes to pay the Insurance Indemnity for the Insured Risks occured within the Validity Period of the Insurance Contract, as mentioned in the Insurance Policy, and which are notified to the Insurer no later than 30 days from the occurance date. In case the Insured Person does not fulfil the obligation to notify within 30 days, the Insurer is exempted from the payment of the Insurance Indemnity, if for this reason it could not establish exactly (through its own specialized personnel, counter-assessments made by third parties, etc.) the cause, the circumstances, the date of the occurance of the Insured Risks. The notification will include a brief description of the Insured Risks occured and the events/ circumstances that caused their occurrence, and, mandatory, the health unit that provides or has provided the necessary medical care. The notification can be sent e-mail or letter. The Insurer has the right to verify by legal means the conditions of the medical assistance offered to the Insured.

4.2. The Insurer will communicate to the applicant, in writing, the necessary documentation for opening the claim file. The documentation must be provided by the Insured Person within a maximum of 90 days since the date of the request and will contain, in particular:

- the proof of eligibility by submitting a document with the date of employment and/ or termination of the activity within the Group (if applicable), according to section 2.3;
- as the case may be, for the Contractor’s employees, a REVISAL excerpt may be requested, provided by the Contractor;
- Claim statement;
- proof of the occurance of the Insured Risk (positive Covid-19 test, discharge summary, medical prescriptions, expense invoices/ receipts, etc.);
- Insured Person’s identification documents;
- other documents requested by the Insurer.

The Insurer has the right to request other documents or consults with physicians designated by it in order to determine the validity of the request and the value of the Insurance Indemnity.

4.3. The Insurance Indemnities due for any Insured Risk covered through the Insurance Policy, are personal and are paid exclusively to the Insured Person.

4.4. The Insurer will make the payment of the Insurance Indemnities within 30 days since the date the requested documentation is complete.

4.5. The payment of the Insurance Indemnities will be done in Romania, in Lei and in accordance with the applicable laws regarding taxes and fees, at the date of payment.

4.6. If the Insured Person is a minor at the date of the payment of the Insurance Indemnity, its payment will be done by the Insurer in compliance with the special legal provisions regarding minors' rights.

4.7. The Insurer has the right to reduce the Sum of the Insurance Indemnity or not to pay the Insurance Indemnity if fraudulent evidence by the Insured Person/ Contractor is found.

4.8. If it is found that improper payments were made by the Insurer, the Insurer has the right to turn against the beneficiaries of the improper payments, to recover the sums wrongly paid.

4.9. In order to establish the right to the Insurance Indemnity, the Insurer has the right to empower the Insurer to conduct any kind of inquiries, request documents from treating physicians, which may lead to the complete assessment of the Insured Person's health, as the case may be. To this end, any physician, hospital, polyclinic, or any other medical institution or person holding data or information and/ or documents concerning the health status of the Insured Person may provide, at the written request of the Insurer, complete information on any illness, accident, treatment, examination, consultation or hospitalization involving the Insured Person. In case of occurrence of an Insured Event/ Risk, the Insurer is empowered to take all necessary steps to obtain the documents necessary to establish the extent of the obligation to pay the Insurance Indemnity, the Insured Person releasing from professional secrecy both the physicians who examined/ treated him/ her and any public or private Institution holding information concerning his/ her health status.

Art. 5 General exclusions applicable to all Insured Risks

1. The Insured Risks caused by or resulting from the following situations are not covered:
   a) If the infection with Covid-19, started before the inclusion in the Insurance of the respective Insured Person;
   b) Non-compliance by the Insured Person with the quarantine/ isolation measures imposed by the authorities;
   c) Any conditions unrelated to Covid-19;
   d) The participation of the Insured Person as a subject in medical experiments, clinical studies or research papers declared or not as such;
   e) The non-observance/ ignorance of the Physician's indications and recommendations, the results of self-medication or of a treatment without prescription;
   f) Circumstances that are not due to the Illness occuring during the Validity Period of the Insurance Contract or for which there are no medical/ fiscal supporting documents;
   g) The lack of security measures and worker protection, required by the specific activity, in accordance with the regulations in force;
   h) Events related to pregnancy, birth or their consequences, except infection with the virus that caused Covid-19 disease during pregnancy;
   i) Any event that takes place in a long-term care institution (elderly homes, detoxification/ rehabilitation centres, wellness centres, mental illness treatment units, etc.). Exceptionally, if it is approved by the competent authorities that one of these institutions becomes an accredited medical unit for the treatment of patients infected with SARS-CoV-2, then such entity will be deemed to meet the definition of Hospital and the Insured Risks specified in these Insurance Conditions may be covered.
2. People working in the following fields cannot be included in the Insurance: health, army, police, gendarmerie, social assistance.

Art. 6 Territorial extension

The Coverages are valid worldwide.

Art. 7 Expenses, taxes, duties, interests

All expenses, taxes and duties applicable to Insurance Premiums or Insurance Indemnities are the responsibility of the Contractor, respectively the Insured, in accordance with the applicable legal provisions in the field.

Art. 8 Insurance Contract termination

8.1. The Insurance Contract ends in the following ways:
   a) At 00:00 of the Insurance Contract's End Date, mentioned as such in the Insurance Policy;
   b) In case of unilateral denunciation of the Insurance Contract by the Contractor or by the Insurer, provided that a notice period of at least 20 days since the date of receipt of the notification of the other party is granted. In this case, the Insurance Contract will cease its effects at 00:00 of the calendar day immediately following the expiry date of the notice;
   c) By unilateral denunciation, as follows:
      (i) as of right, without notice or any other formality, without delay, the guilty party being entitled in default by the failure to fulfill the obligation, and without court intervention, in the following situation:
      - If the legal entity or any natural person related to the Insurance Contract appears in the lists of international sanctions adopted at the level of the United Nations, European Union, OSCE, United States of America, or in any other lists applicable in the territory of Romania. In this case and in no other case, the Insurer will not be held liable to pay any Compensation/ Indemnity or to provide any other benefit under this Agreement, insofar as they would expose the Insurer to sanctions, prohibitions or restrictions under the resolutions of the United Nations United or trade or economic sanctions, laws or regulations of the European Union, United States of America, OSCE or of Romania.

(ii) without any prior formalities, without notice of default, the guilty party is in default by operation of law, except for the prior transmission of a notification of termination at least 10 days before the date of termination, in the following situations:
- If, prior to the occurrence of the Insured Risk, it is found that the Contractor's statement/ statements was/ were incomplete and/ or inaccurate and their mala fide cannot be established.
- In case of non-compliance with other essential Contractual obligations by either party (Contractor or Insurer).

d) in the other ways provided by the Romanian civil code or the law applicable to this Contract.

8.2. The provision in letter c) of this article constitutes a last degree commissary pact.

8.3. The Insurance ceases for the Insured Person, which is removed from the Insurance Policy, in the following cases:

a) if the Insured Person submits false statements/ documents and/ or incomplete information regarding the essential circumstances concerning the Insured Risks, information that, if it was brought to the notice of the Insurer, would have caused the non-conclusion/ the Insured Person not to be included in the Insurance or the Insurance to be granted under other conditions;

b) on the date when the Contractual relations cease, for any reason, between the Insured Person and the Contractor;

c) the breach of Contractual obligations by the Insured Person;

d) on the date of retirement, for those who have retired, regardless of the reason (age limit, early retirement, disability, etc.).

Art. 9 Other regulations

The provisions of these General Conditions are supplemented by the provisions of the Particular Conditions of Insurance and form an integral part of the Insurance Contract concluded. The provisions of these Insurance Conditions are supplemented by the legal provisions in this matter. The provisions of the Insurance Policy and its annexes shall prevail over the provisions of the Insurance Conditions.

The Guarantee Fund: Defined by Law no. 213/2015, with subsequent amendments and additions, is intended to protect the Insured, the Beneficiaries of the Insurance, as well as the third parties injured, in case the Insurance Company is in insolvency. The Fund is constituted with the contribution of all the Insurers, being administered according to the law.

Disputes. Means to resolve complaints: Any dissatisfaction on the part of the Contractors/ Insured will be resolved amicably. In this respect, the request will be sent in writing (including in electronic form, at info.ro@generali.com and on the Generali website at https://www.generali.ro/contact/ sugestii-reclamatiiintrebari/), to the Insurer's HQ. The Insurer will register the petition and proceed to resolve the formulated dissatisfaction. The petitioner will subsequently receive, through an official notification, the Insurer's point of view, containing the necessary clarifications and, possibly, the way of solving the request. If, from the petitioner's point of view, the Insurer's answer does not correspond to its requirements, at its request, the parties may agree to organize a meeting in which the request will be settled. If the case has not been resolved amicably, the parties can address the competent authorities. The Contractor/ Insured Person may appeal to the Alternative Dispute Resolution and may go before SAL-FIN, an alternative dispute resolution entity in the non-banking financial field that operates within the Financial Supervisory Authority. The requests are addressed in writing, directly to the SAL-FIN headquarters, by post or by electronic means of communication. Detailed information on alternative dispute resolution methods and conditions can be obtained at http://www.salfin.ro. Any dispute, arising from or in connection with the Insurance Contract and which cannot be settled amicably, will be resolved by the competent courts with headquarters in Romania.

Taxes: All fees charged by different institutions (General practitioner, Hospital, Police, Public Prosecutor's Office, Institute of Legal Medicine, etc.) for issuing the documents requested by the Insurer, in order to pay the Insurance Indemnity, if applicable, are borne by the Insured person.

Force majeure: Exonerates the Contracting parties from the fulfilment of the obligations undertaken in this Insurance Contract, for the whole period in which it acts. The fulfilment of the Insurance Contract will be suspended during the period of action of the force majeure, but without prejudice to the rights that were due to the parties until its occurrence. The Contracting party invoking the force majeure has the obligation to notify the other party, immediately and completely, of its production and to take any measures available to it in order to limit the consequences. If the force majeure acts or is expected to act for a period greater than 6 months, each party shall have the right to notify the other party of the termination of this Insurance Contract in full, without either party being able to request claims to the other. The force majeure must be ascertained by a competent authority.

Data protection: The Insured Person has all the rights regulated by the legislation in force regarding the protection of persons concerning the processing of personal data and the free movement of these data in accordance with Regulation (EU) 2016/679 of the European Parliament and of the Council of April 27, 2016 on the protection of natural persons with regard to the processing of personal

data and the free movement of these data as well as Law no. 190/2018 on the measures to implement Regulation (EU) 2016/679. The Insured Person can exercise his/ her rights by submitting a written, dated and signed application to the Insurer. In the application, the applicant may indicate whether he/ she wishes the information to be communicated to a particular mailing address or through a correspondence service to ensure that the delivery will be exclusively made to him/ her personally.

Applicable law: The Insurance Contract will be governed by the Romanian law.

Tax deductions. General provisions: According to the tax legislation in force (Law 227/2015 on the tax code, as subsequently amended and supplemented), private health Insurance is tax deductible, up to a limit of €400/ person/ year, both for the employee and for the employer. These tax specifications are valid subject to the modification of the tax legislation (the Fiscal Code and any other normative act adopted in its application).

Particular Insurance Conditions

Daily Indemnity for Continued hospitalization as a result of Covid-19

These Insurance Conditions regulate the coverage provisions of the Daily Hospitalization Indemnity as a result of Covid-19, along with the General Insurance Conditions.

1. If, as a result of infection with the new coronavirus that causes Covid-19 during the Validity Period of the Insurance Policy, the Insured is hospitalized for more than 5 days, the Insurer will pay an Indemnity for each day of Continuous hospitalization, starting with the 6th day of hospitalization, for a maximum period of 14 days. The day of discharge is not paid.
   A day of hospitalization is considered a calendar day, regardless of the time of hospitalization and discharge of the Insured Person.
2. For the purposes of these Insurance Conditions, hospitalization means the form of hospitalization to a ward/ department of an accredited medical unit, which provides curative medical assistance for the treatment provided to the Insured Person in case of Covid-19 illness, during the Insured Period, with the drafting of an FOCG (General Clinical Observation Sheet).
   Continuous hospitalization is not considered to be the admission to:
   - units for the care of persons addicted to alcohol or psychoactive substances;
   - units intended for the care of the elderly and retirement homes;
   - the medical-social units or the Hospitals, the wards destined for the admission of social cases;
   - “day hospitalization” structures;
   - home health care institutions;
   - spa sanatoriums and balneophysiotherapy wards;
   - cosmetic surgery and beauty clinics;
   - TBC sanatoriums and prevention units, as well as pneumophtisiology or phtisiology units or wards, except for the situations in which the medical documents accurately show that the patient was treated in such institutions for conditions other than tuberculosis or its complications;
   - the units or wards that provide medical recovery-rehabilitation services;
   - Hospital as an attendant.

   Exceptionally, if it is approved by the competent authorities that one of the institutions above becomes an accredited medical unit for the treatment of patients infected with Covid-19, then such institution will be deemed to meet the definition of a Hospital and the Insured Risks specified in these Insurance Conditions may be covered.
3. The Insurance Indemnity is paid in compliance with the provisions of art. 4 of the general Insurance Conditions for “GENERALI Co-Protect”.
4. If the Risk (the start date of the hospitalization period) occurred before the Insurance Policy expired, the maximum total number of days of Continuous Hospitalization paid after the expiration date is 14 days. These will be paid even if the Policy has expired, provided that the diagnosis of Covid-19 is made during the Insured Period and the first day of hospitalization is included in the Validity Period of the Policy.
5. Hospitalization Indemnities are granted only to the Insured Person to whom the specialist Physician recommends hospitalization in order to treat the Covid-19 illness. The hospitalization performed at the request of the Insured Person, the provision of medical services in Hospitals in other forms than the continuous hospitalization or any other illnesses not related to the Covid-19 illness are not covered.
6. For this Risk, Insurance Indemnities are granted only to the Insured Person; in this case, no invoices issued by Hospitals to cover the cost of hospitalization or other services provided during the hospitalization period are covered.
7. The Insurance Indemnity is personal and is paid exclusively to the Insured Person. In the event of death of the Insured Person, the Insurer will not pay the Insurance Indemnity.
8. The Indemnity for Continuous hospitalization due to Covid-19 is not granted for the period of Continuous hospitalization in intensive care units due to Covid-19.

Daily Indemnity for Continued hospitalization in Intensive Care Units as a result of Covid-19

These Insurance Conditions regulate the coverage provisions of the Daily Hospitalization Indemnity in Intensive Care Units as a result of Covid-19, along with the General Insurance Conditions.

1. If, as a result of infection with the virus that causes Covid-19 during the validity of the Insurance Policy, the Insured Person is hospitalized to an Intensive Care Unit, upon written recommendation of a physician, the Insurer will pay an Indemnity for each day of Continuous hospitalization in intensive care units, starting with the first day of hospitalization in such unit, for a maximum period of 14 days. The day of discharge is not paid.
   A day of hospitalization in the Intensive Care Unit is considered the interval of 24 hours actually spent by the Insured Person in an Intensive Care Unit (ICU).
   As an exception, coverage is also provided within the mobile Intensive Care units, if they are accredited by the Ministry of Health and fitted according to the legislation in force.
2. For the purposes of these Insurance Conditions, hospitalization in the Intensive Care Unit means the form of hospitalization in an Intensive Care Unit within an accredited medical unit, which treats critically ill patients as a result of Covid-19, who require permanent monitoring and the maintenance, recovery or replacement of at least one vital function with the help of equipment suitable for these medical manoeuvres.
3. The Insurance Indemnity is paid in compliance with the provisions of art. 4 of the General Insurance Conditions for "GENERALI Co-Protect".
4. If the Risk (the start date of the hospitalization period) occurred before the Insurance Policy expired, the maximum total number of days of Continuous Hospitalization paid after the expiration date is 14 days.
5. Hospitalization Indemnities are granted only to the Insured Person to whom the specialist Physician recommends hospitalization to an Intensive Care Unit or, as an exception, to a mobile Intensive Care Unit, in order to treat the Covid-19 illness. The hospitalization performed at the request of the Insured Person, the provision of medical services in Hospitals in other forms than the continuous hospitalization or any other illnesses not related to the Covid-19 illness are not covered.
6. For this Risk, Insurance Indemnities are granted only to the Insured Person; in this case, no invoices issued by Hospitals to cover the cost of hospitalization or other services provided during the hospitalization period are covered.
7. The Insurance Indemnities is personal and is paid exclusively to the Insured Person. In the event of death of the Insured Person, the Insurer will not pay the Insurance Indemnity.
8. The Indemnity for continuous hospitalization in intensive care units due to Covid-19 is not granted for the period of continuous hospitalization due to Covid-19.

Insurance for post-hospitalization expenses as a result of Covid-19, to cover basic needs

1. This coverage is applicable when, as a result of at least 5 days of hospitalization caused by Covid-19 illness during the Insured Period, the Insured Person must bear the following expenses to cover the basic needs:
   - transportation to specialized medical centres (Hospital/ Clinic/ Medical Office);
   - child support services;
   - support services at the Insured Person's home;
   - procurement of Medicines, according to the recommendation of the specialist physician;
   - food delivery services;
   - other potential medical expenses related to the post-hospitalization medical recovery period following Covid-19 illness: examinations, laboratory tests, etc.

   The transportation of the Insured Person means the transportation through an accredited Ambulance Service, or unassisted medical transportation, taxi or own means of transportation (with the settlement of the fuel receipt, with the limit of RON 50 per trip). In order to be able to pay the transportation-related expense, a Medical Report issued by the treating physician on the day the Insured Person was transported to the specialized medical centre must be produced.
   The support services to the Insured Person's children means the provision of support services for the Insured Person's children up to 14 years of age, by specialised companies/ people, issuing tax invoices to the Insured Person and specifying the number of support days provided.
   Procurement of Medicines means the purchase of pharmaceutical preparations/ medicines by the Insured Person, based on a Prescription, used to treat Covid-19 illness. The following shall not be compensated:
   - products considered herbal/ homeopathic/ food supplements that are not registered in the Nomenclature of medicinal products for human use in Romania, published by the National Agency for Medicines and Medical Devices (ANMDM), as well as alternative, herbal, homeopathic examinations, prescriptions, treatments and check-ups, acupuncture, phytotherapy, api-phytotherapy, crystal therapy, aromatherapy, bioenergy (the listing is illustrative not exhaustive);
   - any medicines for which there is no written Prescription bearing the signature and stamp of a Physician;
   - any preparations/ medicines unrelated to the treatment for Covid-19, for example (the listing is illustrative not exhaustive): recommended treatments for chronic diseases of the Insured Person, dental expenses, etc.

   The support services at the Insured Person's home means the provision of medical care services to the Insured Person, by specialised companies/ people, issuing tax invoices to the Insured and specifying the number of days for which the medical care services were granted, listing such services.
   Food delivery services means the coverage of the costs of catering, including the cost of products purchased up to a maximum of RON 100/ day or the equivalent in another currency.

2. The costs are reimbursed for a recovery period of maximum 15 days starting from the date of discharge from the Hospital, based on supporting documents.
3. The Insurer covers these medical expenses (pays the Insured Person their value), based on the medical and fiscal documents issued to the Insured Person, up to the maximum limit stipulated in the Policy for this Risk. Compensations for this Risk will be paid in compliance with the provisions of art. 4 of the General Insurance Conditions.
4. For the Risk of post-hospitalization expenses, no Insurance Indemnities are granted, but the cost of the expenses incurred for the benefit of the Insured Person is covered. In the event of death of the Insured Person prior to the opening of the claim file, the Insurer will not cover the expenses incurred for this risk.