Guide to the Health Plan 2023

Benefits reimbursed directly by the Fund

Rome and its Province

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Guide to the Health Plan – direct FAST 2023

Tourism Healthcare Fund (Fondo Assistenza Sanitaria Turismo – FAST) – Rome and its Province

LIST OF BENEFITS REIMBURSED DIRECTLY BY THE FUND

Additional information:

1. HEALTHCARE COPAYMENTS

The FAST Fund shall reimburse in full healthcare services provided by the National Health Service for the following services:

- Diagnostic investigations
- Accident and Emergency Department copayments in relation to acute events. No follow-up checks or similar are expected from the date of the event
- Treatment services, meaning those listed exclusively in **point 6.2** of the health plan
- Specialist consultations
- Physiotherapy treatment exclusively for rehabilitation purposes (meaning those listed in **point 6.5.1** of the health plan).

Documentation required for reimbursement

- A copy of the expense documentation (invoice/copayment) showing the service provided;
- A copy of the medical prescription containing the working diagnosis with the condition or suspected condition necessitating the service.

NO reimbursement shall be made for services that report "check-ups, tests, follow-ups, family history" and/or similar as a working diagnosis.

The annual availability for this coverage is €500.00 per Member.

2. MATERNITY PACKAGE

Pregnant women have the right to perform certain specialist and diagnostic services, provided at accredited public and private healthcare facilities, including family counsellors, **free** of charge.
Please consult the Italian Prime Ministerial Decree of 12 January 2017 on the new Essential Levels of Care and Annex 10 for the list of free services

The Fund shall reimburse the following benefits:

- ultrasound;
- amniocentesis;
- chorionic villus sampling
- **Basic NIPT** (non-invasive prenatal testing): trisomies 13, 18, 21 and sex identification (**maximum reimbursement of €350)**
- chemical clinical analysis;
- four ob-gyn check-ups (six for high-risk pregnancies).*
- one anaesthesia consultation
- electrocardiogram

Documentation required for reimbursement

- A copy of the expense documentation (invoice/copayment) showing the service provided;
- For NIPT, a certified description of the chromosomal anomalies investigated is required if the expenditure item does not report them;
- Pregnancy certificate;
- In the case of a high-risk pregnancy, a copy of the medical certificate showing the underlying condition must be attached, and at least two gynaecological consultations must fall within the period indicated on the certificate.*
- For the Maternity Allowance, a copy of the Hospital Discharge Form (SDO) is required, showing that the hospitalisation was for childbirth or for spontaneous or therapeutic abortion with the relevant days of hospitalisation

The annual availability for this coverage is €1,000.00 per event.

Maternity allowance

Upon delivery, and upon presentation of the hospital discharge form (SDO), the FAST Fund shall pay an allowance of €**80.00** per day of hospitalisation, up to a maximum of **7 days**. A day of hospitalisation is defined as admission to a medical institution involving an overnight stay.

The reimbursement of this allowance is to be considered separate to the maximum ceiling of €1,000

3. MAP (MEDICALLY ASSISTED PROCREATION) TREATMENT

For couples preparing for MAP, certain services, provided at accredited public and private healthcare facilities, may be performed **free** of charge
Please consult the Italian Prime Ministerial Decree of 12 January 2017 on the new Essential Levels of Care and Annex 10 for the list of free services.

The following benefit refers to a single treatment throughout a woman's entire fertile life cycle.
The benefit may be claimed by couples in which at least one of the parties has coverage.
Adult couples, whether married or cohabiting, of childbearing age, are eligible.
The following benefits are subject to reimbursement:

- Stimulation therapy
- Ovum/gamete collection
- Insemination techniques

The Fund shall **NOT** reimburse any diagnostic/instrumental examinations and analyses for the pre-, during and post-treatment of infertility or anything that does not fall under the above-mentioned therapies and techniques

Documentation required for reimbursement

- Self-certification of the family status or family registry certification of the Member showing the composition of the family unit and kinship relationships.
- A copy of the MAP Treatment Plan
- Doctor's prescription for the pharmacological treatments indicated on the enclosed plan
- Expense documents showing the service provided and/or tax receipts with the name of the drug purchased, indicated in the enclosed treatment plan.
- The expense items must be in the name of the coverage holder or joint holder (member of the Fund and user of the service)
- If the partner who is not a member uses the service, this situation must be indicated on the invoice

The annual availability for this coverage is €1,000.00 in a lump sum for the entire amount payable

4. ASSISTANCE FOR NON-SELF-SUFFICIENT WORKERS

The Fund shall offer reimbursement for the provision of assistance to non-self-sufficient persons for a period not exceeding two years.

"Non-self-sufficient" is defined as a person who, due to illness or injury, is unable to independently carry out, in whole or in part, the most common activities of daily living, such as bathing, getting dressed, getting undressed, toileting, mobility, etc..

The reimbursements paid by the Fund to the member relate to social and medical services, such as:

- caregivers, support and assistance staff
- hospitalisation in assisted living facilities

Documentation required for reimbursement:

- a certificate of disability issued by the medical commission of the Local Health Authority (U.S.L.) pursuant to Article 4 of Italian Law 104/92, showing that the individual has a *serious disability* (pursuant to Article 3, paragraph 3, of Italian Law 104/92)
- for members legally represented by another person, a copy of the family status showing the relationship with the family member for whom the benefit is requested is required
- hospitalisation certificate and specific assistance programme for assisted living facilities, specifying the costs incurred

For reimbursement of support and assistance staff expenses:

Receipt certifying the payment of contributions to INPS (Italian National Institute for Social Security) and a pay slip issued by the employer, registered with the Fund, showing:

- Name and Surname of the worker with support function (nurse/caregiver)
- Number of hours worked with hourly pay
- Amount of contributions paid
- Signature for worker's receipt (nurse/caregiver)

The annual availability for this coverage is €4,800.00 pro rata for the months of annual subscription

Additional information:
In all cases, non-self-sufficiency status is subject to verification and review every 12 months. Therefore, the Fund shall have the right to request medical examinations attesting to the continuation of the worker's non-self-sufficiency status.
At the end of two years, if the Fund decides to extend the coverage, a new verification of non-self-sufficiency status is required by the Fund for renewal.

5. LONG-TERM CARE – ASSISTANCE FOR NON-SELF-SUFFICIENT FAMILY MEMBERS

The Fund has introduced reimbursement for Long-Term Care, assistance to non-self-sufficient family members, in conditions of serious "non-self-sufficiency".

Members who have been regularly covered for at least 6 months from the date of the invoice requested are eligible for reimbursement.

The benefit is available to first-degree relatives in the direct or collateral line (son/daughter, husband/wife, parent, brother/sister) and for de facto families, cohabiting partners, provided they are listed in the family register

The Fund shall reimburse the following benefits:

1. The 50%, payable by the user, of the fee for stays in nursing homes (Residenze Sanitarie Assistenziali – RSA), accredited by the National Health Service, as regulated by Art. 3 of Italian Legislative Decree 502/92 and subsequent amendments
2. fees for integrated day care centres for health and social care, semi-residential interventions for non-self-sufficient persons
3. fees for stays in care homes
4. nursing and/or rehabilitation care at home
5. carer

Documentation required for reimbursement:

- Certification of the family status of the Member showing the composition of the family unit and kinship relationships with the family member for whom the payment is requested.
- For parents, a historical family status certificate is also required
- copy of the report issued by the local health authority (ASL) pursuant to Italian Law 104/1992, Art. 3, paragraph 3 ("serious condition of non-self-sufficiency")
- a copy of the tax-valid expense documents in the registered employee's name and/or jointly held with the family member who used the benefits, clearly showing the specific care expenses incurred for the non-self-sufficient person, up to the amount of the sum
- copy of the doctor's prescription for the necessary rehabilitation services, which must correspond to those on the invoice
- For the reimbursement of caregiver benefits: Receipt certifying the payment of contributions to INPS (Italian National Institute for Social Security) and a pay slip issued by the employer, registered with the Fund, showing: - Forename and surname of the support worker (caregiver) - Number of hours worked with hourly pay - Amount of contributions paid - Signature for receipt of the worker (caregiver)

The availability for this coverage is €1,500.00 per family unit, in a lump sum for the entire amount payable

6. SPECIFIC PREVENTION FOR WORKERS WITH DOWN SYNDROME

For workers who are members of the Fund and who have Down syndrome, the prevention package provides for reimbursement for the following benefits:

- visual/auditory impairment assessment
- cervical radiography
- bone density assessment

Documentation required for reimbursement:

- Down syndrome certification (Art. 3, paragraph 1, of Italian Law 104/1992)
- A copy of the expense documentation showing the service provided

The annual availability for this coverage is €300.00 per member.

7. PRESCRIPTION LENSES

The Fund provides for the reimbursement of lenses for eyeglasses or contact lenses (for daily lenses, a single request is allowed for a maximum of 12 months of expenditure). This benefit is reimbursable once every three years from the date of the invoices submitted for sight defects with a variation of at least 0.50 diopters per eye, within the period of validity of the coverage

Documentation required for reimbursement

- expense document on which **the cost of the lenses alone** must be clearly shown - maximum 2 lenses;
  or contact lenses, presented as a single solution
- prescription/certificate (dated no more than one year from the date of the invoice sent) from an ophthalmologist indicating the previous and current visual impairment
- certificate of conformity for the new lenses

No reimbursement shall be made for costs related to frames or anything other than prescription lenses alone

The annual availability for this coverage is €100

8. INFLUENZA VACCINES

The following are reimbursed: trivalent influenza vaccines (TIV) containing two type A viruses (H1N1 and H3N2) and one type B virus, as well as quadrivalent vaccines containing two type A viruses (H1N1 and H3N2) and two type B viruses

Documentation required for reimbursement:

- The expense item showing the type of vaccine
- The documentation submitted must contain only the service to be reimbursed, in order to facilitate future operations regarding both reimbursement and tax form 730

The annual availability for this coverage is €15

9.PHARMACOLOGICAL TREATMENT OF SEVERE OBESITY

Severe and/or complicated obesity (BMI >40 kg/m2 or BMI >30 kg/m2 and stage 2 or higher according to the Edmonton Obesity Staging System)

The Edmonton Obesity Staging System is an internationally recognised system for assessing the severity of obesity. It forms part of the Italian ADI-SIO Standards for the diagnosis and treatment of obesity.

The FAST Fund, in collaboration with the **S.I.O. (Società Italiana dell'Obesità – Italian Society of Obesity)** [for further information, please consult the website hiips://sio -obesita.org], aims to continue its efforts to increase knowledge of this multifactorial chronic disease by specifically reimbursing associated and nationally recognised pharmacological treatments.

- LIRAGLUTIDE 3.0 mg (brand name SAXENDA)
- NALTREXONE/BUPROPION (brand name MYSIMBA)

Documentation required for reimbursement

- Assessment of severe obesity issued by a specialist doctor
- Treatment plan and/or indication of the course of medication
- Tax receipts with the name of the drug purchased, indicated in the enclosed treatment plan

The annual availability for this coverage is €1,000.00 per member.

The reimbursement is to be considered as a lump sum

10. REIMBURSEMENT FOR CHRONIC CONDITIONS - SPECIALIST CONSULTATIONS

As of 01/07/2023, the fee of €35 shall be reimbursed ONLY for specialist consultations relating to the following chronic conditions:

Diabetes mellitus (chronic disease sufficient for the recognition of "chronic disease exemption" code 013)

- Specialist diabetic/endocrinology consultations
- Specialist cardiology consultations
- Specialist nephrological consultations
- Specialist angiology consultations
- Specialist ophthalmology consultations

Ischaemic heart disease with remaining damage (chronic disease sufficient for the recognition of "chronic disease exemption" code 021 heart failure (NYHA classes III and IV))

- Specialist cardiology consultations
- Specialist nephrological consultations
- Specialist angiology consultations

Ischaemic and/or haemorrhagic cerebrovascular disease (chronic disease requires certification of the presence of motor/sensory deficits as an effect of acute cerebral vascular disease)

- Specialist neurology consultations
- Specialist cardiology consultations

COPD with the need for oxygen therapy (chronic disease sufficient for the recognition of "chronic disease exemption" code 024)

- Specialist pulmonology consultations
- Specialist cardiology consultations

Documentation required for reimbursement

- A copy of the medical prescription containing the working diagnosis with the condition or suspected condition necessitating the service.
- UniSalute authorisation
- Certificate of chronic disease assessment
- Expense document showing the amount borne by the member

The annual availability for this coverage is €500.00 per member.

11. REIMBURSEMENT FOR CHRONIC CONDITIONS - DIAGNOSTIC EXAMINATIONS

As of 01/07/2023, the fee of €50 shall be reimbursed ONLY for specific diagnostic examinations for the following chronic conditions:

Diabetes mellitus (chronic disease sufficient for the recognition of "chronic disease exemption" code 013)

- Cardiac Doppler echocardiography including colour
- Colour Doppler echocardiography of the lower and upper limbs
- Colour Doppler echocardiography of the abdominal aorta
- Colour Doppler echocardiography of the supra-aortic tracts
- Electrocardiogram (ECG) with analogue devices (holter)
- Electromyography
- Evoked potentials
- Ocular fluoroangiography
- Ischaemic heart disease with residual effects
- Cardiac Doppler echocardiography including colour
- Cardiac cine MRI
- MR angiography with contrast
- Myocardial perfusion imaging
- SPECT myocardial tomoscintigraphy
- Electrocardiogram (ECG) with analogue devices (holter)
- Continuous monitoring (24 hours) of blood pressure
- Ischaemic and/or haemorrhagic cerebrovascular disease
- Colour Doppler echocardiography of the supra-aortic tracts
- Extracranial or intracranial CT angiography
- MR angiography with contrast
- Sleep-deprived electroencephalogram (EEG)
- Dynamic 24-hour electroencephalogram (EEG)
- Electroencephalogram

COPD with the need for oxygen therapy (chronic disease sufficient for the recognition of "chronic disease exemption" code 024)

- High-definition multilayer spiral CT scan
- CT scan with and without contrast medium
- Diagnostic tracheobronchoscopy

Documentation required for reimbursement

- A copy of the medical prescription containing the working diagnosis with the condition or suspected condition necessitating the service.
- UniSalute authorisation
- Certificate of chronic disease assessment
- Expense document showing the amount borne by the member

The annual availability for this coverage is €500.00 per member.

12. DEDUCTIBLE FOR SURGICAL PROCEDURES

For surgery carried out within the network and with surgery dates starting from 01/07/2023, the deductible of 20% shall be reimbursed at the expense of the member ONLY for the following surgical procedures:

NEUROSURGERY
- Removal of spinal space-occupying lesions (intramedullary and/or extramedullary)
- Removal of orbital tumours
- Neurosurgery for malignant oncological diseases
- Transsphenoidal pituitary surgery

GENERAL SURGERY
- Surgery for the removal of malignant breast neoplasms with the potential fitting of implants

OPHTHAMOLOGY
- Surgery for neoplasms of the eyeball

OTORHINOLARYNGOLOGY
- Removal of malignant tumours in all anatomical regions related to otorhinolaryngology
- Surgery for neurinoma of the eighth cranial nerve

NECK SURGERY
- Retrosternal goitre surgery with mediastinotomy
- Total thyroidectomy with or without lymphadenectomy

RESPIRATORY SYSTEM SURGERY
- Surgery for tumours of the mediastinum
- Surgery for tracheal, bronchial, pulmonary or pleural tumours
- Total or partial pneumonectomy

CARDIOVASCULAR SURGERY
- Aneurysm surgery: resection and transplantation with prostheses
- Abdominal aortic laparotomy surgery
- Surgery of the heart and large blood vessels with any form of access through the chest
- All heart procedures in the hemodynamics room

DIGESTIVE SYSTEM SURGERY
- Total or partial resection of the oesophagus Surgery of the anus and rectum for malignant oncological diseases

Documentation required for reimbursement

- Medical record
- UniSalute authorisation
- Expense document showing the 20% amount borne by the member

The annual availability for this coverage is €500.00 per member.

I. HOW TO REQUEST REIMBURSEMENT

The Member must access their PERSONAL SPACE on the website www.fondofast.it, upon registration, and upload all the documentation necessary for reimbursement.

The reimbursement procedures shall be carried out by the Fund on a monthly basis directly to the member's current account.

II. CASES OF NON-OPERABILITY OF THE PLAN

The Health Plan does not cover:

- treatment and/or procedures for the elimination or correction of physical defects* or malformations** that were pre-existing when signing the Health Plan, except as provided for in the point "Newborns";
- the treatment of mental illnesses and mental disorders in general, including neurotic behaviour, with the exception of the provisions in the "Specialist consultations" section of the Health Plan,
  referred to psychiatric consultations and a subsequent course of sessions;
- dental prostheses, the treatment of periodontal disease, dental care and dental tests, except as provided for in the "Implantology services" and "Special dental services" sections of the Health Plan;
- medical services for aesthetic purposes (except for reconstructive plastic surgery made necessary by injuries or destructive procedures occurring during the period of validity of the Health Plan);
- treatment, procedures and tests for the treatment of infertility and those relating to artificial insemination, except as provided for in the "MAP treatments" section of the Health Plan;
- procedures for the replacement of orthopaedic prostheses of any type;
- the treatment of illnesses resulting from the abuse of alcohol and psychoactive drugs, as well as from the non-therapeutic use of narcotics or hallucinogens; persons who can prove that they have followed and successfully completed a detoxification programme for alcohol or drug abuse are not subject to this exclusion;
- accidents resulting from the practice of air sports in general or any professionally practised sport;
- accidents resulting from participation in motor races or competitions that are not purely regularity races, motorbike or motorboat races and related trials and training;
- accidents caused by wilful misconduct by the Member;
- the direct or indirect consequences of transmutation of the nucleus of an atom, and radiation caused by artificial acceleration of atomic particles and exposure to ionising radiation;
- the consequences of war, insurrections, earthquakes and volcanic eruptions;
- treatments not recognised by official medicine;

*Physical defect is defined as deviation from the normal morphological arrangement of an organism or parts of its organs due to acquired medical conditions or trauma.

**Malformation is defined as deviation from the normal morphological arrangement of an organism or parts

of its organs due to congenital medical conditions.

III. SOME IMPORTANT CLARIFICATIONS

GEOGRAPHICAL COVERAGE AREA

The Health Plan is valid worldwide in the same way as it is effective in Italy.

AGE LIMITS

The Health Plan may be taken out or renewed until the Member reaches **75** years of age, and will automatically terminate on the first expiry date after the Member reaches that age.

HANDLING OF EXPENDITURE DOCUMENTS (INVOICES AND RECEIPTS)

Should the FAST Fund require the Member to produce the originals, the expense documentation must be transmitted to the FAST Fund - Via Toscana, 1 – 00187 Rome, otherwise all the expense items and other documents necessary for reimbursement shall be managed through the personal space for the processing of the claim.

For claims occurring abroad, reimbursements shall be made in Italy, in euros, at the average exchange rate for the week in which the expense was incurred.

The Fund may, at its sole discretion, request that the original documentation be sent at any time for verification purposes. We remind you that in the event of forged or counterfeit documents, the Fund shall immediately notify the competent judicial authorities for the appropriate checks and the ascertainment of any criminal liability.

Please note

Reimbursement requests must be submitted within a period of two years from the date of the invoice or expense document relating to the service provided, together with other necessary documentation. For hospitalisation, this time period begins on the date of discharge. Invoices and expense documents transmitted after two years shall not be reimbursed.

For services on an experimental basis, documentation for reimbursement must be submitted at the end of the trial.