Insurance Contract for reimbursement of healthcare expenses

PID – Pre-Contractual Information Document on non-life insurance contracts

Company: RBM ASSICURAZIONE SALUTE S.p.A. – General Headquarters in Italy – Company registered under number 1.00161 of the Register of Insurance Companies

Product: UNICA DIPENDENTI NUOVA PLUS

The complete pre-contractual and contractual information relating to the product is provided in other documents

What kind of insurance is this?

The coverage provides for reimbursement of the expenses incurred as a result of an accident or illness for the hospitalisation services area, the non-hospital specialist and/or outpatient services area, the additional services area and the prevention area.

What is insured?

The Company reimburses the following expenses:

- ✓ Medical expenses in case of hospitalisation with/without surgery, Day Hospital with/without surgery, Outpatient surgery, Childbirth / Therapeutic abortion, Dental surgery, Major Surgical Procedures (MSP), Transplantations, Post-surgical rehabilitation, Severe Morbid Events (SME);
- ✓ Hospital confinement indemnity for hospitalisation with or without surgery: the Company pays a hospital confinement indemnity for each hospitalisation day;
- ✓ Newborn: reimbursement of expenses incurred for treatment and surgery due to malformations and/or physical defects;
- ✓ High Specialisation Care and Diagnostics: the Company reimburses expenses for a list of highly specialised services and treatments related to oncological diseases, endoscopic treatments and investigations;
- ✓ Non-invasive prenatal genetic tests on Foetal DNA;
- ✓ Ordinary diagnostics and specialist examinations: the Company reimburses expenses for diagnostic tests and exams and medical fees for specialist examinations;
- ✓ Cancer treatment: the Company reimburses expenses for home nursing care, chemotherapy, radiotherapy, other cancer treatment therapies and specialist examinations;
- ✓ Physiotherapy services: the Company reimburses physiotherapy expenses following a list of illnesses;
- ✓ Speech therapy: the Company reimburses expenses for speech therapy following an accident;
- ✓ Specific child learning disabilities;
- ✓ Orthopaedic and acoustic prostheses: expenses incurred to purchase, repair and replace orthopaedic and acoustic prostheses are reimbursable;
- ✓ Dental care due to accident;
- ✓ Additional services: the Company reimburses expenses incurred for paediatric examinations;
- ✓ Lenses: the guarantee is valid for purchases of lenses and glasses (including frames) or corrective contact lenses following modification of the visus;
- ✓ Maternity package: expenses incurred for check-up examinations and investigations are reimbursed;
- ✓ Psychotherapy;
- ✓ Emergency room services;

Follows on the next page

What is not insured?

- × Inclusion in the policy of new policyholders who have already reached the age of 85 on 31 December 2019 is not allowed.

Please note that there is a series of cases for which the insurance coverage does not apply. For example, coverage is excluded for accidents resulting from carrying out air sports and participating in professional competitions and the related training, as well as accidents, diseases and intoxications resulting from alcoholism, misuse of psychopharmaceutical drugs, use of narcotic drugs (except for therapeutic administration) or hallucinogens. Also excluded are expenses incurred for a series of healthcare services (including voluntary non-therapeutic abortion) or due to treatment and surgery for the consequences or complications of non-reimbursable injuries or illnesses under the policy. We reiterate that this is merely a brief description of the excluded risks that does not include all cases of exclusion set out in the policy.

Are there coverage limits?

- ! The coverage includes specific deductible sums and percentage excesses per guarantee, which can cause the reduction or non-payment of the indemnity.

What is insured?

The Company reimburses the following expenses:

- ✓ Treatment for drug addicts;
- ✓ Nursing care;
- ✓ Repatriation of remains;
- ✓ Home hospitalisation;
- ✓ Medically assisted procreation;
- ✓ Postpartum care: postpartum psychological care, lower limbs check-up and wellness weekend;
- ✓ Thermal treatments for minors;
- ✓ Down syndrome;
- ✓ Health Account;
- ✓ Indemnity for health and care expenses incurred for parents admitted to a nursing home;
- ✓ Expenses for check-up examinations, herpes zoster prevention, heterologous fertilisation, paediatric check-up, nutrition consultation and personalised diet and stem cell conservation.

The coverage has an annual maximum limit (cap) of the indemnities recognised by the individual guarantees.

Where does the coverage apply?

- ✓ The insurance applies worldwide.

What are my obligations?

- When the Insured signs the contract, he or she is obliged to make truthful, exact and complete statements about the risk to be insured and to disclose, during the contract term, the changes that lead to an aggravation of the insured risk. Untruthful, inaccurate or reticent statements, or the failure to disclose the aggravation of the risk, may result in the total or partial loss of the right to the indemnity as well as in termination of the coverage.
- The Policyholder, the Insured or their beneficiaries must report the claim to the Company as soon as possible. Failure to comply with this obligation may result in the total or partial loss of the right to reimbursement of the expenses incurred, in accordance with Article 1915 of the Civil Code.
- If the Insured receives reimbursement from Funds or Entities, the settlement documentation of these Entities must be sent together with photocopies of the invoices relating to the aforementioned reimbursement.
- The medical documentation, including the diagnosis in the name of the Insured, must be submitted to obtain the settlement of the claims.
- In the event of an accident, if the harmful event is attributable to the liability of a third party, the Insured must disclose the name and address of the liable third party to the Company and forward the Emergency Room medical report.
- In the event of a road accident, the Insured must transmit the report drawn up by the police relating to the accident, or the CID [Amicable Accident Description] Form, to the Company together with the first request for reimbursement for health services that became necessary as a result of the accident.

Please note that if the Insured intends to use an affiliated facility and/or an affiliated physician and/or an affiliated dentist, he or she must always use them under the direct assistance scheme.

When and how must I pay?

- The premium, although annual and indivisible, provides for an advance monthly subdivision as shown on the policy certificate.
- The Policyholder must pay the premium by bank transfer to the Company to which the policy is assigned.

When does coverage begin and when does it end?

- The insurance contract has a term of two years starting as of zero hundred hours on 1 January 2020, if the premium or the first premium instalment has been paid; otherwise, it takes effect as of zero hundred hours of the day following the payment.
- The coverage expires at twenty-four hundred hours on 31 December 2021.

How can I terminate the policy?

- This coverage is without tacit extension and, therefore, it is automatically terminated upon its natural expiry.

Insurance for reimbursement of medical expenses

Additional pre-contractual information document for non-life insurance products (Additional Non-Life Pre-Contractual Information Document)

RBM Assicurazione Salute S.p.A.

Product: UNICA DIPENDENTI NUOVA PLUS

Last release 11 September 2019

This document contains additional and complementary information with respect to that contained in the pre-contractual information document for non-life insurance products (Non-Life Pre-Contractual Information Document), to assist the potential policyholder to understand more in detail the features of the product, the contractual obligations and the company's financial position.

The policyholder must review the insurance conditions before signing the contract.

RBM Assicurazione Salute S.p.A., with registered office at Via Forlanini 24, 31022 Borgo Verde, Preganziol (TV) tel. +39 0422 062700 website: www.rbmsalute.it; e-mail: info@rbmsalute.it; certified e-mail: rbmsalutespa@pecrbmsalute.it
The Company has been authorised to exercise Insurance activities by the ISVAP Provision No.2556 and it is registered with the Register of Insurance Companies under number 1.00161.

Equity figures as at 31 December 2018

Shareholders' equity: EUR 230,873,000 of which share capital EUR 120,000,000 and total of the equity reserves EUR 73,766,000. The equity figures (shareholders' equity, share capital, reserves and solvency index) are updated annually following the approval of the Company's financial statements. To view them, please refer to the website www.rbmsalute.it ("Informazioni Societarie" [Corporate Information] section). The results of the assessment of the Company's risk profile reveal the following fundamental parameters:

- Solvency Capital Requirement (SCR) = EUR 139,405,000
- Minimum Capital Requirement (MCR) = EUR 34,851,000
- Own funds eligible to cover the SCR = EUR 243,975,000
- Own funds eligible to cover the MCR = EUR 235,671,000
- Solvency ratio: 175% (189% net of the capital add-on).

The contract is subject to Italian law.

What is insured?

There is no additional information with respect to that provided in the Pre-Contractual Information Document; the extent of the Company's commitment is related to the coverage caps and the insured sums agreed with the policyholder.

What is not insured?

Excluded risks	The following expenses are excluded from reimbursement: 1. myopia correction or elimination surgery, except as provided for; 2. dental prostheses, treatment of periodontal diseases, dental care and dental examinations, except as provided for in the "Hospitalisation area" and the "Non-hospital specialist and/or outpatient services area"; 3. medical services for aesthetic purposes, except for reconstructive plastic surgery required due to accidents or destructive surgical procedures or cancer surgery (limited to the anatomical site of the injury) and those for children under three years of age; 4. hospitalisations solely for physical examinations or therapies that, due to their technical nature, can also be performed in an outpatient clinic, as long as permitted by the Insured's state of health; 5. hospitalisations caused by the Insured Person's need for assistance from third parties to carry out the basic acts of everyday life and long-term stays, determined by the Insured's physical conditions that no longer allow healing with medical treatments and that make permanence necessary in a medical institute for maintenance care or physiotherapy

	interventions; 6. intoxications and accidents resulting from: - alcohol abuse; - use of hallucinogens; - non-therapeutic use of psychotropic drugs and narcotics; 7. voluntary non-therapeutic abortion; 8. correction or elimination of malformations or physical defects, unless they lead to a disease or are the result of an accident and without prejudice to the provisions for "Newborn"; 9. all procedures and operations aimed at assisted fertilisation, except as provided for by the "Medically assisted procreation" guarantee. The daily hospital confinement indemnity is not paid for this type of surgeries; 10. accidents suffered as a result of criminal actions intentionally committed or attempted by the Insured, as well as intentionally carried out or permitted by the Insured against him or herself; 11. clinical check-ups; 12. acupuncture; 13. physiotherapy services (where envisaged) not carried out by a specialist physician or a professional with a degree in physiotherapy or equivalent qualification recognised in Italy, or carried out at beauty or fitness centres; 14. direct or indirect consequences of the transmutation of the atom nucleus, as well as of radiation caused by the artificial acceleration of atomic particles; 15. consequences of wars, insurrections, earthquakes and volcanic eruptions; 16. accidents resulting from exercising air sports in general or from any professionally exercised sport; 17. accidents resulting from participating in non-regular motorcar, motorcycle and motorboat competitions or races, and related tests and training sessions; 18. accidents suffered and illnesses that occurred during performance of the military service or the substitute service thereof, voluntary recruitment, call for mobilisation or for reasons of an exceptional nature; 19. expenses incurred as a result of the following mental illnesses: psychoses, neurotic personality disorders and other non-psychotic mental disorders, mental retardation and in any case all illnesses included in chapter 5 (PSYCHIC DISORDERS) of the 9th revision of the International Classification of Diseases (ICD9-CM) of the World Health Organisation and/or of the intake of psychotropic drugs for therapeutic purposes; 20. services performed at convalescent and residential care facilities, health camps and care facilities with dietary and aesthetic purposes or intended for long-term stays (nursing homes), since they are not considered "Medical Institutes", as well as gyms, sports clubs, beauty centres, health hotels, medical hotels, wellness centres even if they have an attached medical centre.

Are there coverage limits?

The Policyholder / Insured must notify the Company in writing of the existence and subsequent conclusion of other insurance policies for the same risk; in the event of a claim, the Policyholder or the Insured must notify all insurers thereof indicating to each the name of the others, in accordance with Article 1910 of the Civil Code. The aforementioned also applies where the same risk is covered by contracts concluded by the Insured with Entities, Funds and Supplemental Health Funds. Without prejudice to Company's right of recourse.
The coverage caps/insured sums, percentage excesses and deductible sums referring to the various options are shown below. Unless otherwise indicated, the coverage caps are intended per Year/Nucleus and the percentage excesses and deductible sums per event.

HOSPITALISATION AREA	
Hospitalisation with/without surgery, Day Hospital with/without surgery, Outpatient surgery, Childbirth / Therapeutic abortion, Dental surgery, Major Surgical Procedures (MSP), Transplantations, Post-surgical rehabilitation, Severe Morbid Events (SME)	extended list for Surgical procedures with ceilings (Int_PLAFONATI), Major Surgical Procedures and Dental surgery (Int_ODONTOIATRICI)
Coverage cap	EUR 150,000; EUR 300,000 per Major Surgical Procedure
Conditions:	
In-network	deductible sum EUR 200 per event; EUR 100 for outpatient surgery; not envisaged for Major Surgical Procedures
In-network not in direct form (no TOP Clinics)	percentage excess 15%, min. EUR 2,250 per event (EUR 1,500 for Day Hospital with/without surgery; EUR 750 for outpatient

	surgery); not envisaged for Major Surgical Procedures
in TOP Clinics not in direct form, Major Surgical Procedures included	percentage excess 20%, min. EUR 3,000 per event (EUR 2,000 for Day Hospital with/without surgery; EUR 1,000 for outpatient surgery);
Out-of-network and with Physician working privately in a public hospital	percentage excess 10%, min. EUR 1,500 per event (EUR 1,000 for Day Hospital with/without surgery; EUR 500 for outpatient surgery); not envisaged for Major Surgical Procedures
Hospitalisation without surgery	maximum limit of five days for hospitalisation and up to three hospitalisations per year excluded if for diagnostic purposes and for pre-surgery diagnosis
Hospitalisation for long-term stays	for hospitalisation exceeding 30 days
Caesarean section / Therapeutic abortion (Pre/Post excluded)	
Sub coverage cap:	EUR 6,000
Newborn expenses (sub-limit)	EUR 1,000
Obstetric care (sub-limit)	EUR 1,500
Conditions:	100%
Natural childbirth (Pre/Post excluded)	
Sub coverage cap:	EUR 3,000
Newborn expenses (sub-limit)	EUR 1,000
Conditions:	100%
Dental surgery	extended list (Int_ODONTOIATRICI)
Sub coverage cap:	EUR 10,000
Conditions:	
In-network	deductible sum EUR 200 per event
In-network not in direct form (no TOP Clinics)	percentage excess 30% min. EUR 1,500
in TOP Clinics not in direct form, Major Surgical Procedures included	percentage excess 40% min. EUR 2,000
Out-of-network and with Physician working privately in a public hospital	percentage excess 20% min. EUR 1,000
Myopia	with differential greater than 4 dioptres (not caused by previous corrective surgery) or visual defect of an eye equal to or greater than 8 dioptres
Conditions:	
In-network	deductible sum EUR 200 per event
In-network not in direct form (no TOP Clinics)	percentage excess 15% min. EUR 1,500
in TOP Clinics not in direct form, Major Surgical Procedures included	percentage excess 20% min. EUR 2,000
Out-of-network and with Physician working privately in a public hospital	percentage excess 10% min. EUR 1,000

Reconstructive dental surgery	mastectomy or quadrantectomy
Coverage cap	EUR 5,000
Pre/Post	90 days/90 days
Conditions:	
In-network	deductible sum EUR 1,000 per event
In-network not in direct form (no TOP Clinics)	percentage excess 30% min. EUR 1,500
in TOP Clinics not in direct form, Major Surgical Procedures included	percentage excess 40% min. EUR 2,000
Out-of-network and with Physician working privately in a public hospital	percentage excess 20% min. EUR 1,000
Newborn Correction Congenital Malformations	in the first year of life, raised to the first 10 years of life due to the impossibility of performing surgery in the first year of life
Surgical procedures with ceiling	extended list (Int_PLAFONATI)
Conditions:	100% for the main surgery, 70% for the secondary surgeries
Hospitalisation charge limit only Out-of-network	EUR 300 per day; EUR 250 for Day Hospital with/without surgery; not envisaged for Childbirth / Therapeutic Abortion
Pre/Post	100 days/100 days
Post-surgery physiotherapy / rehabilitation treatments	120 days, not envisaged for Natural childbirth, Myopia and Dental surgery
Charge for accompanying person	EUR 60 per day, max. 30 days, not envisaged for Dental surgery and Myopia
Nursing Care Limit for hospitalisation without surgery	EUR 50 per day max. 30 days per event
Nursing Care for Day Hospital without surgery, Outpatient surgery, Childbirth / Therapeutic abortion, Dental surgery	NOT ENVISAGED
Transport	EUR 2,000, not envisaged for Outpatient surgery, Dental surgery, Myopia and National Health Service (NHS)
Hospital confinement indemnity	
Coverage cap	180 days per person / year
Hospitalisation with surgery	EUR 80 per day
Hospitalisation without surgery	EUR 60 per day
Major Surgical Procedures	EUR 100 per day
Day Hospital with surgery	EUR 40 per day
Day Hospital without surgery	EUR 30 per day
Pre/Post	100 days/100 days, 100% (excluding the case of hospitalisation under the private services in a public hospital scheme)
Post-surgery physiotherapy / rehabilitation treatments	100%, 120 days, not envisaged for Natural childbirth, Myopia and Dental surgery, 100% (excluding the case of hospitalisation under the private services in a public hospital scheme)
NON-HOSPITAL SPECIALIST AND/OR OUTPATIENT SERVICES AREA	

HIGH SPECIALISATION (HS) CARE AND DIAGNOSTICS	extended list (ALTA_D)
Coverage cap	EUR 5,000
Conditions:	
In-network	deductible sum EUR 10 per invoice
In-network not in direct form	percentage excess 30% min. EUR 90 per invoice
In TOP Clinics not in direct form	percentage excess 40% min. EUR 120 per invoice
Out-of-network	percentage excess 20% min. EUR 60 per invoice
Co-payment	100%
Non-invasive prenatal genetic tests on foetal DNA	included in the HS coverage cap
Ordinary Diagnostics and Specialist Examinations (SE)	excluding the investigations envisaged in the HS and the dental and orthodontic investigations not due to accident; including the specialist examinations / dental and orthodontics investigations due to accident with Emergency Room certificate within 24 months from the event
Coverage cap	EUR 3,000
Conditions:	
In-network	deductible sum EUR 10 per invoice
In-network not in direct form	percentage excess 30% min. EUR 90 per invoice
In TOP Clinics not in direct form	percentage excess 40% min. EUR 120 per invoice
Out-of-network	percentage excess 20% min. EUR 60 per invoice
Co-payment	100%
Cancer treatment	services for cancer diseases for home nursing care, chemotherapy, radiotherapy, other cancer therapies, specialist examinations; once this coverage cap has been reached, those of HS and SE will be used
Coverage cap	EUR 10,000
Conditions:	100%
Physiotherapy services	only due to accident with Emergency Room certificate within 24 of the event; brain stroke; neoplasms; degenerative and homoplastic neurological forms (multiple sclerosis, ALS, etc.); neuromyopathic forms: mixed morbid forms affecting the neuromuscular system; cardiac surgery, thoracic surgery and limb amputation
Coverage cap	EUR 1,400
Conditions:	
In-network	deductible sum EUR 40 per treatment cycle
Direct at home	deductible sum EUR 20 per use
In-network not in direct form	percentage excess 30% min. EUR 90 per treatment cycle
In TOP Clinics not in direct form	percentage excess 40% min. EUR 120 per treatment cycle
Out-of-network	percentage excess 20% min. EUR 60 per treatment cycle

Co-payment	100%
Speech therapy	due to accident with Emergency Room certificate within 24 months of the event or due to illness if carried out by a specialist physician or graduate speech therapist
Coverage cap	EUR 1,000
Conditions:	
In-network	deductible sum EUR 40 per invoice
In-network not in direct form	percentage excess 30% min. EUR 90 per invoice
In TOP Clinics not in direct form	percentage excess 40% min. EUR 120 per invoice
Out-of-network	percentage excess 20% min. EUR 60 per invoice
Co-payment	100%
Specific child learning disabilities	as set forth in DSM - 5, provided the diagnosis is certified by a child neuropsychiatry specialist of the National Health Service
Coverage cap	EUR 1,500.00 per nucleus and per year for moderate or severe cases or up to € 500.00 per nucleus and per year for mild cases
Conditions:	
In-network	deductible sum EUR 40 per invoice
In-network not in direct form	percentage excess 30% min. EUR 90 per invoice
In TOP Clinics not in direct form	percentage excess 40% min. EUR 120 per invoice
Out-of-network	percentage excess 20% min. EUR 60 per invoice
Co-payment	100%
Orthopaedic and acoustic prostheses	
Coverage cap	EUR 3,000
Conditions:	100%
Dental care due to accident	with Emergency Room certificate within 24 months from the event
Coverage cap	EUR 4,000
Conditions:	100%
Additional services	paediatric examinations (up to 14 years old)
Coverage cap	EUR 1,500, sub-limit EUR 500 per year / person
Conditions:	percentage excess 30%
Lenses	
Coverage cap	EUR 400, sub-limit EUR 150 per year / person
Conditions:	100%
Comparative diagnosis	ENVISAGED
Maternity package	check-up examinations and investigations during the first six months of pregnancy; in the event of miscarriage, within three months, one gynaecological examination and three psychological examinations

Coverage cap	EUR 500
Conditions:	100%
Psychotherapy	
Coverage cap	EUR 1,000
Conditions:	percentage excess 50%
ACCESSORY SERVICES AREA	
Emergency room services	outpatient services following an accident without hospitalisation; the following services are also included when there is an Emergency Room prescription: plaster cast application and removal, diagnostic tests, medical care, medicines and transport
Coverage cap	EUR 1,000 per event and per year
Treatment for drug addicts	for recovery from drug addiction in Local Health Authority affiliated rehabilitation communities
Coverage cap	EUR 3,000 per person and year, maximum of EUR 30,000 for all the Insured
Conditions:	if the total requests of the Insured exceed the amount of EUR 30,000, the contribution will be distributed proportionately among the applicants
Advance payment for healthcare expenses	per Major Surgical Procedure, maximum of 50% of the expense to be incurred within 50% of the Hospitalisation Area coverage cap
Nursing Care	for terminal illness with appropriate medical / hospital certification
Conditions:	EUR 50 per day up to 90 days
Repatriation of remains	in the event of the death of the Insured following a hospitalisation (also under the Day Hospital scheme) in a healthcare facility abroad for illness or accident, with or without surgery
Coverage cap	EUR 2,000
Conditions:	excluding expenses for funeral ceremonies and burial
Home hospitalisation	post-hospitalisation expenses per Major Surgical Procedure
Coverage cap	EUR 15,000, maximum 50 days per hospitalisation
Conditions:	
In-network	100%
Out-of-network	percentage excess 10% min. EUR 1,200 per event
Medically assisted procreation	
Coverage cap	EUR 700 per nucleus and per year
Conditions:	excluding the expenses related to the travel / transfer of the insured and the costs of the possible accompanying person if the treatment is carried out abroad
Post-partum care	
Coverage cap	Unlimited
Conditions:	extended list (POST_P), within one year from the childbirth

Thermal treatments for minors	
Coverage cap	Unlimited
Conditions:	max. one cycle per year, max. EUR 35.00 per session
Down Syndrome (children of insured)	
Coverage cap	EUR 1,000 per year, max. five years
Conditions:	for diagnosis of Trisomy 21 within the first three years of life
Health Account	ENVISAGED
Indemnity for Parents in Nursing Home	for admission to Nursing Home lasting at least 12 consecutive months
Coverage cap	EUR 350 per person / year
Conditions:	in the absence of healthcare reimbursements during the insurance year
PREVENTION AREA	
Check-up examinations	
Coverage cap	Unlimited
Conditions:	one year visit for the holder (one additional visit per year for one of the members of the insured nucleus other than the holder)
Influenza vaccination	
Coverage cap	Unlimited
Conditions:	one annual vaccination per Insured
Herpes zoster prevention	
Coverage cap	Unlimited
Conditions:	age > 55 years, deductible sum EUR 36.15 per service
Paediatric check-up	
Coverage cap	Unlimited
Conditions:	as per list, between six months and six years of life
Nutrition consultation and personalised diet	One nutrition consultation and personalised diet per two-year period and per person
Coverage cap	
In-network	Unlimited
Out-of-network	EUR 50.00 for the consultation and EUR 30.00 for the diet
Stem cell preservation	
Coverage cap	EUR 500 per nucleus and per year

What are my obligations? What obligations does the company have?

What do I do in the event of a claim?	**Reporting a claim:** The Insured or his or her beneficiaries must report the claim to the Company as soon as they can, communicating it to the Company in writing or via the web (restricted area / mobile app). The indemnity request can be sent in the same way.

	Direct assistance / Assistance under affiliation agreement: the Insured is entitled to access, by prior activation of the Operations Centre, the healthcare and dental services provided by the facilities belonging to the Network made available by the Company.
	Management by other companies: not envisaged.
	Limitation period: in accordance with Article 2952 of the Civil Code, the right to payment of the premium instalments lapses in one year from the individual deadlines. The other rights deriving from the insurance contract lapse in two years from the day on which the fact on which the right is based occurred.
Inaccurate or reticent statements	The Company gives its consent to the insurance and determines the premium solely based on the statements made by the Policyholder and/or the Insured on the data and circumstances covered by a request of the Company and resulting from the contractual documents. Any inaccuracy and reticence of the Policyholder and/or the Insured relating to the circumstances that affect the risk assessment may result in the total or partial loss of the indemnity, as well as in the termination of the insurance, in accordance with Articles 1892, 1893 and 1894 of the Civil Code. In this event, the Company is entitled, in addition to the overdue and unpaid premium instalments, to the overall premium relating to the insurance year in progress when the circumstance that caused the termination occurred.
Obligations of the company	The Company undertakes: **a) Direct assistance scheme** - to authorise the complete request for which the technical-medical-insurance verifications have had a positive outcome. To this end, therefore, the Insured must act adequately in advance and in any case with a notice at least two working days (48 hours) before the last date expected for the Operations Centre's reply. **b) Reimbursement scheme** - to pay the indemnity to the Insured within 10 working days from receipt of the request for reimbursement accompanied by all required supporting medical and expenditure documentation.

When and how must I pay?

Premium	The premium, although annual and indivisible, must be paid by advance monthly instalment. The insured sums and the premiums are not indexed. The premiums include tax. The Policyholder must pay the premium by bank transfer to the Company to which the policy is assigned.
Refund	The refund of the premium is not envisaged since, in the event of loss during the year of the requirements for benefiting from the insurance coverage, the guarantees are operative until the first useful expiry date.

When does coverage begin and when does it end?

Term	The insurance contract has a term of two years starting as of zero hundred hours on 1 January 2020, if the premium or the first premium instalment has been paid; otherwise, it takes effect as of zero hundred hours of the day following the payment. The coverage expires at twenty-four hundred hours on 31 December 2021. The policy does not provide for waiting periods (during which coverage is not active).
Suspension	If the Policyholder does not pay the subsequent premiums or premium instalments, the insurance will be suspended as of twenty-four hundred hours on the 15th day after the expiry date and will be effective again as of zero hundred hours on the day after the payment, without prejudice to the following deadlines, in accordance with Article 1901 of the Civil Code. Once the aforementioned deadline has passed, the Company is entitled to declare the termination of the contract by registered letter, without prejudice to the right to the overdue premiums, or to demand enforcement in legal proceedings.

How can I cancel the policy?

Reconsideration after the conclusion	The right of withdrawal by the policyholder is envisaged.
Termination	There are no cases, other than those provided for by the law, in which the Policyholder has the right to terminate the contract.

For whom is this product?

The insurance product is intended for active employees of the UniCredit Group with Italian contracts, provided such employees are registered with Uni.C.A., who intend to obtain reimbursement of health expenses incurred as a result of an accident or illness.

What costs must I incur?

There are no additional costs for the policyholder.

HOW CAN I SUBMIT COMPLAINTS AND RESOLVE DISPUTES?

To the insurance company	Any complaints regarding the contract or an insurance service must be submitted in writing to the Complaints Office of RBM Assicurazione Salute S.p.A. in one of the following ways: - by filling out a specific e-mail form, available on the Company's website www.rbmsalute.it in the complaints section, which can be filled out directly online; - by ordinary or registered mail addressed to RBM Assicurazione Salute S.p.A. - Ufficio Reclami - Sede Legale - Via E. Forlanini 24 - 30122 Preganziol (TV) - loc. Borgo Verde; - by fax to the number +39 0422/062909; - by e-mail to the e-mail address reclami@rbmsalute.it. If the e-mail form is not used, it is necessary to indicate the following items in the complaint so that the position can be correctly identified and the case file promptly processed in order to provide a clear and complete answer: - name, surname, domicile and date of birth of the Insured; - name, surname, domicile of the person submitting the complaint, if different from the Insured (e.g. consumer association, lawyer, family member, etc.), with proxy to submit the complaint signed by the Insured and copy of the relative identity document; - case file number; - brief and exhaustive description of the facts and the reasons for the complaint. Requests for information or clarifications, compensation for damages or performance of the contract are not considered complaints. RBM Assicurazione Salute will send a reply to the complaint within 45 days from the date of receipt thereof.
To the IVASS [Insurance Supervisory Authority]	In the event of an unsatisfactory outcome or a late reply, you can contact the IVASS, Via del Quirinale, 21 - 00187 Roma, fax +39 06.42133206, certified e-mail: **ivass@pec.ivass.it**. Information at: **www.ivass.it**
BEFORE APPLYING TO THE JUDICIAL AUTHORITY, alternative dispute resolution systems can be used, such as:	
Mediation	It is mandatory to consult a Mediation Body among those found in the list of the Ministry of Justice available on the website **www.giustizia.it** (Law No. 98 of 9 August 2013).
Assisted negotiation	By request of your lawyer to the Company.
Other alternative dispute resolution systems	For the resolution of cross-border disputes, you may lodge a complaint with the IVASS directly or with the competent foreign system requesting the activation of the FIN-NET procedure or the applicable legislation.

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UniC.A. Healthcare Coverage - **Assistance** Fund for the UNICREDIT S.p.A. GROUP

Insurance Contract for the reimbursement of medical expenses due to illness and accident for Active Personnel – NUOVA PLUS HEALTHCARE PLAN

Insurance Contract for the reimbursement of medical expenses due to illness and accident prepared according to the Guidelines issued by ANIA [National Association of Insurance Companies] at the outcome of the “Simple and Clear Contracts” Technical Panel (6 February 2018)

CONDITIONS OF INSURANCE

Read the conditions of insurance carefully before signing

FORM FI0856
Edition 1 January 2020

RBM Assicurazione Salute S.p.A. - Sole Shareholder

RBM ASSICURAZIONE SALUTE S.p.A. - Socio Unico
Capitale Sociale € 160.000.000 i.v. - C.C.I.AA. di TV C.F./P. IVA 05796440963 - R.E.A. 360145
Impresa Iscritta al numero 1.00161 dell’Albo delle imprese di assicurazione, autorizzata all’esercizio delle Assicurazioni con Prowedimento ISVAP n. 2556 del 17/10/2007 (G.U. 02/11/2007 n. 255).

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In accordance with Article 166 of the Insurance Code (Legislative Decree No. 209 of 7 September 2005) and the Guidelines issued by the ANIA [National Association of Insurance Companies] at the outcome of the "Simple and Clear Contracts" Technical Panel (6 February 2018), the forfeitures, nullities, limitations of guarantees and charges bearing on the Policyholder or Insured, contained in this contract, are shown in "underlined and bold" characters.

Section I

GLOSSARY

Company	RBM Assicurazione Salute S.p.A.
Policyholder	Uni.C.A. Cassa Assistenza, registered with the Registry of Health Funds.
Insured	The person in whose favour the insurance is provided.
Claim	The harmful event for which insurance is provided.
Insurance	The insurance contract.
Premium	The sum owed by the Policyholder.
Indemnification or Indemnity	The sum owed by the Company to the Insured in the event of a claim through the Policyholder.
Healthcare Facility	Any medical institution, institute, hospital in Italy or abroad, duly authorised according to the legal requirements and by the competent authorities to provide hospital-based healthcare.
Affiliated Healthcare Facility	Any medical institution, institute, hospital – as defined above – included in the service under affiliation agreement with Cassa Uni.C.A.
Surgical Team	The group consisting of the surgeon, the junior surgeon, the assistant surgeon, the anaesthesiologist and any other person who has an active part in the surgical procedure.
Affiliated Surgical Team	Every surgical team – as defined above – included in the service under affiliation agreement with Cassa Uni.C.A.
Nursing Care	Professional nursing care provided by personnel holding a specific diploma.
Hospitalisation	The stay involving an overnight stay in a Healthcare Facility.
Day Hospital	The stay in a medical facility that normally ends on the same day following medical treatment or surgical services.
Outpatient Surgery	Surgery without hospitalisation.
Severe Morbid Events	The events listed in the specific section of the policy (Annex 3).
Long-term Stay	Medical hospitalisation in rehabilitation stay for the recovery and/or improvement of the Insured's physical conditions through medical and/or physiotherapy treatments with stay at long-term stay Healthcare Facilities (e.g. nursing homes), or wards of long-term stay healthcare facilities; therefore, excluding cases of long-term stay hospitalisation in which the Insured's physical conditions are such that healing cannot be achieved with medical treatment and the stay in a medical facility is necessitated by essentially maintenance care or physiotherapy measures.
Ceiling	The maximum amount indemnifiable by the Company, in the event of a surgical procedure reported in the Table "List of surgical procedures with ceilings".
Deductible Sum	For the guarantees that reimburse the expenses incurred by the Insured, it is the sum determined as a fixed amount, deducted from the expenses actually incurred and indemnifiable under the terms of the contract, to be borne by the Insured.

	For the guarantees that provide for the payment of an indemnity for each hospitalisation day, it is the number of days for which the indemnity is not paid to the Insured.
Percentage Excess	The sum expressed in percentage value, deducted from the expenses actually incurred and indemnifiable under the terms of the contract, to be borne by the Insured.
Plaster Cast	A fixed and rigid means of immobilisation consisting of plastered bands or of bandages or of other apparatus that completely immobilises a skeletal joint or segment and that cannot be removed independently.
Accident	The event due to a fortuitous, violent and external cause that produces objectively ascertainable bodily injuries.
Disease	Any alteration of the state of health not due to accident.
Cancer Disease	Any disease determined by the presence of a benign or malignant neoplasm, including leukaemias, lymphomas, Hodgkin's disease, in situ cancer. Tumours with direct invasion of nearby organs, in the metastatic phase and relapses, are also included.
Family Nucleus	The entire family nucleus as defined in Clause 9.1 "Insurable Persons" of the Conditions of Insurance (hereinafter also referred to as the COI).
Medical Record:	an official document having the nature of a public deed, drawn up during the stay, whether daytime or overnight, in a medical facility, containing the patient's full personal details, admission diagnosis and discharge diagnosis, past and recent medical history, treatments carried out, surgeries performed, examinations and clinical diary, the Hospital Discharge Form (HDF).
Fund	Uni.C.A Cassa Assistenza, with registered office at Via San Protaso 1, Postcode 20121 – MILAN Tax Code 97450030156, entity with welfare purposes and authorised by law, also in accordance with Article 51 of Presidential Decree No. 917/1986, to receive the contributions and to be the policyholder of the health scheme for tax and contributory purposes.
Medical Centre	a facility, also not intended for hospitalisation, not aimed at treating aesthetic problems, organised, equipped and regularly authorised based on the current legislation to provide particularly complex diagnostic or therapeutic health services (instrumental diagnostic tests, laboratory tests, electromedical equipment use, physiotherapy and rehabilitation treatments) and with a medical management office.
Acoustic Prosthesis (Hearing Aid)	a wearable external electronic device with the function of amplifying and/or modifying the sound message in order to qualitatively and quantitatively correct the hearing deficit resulting from morbid events, having a clinical stabilisation nature.
Orthopaedic Prostheses	artificial replacement of part of the body's limbs (therefore excluding, for example, orthoses, i.e. braces, corsets, knee braces, orthotics).
Physiotherapy and Rehabilitation Treatments	physical and rehabilitation medical services performed by a physician or a professional with a degree in physiotherapy or an equivalent qualification recognised in Italy, carried out exclusively at Medical Centres, aimed at enabling recovery of the functions of one or more organs or apparatuses affected by illness or accident indemnifiable under the policy terms. In any case, this coverage excludes all services aimed at treating aesthetic problems, as well as services performed with instruments used predominantly in the field of aesthetic medicine.
Specialist Examination	the healthcare service, performed by a physician with a specialisation, for diagnoses and prescriptions of treatments pertaining to the field of that

	specialisation. Only conventional medicine examinations are allowed. Those performed by physicians specialised in general medicine are not considered specialist examinations.
Previmedical Authorised Centre	a centre belonging to the Network of affiliated facilities that participates in specific promotional initiatives of RBM Assicurazione Salute. The list of RBM Assicurazione Salute Authorised Centres is available at the website www.rbmsalute.it.
Direct form/In-Network	services under affiliation agreement with facilities / specialists included in the service under affiliation agreement with Cassa Uni.C.A. with direct payment by the Company to the affiliated facilities / specialists of the amounts owed for the services received by the Insured.
Indirect form/Out-of-Network:	services at facilities / specialists not included in the service under affiliation agreement with Cassa Uni.C.A. or at facilities / specialists included in the service under affiliation agreement with Cassa Uni.C.A., but for which the Insured did not follow the procedures required for access to In-Network services.

CHAPTER 1 – GENERAL INFORMATION

1. General information on the insurance company

RBM ASSICURAZIONE SALUTE S.p.A. (hereinafter referred to in short also as RBM Salute S.p.A.); Registered office and general headquarters: Via Forlanini 24, 31022 Borgo Verde - Preganziol, Treviso (Italy) / Secondary establishment: Via Victor Hugo 4, 20123 Milan (Italy);

Telephone numbers: +39 0422 062700 (registered office and general headquarters) / +39 02 91431789 (secondary establishment); website: www.rbmsalute.it; e-mail address: info@rbmsalute.it; certified e-mail address: rbmsalutespa@pec.rbmsalute.it;

RBM ASSICURAZIONE SALUTE S.p.A. is registered under number 1.00161 of the Register of Insurance Companies, authorised to exercise Insurance activities by the ISVAP Measure No. 2556 of 17/10/2007 (O.J. No. 255 of 2/11/2007).

2. Information on the company's equity position[1]

Equity figures as at 31 December 2018

Shareholder's equity:	EUR 230,873,414.00
of which	
- share capital:	EUR 120,000,000.00
- total of the equity reserves:	EUR 73,765,532.00
Solvency index[2]:	175% (189% net of the capital add-on)

3. Contractual waiting periods

The policy **does not provide for waiting periods** (during which coverage is not active).

4. Adjustment of the premium and the insured sums

The insured sums and the premiums are not indexed.

5. Right of withdrawal

The right of withdrawal by the Policyholder / Insured is envisaged.

6. Lapse and forfeiture of the rights deriving from the contract

In accordance with Article 2952 of the Civil Code, the right to payment of the premium instalments lapses in one year from the individual deadlines. The other rights deriving from the insurance contract lapse in two years from the day on which the fact on which the right is based occurred.

7. Complaints

Any complaints regarding the contract or an insurance service must be submitted in writing to the Company in one of the following ways:

[1] The equity figures (shareholders' equity, share capital, reserves and solvency index) are updated annually following the approval of the Company's financial statements. To view them, please refer to the website www.rbmsalute.it ("Informazioni Societarie" [Corporate Information] section).

[2] The solvency index represents the ratio between the amount of the available solvency margin and the amount of the solvency margin required by current legislation.

- by filling out a specific e-mail form, available on the Company's website www.rbmsalute.it in the complaints section, which can be filled out directly online;
- by ordinary or registered mail addressed to RBM Assicurazione Salute S.p.A. - Ufficio Reclami - Sede Legale - Via E. Forlanini 24 - 30122 Preganziol (TV) - loc. Borgo Verde;
- by fax to the number 0422/062909;
- by e-mail to the e-mail address reclami@rbmsalute.it.

If the e-mail form is not used, it is necessary to indicate the following items in the complaint so that the position can be correctly identified and the case file promptly processed in order to provide a clear and complete answer:

- name, surname, domicile and date of birth of the Insured;
- name, surname, domicile of the person submitting the complaint, if different from the Insured covered by the policy (e.g. consumer association, lawyer, family member, etc.), with proxy to submit the complaint signed by the Insured and copy of the relative identity document;
- case file number;
- brief and exhaustive description of the facts and the reasons for the complaint.

Requests for information or clarifications, compensation for damages or performance of the contract are not considered complaints.

RBM Assicurazione Salute will send a reply to the complaint within 45 days from the date of receipt thereof.

If the complainant is not satisfied with the reply received, or if the complainant does not receive a reply within 45 days from the submission of the complaint, before applying to the Judicial Authority, the complainant may:

- address the IVASS, Via del Quirinale 21 - 00187 Roma, fax 06.42133206, certified e-mail: ivass@pec.ivass.it. Information at: www.ivass.it
- resort to the mandatory mediation procedure in accordance with Legislative Decree No. 28/2010 for disputes concerning insurance contracts, by addressing a Mediation Body – chosen at his or her sole discretion – accredited with the Ministry of Justice;
- resort to the other alternative systems in force for the resolution of disputes.

The right to apply to the Judicial Authority remains unaffected in any case.

As regards disputes concerning the quantification of the services and the attribution of the liability, please note again that, in addition to the right to resort to any existing conciliation systems, the exclusive jurisdiction of the Judicial Authority holds firm.

For the resolution of the cross-border dispute to which he or she is a party, the complainant with domicile in Italy can submit the complaint to the IVASS or directly to the competent foreign system – identifiable by accessing the website http://www.ec.europa.eu/fin-net – requesting activation of the FIN-NET procedure.

In the event of a dispute brought against Uni.C.A. – Cassa di Assistenza by an Insured in respect of whom the Company has decided that the indemnity is not owed under the conditions of the guarantees given with this policy, the Company, upon request of Uni.C.A. – Cassa di Assistenza, undertakes to handle the dispute on its behalf, both in and out of court, paying all charges and bearing the indemnity in addition to the expenses, fees and anything else owed by virtue of the judgment, should it be owed at the outcome of the dispute.

CHAPTER 2 – CONDITIONS OF INSURANCE

8.1 Declarations on the circumstances of the risk

The Company gives its consent to the insurance and determines the premium solely based on the statements made by the Policyholder and/or the Insured on the data and circumstances covered by a request of the Company and resulting from the contractual documents.

Any inaccuracy and reticence of the Policyholder and/or the Insured relating to the circumstances that affect the risk assessment may result in the total or partial loss of the indemnity, as well as in the termination of the insurance, in accordance with Articles 1892, 1893 and 1894 of the Civil Code. In this event, the Company is entitled, in addition to the

overdue and unpaid premium instalments, to the overall premium relating to the insurance year in progress when the circumstance that caused the termination occurred.

8.2 Effective date of the Insurance

The insurance takes effect as of zero hundred hours on 1 January 2020, if the premium or the first premium instalment has been paid; otherwise, it takes effect as of zero hundred hours of the day following the payment and it will expire at twenty-four hundred hours on 31 December 2021.

8.3 Policyholder's obligations to deliver documents

Before a subscription to the insurance coverage, the Policyholder is obliged to make the following documents available to the Insured, also through remote communication means:

a) Subscription Request
b) Privacy Policy (consent to the processing of personal data),
c) Conditions of Insurance.

A copy of the Subscription Request and the Privacy Policy, both signed by the Insured, also in electronic form, must be retained by the Policyholder, which undertakes to deliver it promptly to the Company should it make a request to this effect.

8.4 Subscription to the coverage – Changes in the Insured persons

The insurance is provided for the Insured persons with residence in Italy, employees and their relative family members as identified in the definition of family nucleus, which the Policyholders must indicate:

- by 28 February 2020 for active employees;
- by 30 April 2020 for long-term absent or redundant active employees.

Once these deadlines have passed, changes in the Insured persons will not be possible, subject to the exceptions indicated below.

1) Inclusion during the year

An inclusion after the aforementioned dates is allowed only in the following cases:

a) new recruitment;
b) return to Italy of a previously expatriate UniCredit employee (former Expat), starting from the day of return, or, if later, from the day following the end of the coverage provided for expatriated employees;
c) birth, adoption or fostering of a child;
d) marriage;
e) emergence of cohabitation for the more uxorio cohabitant and/or family member;
f) exclusion of a family member from another coverage for reimbursement of healthcare expenses entered into by the employer.

In such cases, the insurance takes effect as of twenty-four hundred hours on the date of the event resulting from a registry certification and provided it is communicated by written notice to be sent to the Company within 90 days from the aforementioned date.

For inclusions made during the insurance period and that involve the payment of a premium, such premium will be calculated to the extent of:

- - 100% of the annual premium, if the inclusion occurs in the first half of the insurance period;
- - 60% of the annual premium, if the inclusion occurs in the second half of the insurance period.

2) Termination of the coverage during the year

Termination of the coverage before its natural expiry on 31 December 2021 is possible only if the following events occur:

a) termination of the employee's employment relationship;

b) death of the employee or an insured family member;

c) divorce / separation by virtue of a judgment for the employee's spouse;

d) termination of the cohabitation for the more uxorio cohabiting partner and/or non-dependent family member; in the case of a non-dependent child, termination of the coverage is only possible if one of the two cases also occurs:

- the child establishes his or her own family nucleus (marriage / more uxorio cohabitation);
- the child achieves a total income exceeding EUR 26,000 gross per year in the tax year in which he or she leaves the nucleus;

e) subscription of a family member to another coverage for reimbursement of healthcare expenses entered into by the employer;

f) reaching the age of 85, subject to the possibility of maintaining coverage under the terms set forth in Clause 9.9 "Age limit";

g) exclusion of the employee resolved under the Articles of Association and Regulations by the Policyholder's Board of Directors.

In the cases under points a), c), d), e) and f), the insurance will cease to be valid on the first annual expiry date following the occurrence of the event.

In the event of termination of the employee's employment relationship (except for dismissals for just cause and justified subjective reason or terminations with the establishment of an employment relationship with a Company outside the UniCredit Group), the employee and any insured family members will remain under coverage until the first annual expiry date following the event.

In the event of death of the active employee, any insured family members will remain under coverage until the first annual expiry date following the event.

In the event of exclusion of the employee resolved under the Articles of Association and Regulations by the Policyholder's Board of Directors, the coverage of the employee and any insured family members will cease immediately upon occurrence of the event.

There will be no reimbursement of the premium in all aforementioned cases.

3) Change in the coverage during the year

The following changes may occur during the coverage period.

a) Management of the tax burdens:

the Insured must communicate the tax burden in each year based on the income situation of the Insured's member consolidated in the previous year. Therefore, any changes in the income situation of the Insured's family member during the year will not affect the determination of the premium for the current year, but will only be the basis for determining the premium in the following year.

b) Attribution of the position of Manager to an employee during the year or, for employees who are already Managers, in the event of assignment to another Global Bandi Title and vice versa:

the Insured remains included in the insurance until the end of the year in which the change in the professional position occurred.

As of 1 January of the following year, the Insured will be subject to the conditions set by the "Insurance Plan" relating to the new professional position / Global Bandi Title for the Managers. The Insured, through the Policyholder, has the option of including the employee's family members referred to in Clause 9.1 "Insurable Persons", points 1) to 5) in the insurance.

c) Termination of the employment relationship due to retirement;

in the event of the employee's retirement, the insurance remains in force until the end of the year in which the termination of the employment relationship occurred.

d) Change for an already insured family member in the status of cohabitation / non-cohabitation resulting from the family status certificate:

the change in the cohabitation status for an already insured family member during an insurance year does not affect the premium owed for the year in which the change occurred.

e) Change from more uxorio cohabitant to spouse:

in the event of a marriage during an insurance year with an already insured more uxorio cohabitant, the change will not affect the premium owed for the year in which the marriage occurred.

8.5 Tax charges

The Policyholder will bear the tax charges related to the Insurance.

8.6 Referral to the law

The insurance is governed by Italian law. All matters not expressly regulated by this contract are subject to the provisions of law.

It is understood that should legislative changes occur that require amendments to the contractual conditions, the Parties will meet to define the new insurance terms.

8.7. Court with jurisdiction

Without prejudice to the Parties' right to resort to any existing conciliation systems, the Judicial Authority with jurisdiction for resolving disputes arising from this Contract is identified as follows:

- for any dispute between the Company and the Policyholder, jurisdiction lies with the Judicial Authority of the place of the Policyholder's registered office;

- for any dispute between the Company and the Insured, jurisdiction lies with the Judicial Authority of the place of residence or domicile of the Insured or the beneficiary.

8.8 Disputes

In accordance with Legislative Decree No. 28/2010 and subsequent amending and supplementing provisions, any dispute relating to this contract or connected therewith – including disputes relating to its interpretation, validity, performance and termination – must be first submitted to a mediation procedure before a Mediation Body that is registered in the specific register established at the Ministry of Justice and that has its registered office in the place of the Judicial Authority with territorial jurisdiction over the dispute.

The execution of the mediation attempt is a condition for admissibility of the judicial application.

If the dispute is not settled in the context of the mediation, the Parties will be free to apply to the Judicial Authority with jurisdiction for resolving disputes arising from this contract, identified according to the provisions of Clause 8.7 "Court with jurisdiction".

Section II

CHAPTER 1 – INSURANCE RULES ON THE REIMBURSEMENT OF HEALTHCARE EXPENSES

9.1 Insurable persons

The Insurance is provided for active employees of the UniCredit Group with Italian contracts, provided such employees are registered with Uni.C.A..

The Insurance covers also the family members specified below:

- free of charge, for the dependent spouse and children;
- with payment of the related premium for:

1) the non-dependent spouse or the "more uxorio" cohabitant (the latter as long as resulting from the family status certificate);
2) the non-dependent children resulting from the family status certificate, to whom the non-dependent children resulting on the family status certificate of the other separated or divorced parent are equated;
3) the other family members resulting from the family status certificate including only the children of the spouse / more uxorio cohabitant;
4) non-dependent and non-cohabitant children who have not turned 35 on the date of inclusion in the coverage, not married and not cohabitating more uxorio (with a total income limit of EUR 26,000 gross per year);
5) non-cohabitant parents over the age of 60 (with a total income limit of EUR 26,000 gross per year).

In cases 1), 2) and 3), the inclusion must involve all persons resulting from the family status certificate (except for those who already benefit from another form of health care organised by their employer for whom the exemption from the aforementioned obligation is requested).

In the event of assignment to a new place of work, if the insured active employee moves to the new place without the entire family nucleus, the Insurance will nevertheless continue to be effective for the insured persons who did not make the move.

The spouse, also legally and actually separated, can always be included in the guarantee, even if he or she has a different domicile and/or residence from the insured active employee.

Should Insured persons subscribe to this insurance during the validity of the contract – as long as expressly allowed by the Conditions of Insurance (e.g. marriage, new births, etc.), the annual coverage cap for each family nucleus applies.

The Insurance is valid:

- regardless of the Insured's physical conditions;

- without territorial limitations;

- until the end of the year (31 December) in which the Insured's 85th birthday took place, except as established by Clause 9.9 "Age limit".

9.2 Scope of the insurance

The Company guarantees the following services, provided they are consequent to accident, illness or childbirth, indemnifiable under the terms of the contract for the expenses incurred by the Insured, whether directly or indirectly (in the affiliated network or in application of the reimbursement scheme), who has subscribed to the NUOVA PLUS Collective Health Plan.

NUOVA PLUS OPTION

9.3 HOSPITALISATION AREA

The Company guarantees the direct payment or reimbursement of the services indicated below, up to a maximum amount of **EUR 150,000.00** per family nucleus and per insurance year. Subject to the application of any percentage excesses or deductible sums envisaged by the individual services.

The aforementioned coverage cap is raised to **EUR 300,000.00** only in the cases of the surgeries reported in the list "Major Surgical Procedures" set out below.

In addition, in the event of a surgery reported in the specific Table "List of surgical procedures with ceilings", the Company reimburses the expenses incurred up to the maximum amount indicated in the aforementioned Table, subject to application of any envisaged percentage excesses or deductible sums.

The reimbursement sub-limits referred to in the Table "List of surgical procedures with ceilings" refer exclusively to the expenses incurred during the hospitalisation period involving the surgery. Any percentage excesses or deductible sums envisaged for the individual services will be applied only once on the total amount of expenses incurred for the hospitalisation with surgery, considering as such: the expense incurred for the hospitalisation, and any health services incurred before and after the surgery within the timeframes set forth in this Clause 9.3 "Hospitalisation area".

Where the hospitalisation includes more than one surgery that can be identified in the Table "List of surgical procedures with ceiling", the Company will pay 100% of the indemnity up to the maximum amount of the ceiling for the main surgery (defined as such by the surgeon) and 70% of the indemnity up to the maximum amount of the ceilings for the secondary surgeries, subject to application of any envisaged percentage excesses or deductible sums.

A- SERVICES RELATED TO HOSPITALISATION IN A MEDICAL INSTITUTION

1) In the event of **hospitalisation with surgery**, the Company reimburses the expenses relating:

1.1 to the medical team fees, operation theatre fees, surgical material, including the endoprostheses necessary for the recovery of the Insured's autonomy, related to the period of hospitalisation with surgery;

1.2 to the medical and nursing care, medical and specialist consultancies, treatments, diagnostic investigations, as well as to the health recovery services such as physiotherapy and rehabilitation treatments, medicines, all carried out during the hospitalisation period;

1.3 to the stay charges:

- without any daily limitation for hospitalisation made in direct form (in this case both the medical institution and the medical team must be affiliated);

- up to the maximum amount **EUR 300.00** daily for any other hospitalisation made in indirect form.

Expenses on luxuries are excluded in any case;

1.4 diagnostic investigations and physician fees for specialist examinations, carried out in the **100** days before the hospitalisation;

1.5 to the diagnostic investigations, medicines, medical, surgical and nursing services, as well as to the health recovery services such as treatments, including thermal treatments (excluding hotel expenses), carried out in the **100** days following the end of the hospitalisation and made necessary by the event that led to that hospitalisation;

1.6 to the health recovery services such as physiotherapy and rehabilitation treatments, carried out in the **120** days following the end of the hospitalisation and made necessary by the event that led to that hospitalisation;

1.7 to the individual private nursing care;

1.8 in the event of transplantation, the expenses incurred for explantation from a donor are understood to be included.

2) In the event of **hospitalisation without surgery (medical hospitalisation)**, the Company reimburses expenses, up to a maximum limit of **five** hospitalisation days for a maximum of **three** hospitalisations per year / person, relating:

2.1 to the medical and nursing care, medical and specialist consultancies, treatments, diagnostic investigations, as well as to the health recovery services such as physiotherapy and rehabilitation treatments, medicines, all carried out during the hospitalisation period;

2.2 to the stay charges:

- without any daily limitation for hospitalisation made in direct form (in this case both the medical institution and the medical team must be affiliated);

- up to the maximum amount **EUR 300.00** daily for any other hospitalisation made in indirect form.

Expenses on luxuries are excluded in any case;

2.3 diagnostic investigations and physician fees for specialist examinations, carried out in the **100** days before the hospitalisation;

2.4 to the diagnostic investigations, medicines, medical, surgical and nursing services, as well as to the health recovery services such as physiotherapy and rehabilitation treatments, including thermal treatments (excluding hotel expenses), carried out in the **100** days following the end of the hospitalisation and made necessary by the event that led to that hospitalisation;

2.5 to the individual private nursing care, up to **EUR 50.00** per day for a maximum of five days per event, in the event of hospitalisation without surgery.

3) In the event of **hospitalisation under the Day Hospital scheme with surgery**, the Company reimburses the expenses relating:

3.1 to the team fees, operation theatre fees, surgical material, including the endoprostheses necessary for the recovery of the Insured's autonomy;

3.2 to the medical and nursing care, medical and specialist consultancies, treatments, diagnostic investigations, as well as to the health recovery services such as physiotherapy and rehabilitation treatments, medicines, all carried out during the hospitalisation period;

3.3 to the stay charges:

- without any daily limitation for hospitalisation made in direct form (in this case both the medical institution and the medical team must be affiliated);

- up to the maximum amount **EUR 250.00** daily for any other hospitalisation made in indirect form.

Expenses on luxuries are excluded in any case;

3.4 diagnostic investigations and physician fees for specialist examinations, carried out in the **100** days before the hospitalisation;

3.5 to the diagnostic investigations, medicines, medical, surgical and nursing services, as well as to the health recovery services such as treatments, including thermal treatments (excluding hotel expenses), carried out in the **100** days following the end of the hospitalisation and made necessary by the event that led to that hospitalisation;

3.6 to the health recovery services such as physiotherapy and rehabilitation treatments, carried out in the **120** days following the end of the hospitalisation and made necessary by the event that led to that hospitalisation;

3.7 to the individual private nursing care.

4) In the event of **hospitalisation under the Day Hospital scheme without surgery**, the Company reimburses the expenses relating:

4.1 to the medical care, medical and specialist consultancies, treatments, diagnostic investigations, medicines, all carried out during the hospitalisation period;

4.2 to the stay charges:

- without any daily limitation for hospitalisation made in direct form (in this case both the medical institution and the medical team must be affiliated);

- up to the maximum amount **EUR 250.00** daily for any other hospitalisation made in indirect form.

Expenses on luxuries are excluded in any case;

4.3 diagnostic investigations and physician fees for specialist examinations, carried out in the **100** days before the hospitalisation;

4.4 to the diagnostic investigations, medicines, medical, surgical and nursing services, as well as to the health recovery services such as physiotherapy and rehabilitation treatments, including thermal treatments (excluding hotel expenses), carried out in the **100** days following the end of the hospitalisation and made necessary by the event that led to that hospitalisation;

5) In the event of **outpatient surgery**, the Company reimburses the expenses relating:

5.1 to the team fees, any operation theatre fees, surgical material;

5.2 to the medical and nursing care, medical and specialist consultancies, treatments, diagnostic investigations, health recovery services such as physiotherapy and rehabilitation treatments, medicines, all carried out during the hospitalisation period;

5.3 to the diagnostic investigations and physician fees for specialist examinations, carried out in the **100** days before the surgery;

5.4 to the diagnostic investigations, medicines, medical, surgical and nursing services, health recovery services such as treatments, including thermal treatments (excluding hotel expenses), carried out in the **100** days following the end of the hospitalisation and made necessary by the event that led to that hospitalisation;

5.5 to the health recovery services such as physiotherapy and rehabilitation treatments, carried out in the **120** days following the end of the hospitalisation and made necessary by the event that led to that hospitalisation;

6) In the event of **caesarean section / therapeutic abortion**, the Company reimburses the expenses relating:

6.1 to the team fees, delivery room fees, surgical material;

6.2 to the medical and nursing care, medical and specialist consultancies, treatments, diagnostic investigations, medicines, all carried out during the hospitalisation period;

6.3 to the stay charges without any daily limitation. Expenses on luxuries are excluded in any case;

6.4 to the (nursery) stay charge, diagnostic investigations, medical and nursing care provided during the hospitalisation (all relating to the newborn). The services are reimbursed within the sub-limit of **EUR 1,000.00** per year and per nucleus;

6.5 diagnostic investigations and physician fees for specialist examinations, carried out in the **100** days before the hospitalisation;

6.6 to the diagnostic investigations, medicines, medical, surgical and nursing services, as well as to the health recovery services such as treatments, including thermal treatments (excluding hotel expenses), carried out in the **100** days following the end of the hospitalisation and made necessary by the event that led to that hospitalisation;

6.7 to the health recovery services such as physiotherapy and rehabilitation treatments, carried out in the **120** days following the end of the hospitalisation and made necessary by the event that led to that hospitalisation;

6.8 to the obstetric care (during the hospitalisation period and in the days before and after the hospitalisation). The services are reimbursed within the sub-limit of **EUR 1,500.00** per year and per nucleus;

The expenses referred to in points 6.1, 6.2, 6.3 and 6.4 are reimbursed up to a maximum limit of **EUR 6,000.00** per nucleus and per year.

7) In the event of **natural childbirth**, the Company reimburses the expenses relating:

7.1 to the team fees, delivery room fees;

7.2 to the medical, nursing and obstetric care, medical and specialist consultancies, treatments, diagnostic investigations, medicines, all carried out during the hospitalisation period;

7.3 to the stay charges without any daily limitation. Expenses on luxuries are excluded in any case;

7.4 to the (nursery) stay charge, diagnostic investigations, medical and nursing care provided during the hospitalisation (all relating to the newborn). The services are reimbursed within the sub-limit of **EUR 1,000.00** per nucleus and per year;

7.5 to the diagnostic investigations and fees for specialist and obstetric examinations, carried out in the **100** days before the hospitalisation;

7.6 to the diagnostic investigations, medicines, medical, surgical, nursing and obstetric services, treatments, carried out in the **100** days following the end of the hospitalisation and made necessary by the childbirth.

The expenses referred to in points 7.1, 7.2, 7.3 and 7.4 are reimbursed up to a maximum limit of **EUR 3,000.00** per nucleus and per year.

8) In the event of **dental surgery** (maxillary osteites, bone neoplasms of the mandible or maxilla, follicular or radicular cysts, adamantinoma and odontoma), the Company reimburses expenses related:

8.1 to the specialist physician fees, dental implantology, treatments, diagnostic investigations, medicines, all relating to the surgery;

8.2 to the diagnostic investigations and physician fees for specialist examinations, carried out in the **100** days before the surgery;

8.3 to the stay charges:

- without any daily limitation for hospitalisation made in direct form (in this case both the medical institution and the medical team must be affiliated);

- up to a maximum amount of **EUR 300.00** per day, for all other hospitalisations made in indirect form (the amount is reduced to **EUR 250.00** per day in the event of hospitalisation under the Day Hospital scheme). Expenses on luxuries are excluded in any case;

8.4 to the diagnostic investigations, medicines, medical, surgical and nursing services, treatments, carried out in the **100** days following the surgery and made necessary by that surgery.

The expenses referred to in points 8.1, 8.2, 8.3 and 8.4 are reimbursed up to a maximum limit of **EUR 10,000.00** per nucleus and per year.

The medical documentation required to obtain reimbursement of the expenses incurred consists:

- of X-rays and X-ray medical reports for maxillary osteites, follicular cysts, radicular cysts, adamantinoma, odontoma;
- of medical reports attesting to the bone neoplasms of the mandible and/or maxilla.

9) In the event of **myopia** with a differential between the eyes greater than **4** dioptres (provided it is not caused by previous corrective intervention) or a defect in the visual capacity of an eye equal to or greater than **8** dioptres, the Company reimburses expenses relating:

9.1 to the refractive surgery and excimer laser treatments, team fees, operation theatre fees, surgical material;

9.2 to the medical and nursing care, medical and specialist consultancies, treatments, diagnostic investigations, medicines, all carried out during the hospitalisation period;

9.3 to the stay charges:

- without any daily limitation for hospitalisation made in direct form (in this case both the medical institution and the medical team must be affiliated);

- up to a maximum amount of **EUR 300.00** per day, for all other hospitalisations made in indirect form (the amount is reduced to **EUR 250.00** per day in the event of hospitalisation under the Day Hospital scheme);

Expenses on luxuries are excluded in any case;

9.4 to the diagnostic investigations and physician fees for specialist examinations, carried out in the **100** days before the surgery;

9.5 to the diagnostic investigations, medicines, medical, surgical and nursing services, carried out in the **100** days following the surgery and made necessary by that surgery.

10) In the event of **reconstructive surgery** following a mastectomy or quadrantectomy for the related contralateral adjustment procedure, including psychological care, the Company reimburses expenses relating:

10.1 to the team fees, operation theatre fees, surgical material, including the endoprostheses necessary for the recovery of the Insured's autonomy;

10.2 to the medical and nursing care, medical and specialist consultancies, treatments, diagnostic investigations, as well as to the health recovery services such as physiotherapy and rehabilitation treatments, medicines, all carried out during the hospitalisation period;

10.3 to the stay charges without any daily limitation. Expenses on luxuries are excluded in any case;

10.4 diagnostic investigations and physician fees for specialist examinations, carried out in the **90** days before the hospitalisation;

10.5 to the diagnostic investigations, medicines, medical, surgical and nursing services, as well as to the health recovery services such as treatments, including thermal treatments (excluding hotel expenses), carried out in the **90** days following the end of the hospitalisation and made necessary by the event that led to that hospitalisation;

The expenses referred to in points 10.1, 10.2, 10.3, 10.4 and 10.5 are reimbursed up to a maximum limit of **EUR 5,000.00** per nucleus and per year.

11) In the event of **hospitalisation without surgery for post-surgery rehabilitation**, the Company reimburses the expenses relating:

11.1 to the medical and nursing care, medical and specialist consultancies, treatments, diagnostic investigations, as well as to the health recovery services such as physiotherapy and rehabilitation treatments, medicines, all carried out during the hospitalisation period;

11.2 to the stay charges:

- without any daily limitation for hospitalisation made in direct form (in this case both the medical institution and the medical team must be affiliated);

- up to the maximum amount **EUR 300.00** daily for any other hospitalisation made in indirect form.

Expenses on luxuries are excluded in any case;

11.3 diagnostic investigations and physician fees for specialist examinations, carried out in the **100** days before the hospitalisation;

11.4 to the diagnostic investigations, medicines, medical, surgical and nursing services, as well as to the health recovery services such as physiotherapy and rehabilitation treatments, including thermal treatments (excluding

hotel expenses), carried out in the **100** days following the end of the hospitalisation and made necessary by the event that led to that hospitalisation;

11.5 to the individual private nursing care, up to **EUR 50.00** per day for a maximum of **30** days per event, in the event of hospitalisation without surgery.

12) In the event of **hospitalisation without surgery for Severe Morbid Events**, listed in Annex 3, the Company reimburses the expenses relating:

12.1 to the medical and nursing care, medical and specialist consultancies, treatments, diagnostic investigations, as well as to the health recovery services such as physiotherapy and rehabilitation treatments, medicines, all carried out during the hospitalisation period;

12.2 to the stay charges:

- without any daily limitation for hospitalisation made in direct form (in this case both the medical institution and the medical team must be affiliated);

- up to the maximum amount **EUR 300.00** daily for any other hospitalisation made in indirect form.

Expenses on luxuries are excluded in any case;

12.3 diagnostic investigations and physician fees for specialist examinations, carried out in the **100** days before the hospitalisation;

12.4 to the diagnostic investigations, medicines, medical, surgical and nursing services, as well as to the health recovery services such as physiotherapy and rehabilitation treatments, including thermal treatments (excluding hotel expenses), carried out in the **100** days following the end of the hospitalisation and made necessary by the event that led to that hospitalisation;

12.5 to the individual private nursing care, up to **EUR 50.00** per day for a maximum of **30** days per event, in the event of hospitalisation without surgery.

13) In the event of **hospitalisation without surgery for Long-term Stay**, if:

- there was a hospitalisation with surgery and post-surgery rehabilitation within the context of the same hospitalisation and the total stay exceeded **30** days;

- there was a hospitalisation with surgery and further hospitalisation at another medical institute specialised in post-surgery rehabilitation and the total stay exceeded **30** days;

the Company reimburses the following expenses paid at dedicated healthcare facilities:

13.1 to the physician fees, diagnostic investigations, as well as to the health recovery services such as physiotherapy and rehabilitation treatments, medicines, all carried out during the hospitalisation period;

13.2 to the stay charges:

- without any daily limitation for hospitalisation made in direct form (in this case both the medical institution and the medical team must be affiliated);

- up to **EUR 200.00** per day for the first **six** months and **EUR 150.00** for the following months of stay, for all other hospitalisations made in indirect form. This provision applies as of the **31st** day of total stay; until the **30th** day of total stay, the provisions relating to the stay charges referred to in the hospitalisation without surgery for post-surgery rehabilitation will be applied.

Expenses on luxuries are excluded in any case.

If the rehabilitation stay is made in non-long-term stay healthcare facilities, the Company will reimburse stay charges as of the **31st** day of the total stay up to a maximum amount of **EUR 100.00** per day, for hospitalisations made both in direct and indirect form.

If there are no long-term stay healthcare facilities:

- within 50 km from the Insured's residence / domicile;

- or, if the hospitalisation with surgery and post-surgery rehabilitation took place in another city than the city of residence / domicile and the Insured decides to continue the hospitalisation in the same city, within **50 Km** from where the healthcare facility in which the aforementioned hospitalisation took place is located,

the provisions referred to in point 13.2 stay charges of the hospitalisation without surgery for long-term stay will be applied.

B- PERCENTAGE EXCESS

The payment of the expenses referred to in letter A above is made as follows.

Hospitalisation made in direct form

Settlement will be made as follows:

letter A, points 1), 2), 3), 4), 8) 9), 11), 12) and 13): application of a deductible sum of **EUR 200.00** per hospitalisation;

letter A, point 5): application of a deductible sum of **EUR 100.00** per event;

letter A, points 6) and 7): no deductible sum is applied;

letter A, point 10): application of a deductible sum of **EUR 1,000.00** per hospitalisation;

The aforementioned deductible sums, where applicable, also apply to the healthcare services before and after the hospitalisation where they are not carried out under the direct affiliation scheme.

No deductible sum is applied in the event of surgery included in the "List of Major Surgical Procedures".

Hospitalisation made in indirect form

Settlement will be made as follows:

letter A, points 1), 2), 11), 12) and 13): application of a percentage excess of **10%** with a minimum of **EUR 1,500.00** per hospitalisation;

letter A, points 3), 4) and 9): application of a percentage excess of **10%** with a minimum of **EUR 1,000.00** per hospitalisation;

letter A, point 5): application of a percentage excess of **10%** with a minimum of **EUR 500.00** per surgery;

letter A, points 6) and 7): no percentage excess is applied;

letter A, points 8) and 10): application of a percentage excess of **20%** with a minimum of **EUR 1,000.00** per surgery.

No percentage excess or deductible sum is applied in the event of surgery included in the "List of Major Surgical Procedures". However, where the aforementioned major surgical procedures are performed in indirect form in the healthcare facilities indicated in the "List of TOP Clinics", but with non-affiliated operating teams, the percentage excesses and/or deductible sums provided for in this paragraph will apply.

Hospitalisations made in indirect form in affiliated healthcare facilities (excluding those indicated in the "List of TOP Clinics") and with affiliated operating teams

Therefore, settlement will be made as follows:

letter A, points 1), 2), 11), 12) and 13): application of a percentage excess of **15%** with a minimum of **EUR 2,250.00** per hospitalisation;

letter A, points 3), 4) and 9): application of a percentage excess of **15%** with a minimum of **EUR 1,500.00** per hospitalisation;

letter A, point 5): application of a percentage excess of **15%** with a minimum of **EUR 750.00** per surgery;

letter A, points 6) and 7): no percentage excess is applied;

letter A, points 8) and 10): application of a percentage excess of **30%** with a minimum of **EUR 1,500.00** per surgery.

Hospitalisations made in indirect form in the affiliated healthcare facilities indicated in the "List of TOP Clinics" and with affiliated operating teams, also in the event of surgery included in the "List of Major Surgical Procedures"

Therefore, settlement will be made as follows:

letter A, points 1), 2), 11), 12) and 13): application of a percentage excess of **20%** with a minimum of **EUR 3,000.00** per hospitalisation;

letter A, points 3), 4) and 9): application of a percentage excess of **20%** with a minimum of **EUR 2,000.00** per hospitalisation;

letter A, point 5): application of a percentage excess of **20%** with a minimum of **EUR 1,000.00** per surgery;

letter A, points 6) and 7): no percentage excess is applied;

letter A, points 8) and 10): application of a percentage excess of **40%** with a minimum of **EUR 2,000.00** per surgery.

Examples:
Direct assistance scheme
Coverage cap EUR 150,000.00
Cholecystectomy cost EUR 14,298.00
Deductible sum EUR 200.00
Authorised service EUR 14,298.00 of which EUR 14,098.00 bearing on the Company and EUR 200.00 bearing on the Insured
Reimbursement scheme in TOP Clinics with affiliated teams
Coverage cap EUR 150,000.00
Reimbursement request for cholecystectomy EUR 14,298.00
Percentage excess 20% minimum EUR 3,000.00
Indemnity EUR 11,298.00 (EUR 14,298.00 - EUR 3,000.00, because the percentage excess of 20% of the damage is less than the non-indemnifiable minimum)

C- NATIONAL HEALTH SERVICE

With reference to the sole hospitalisation, if the services regulated in the letter A above (except for those referred to in point 5) are borne in full by the National Health Service, a hospitalisation confinement indemnity is paid for each day of hospitalisation (meaning as such one with an overnight stay) to meet the needs for recovery following the illness, accident or childbirth, in order to promote the autonomy and the home stay contingent on these events amounting to:

- **EUR 80.00** per day for hospitalisation with surgery;
- **EUR 60.00** per day for hospitalisation without surgery;
- **EUR 100.00** per day in the event of a major surgical procedure (indicated in the specific list).

Furthermore, for a hospitalisation under the Day Hospital scheme referred to in letter A, points 3), 4), 8) and 9) above that ends on the same day, a hospitalisation confinement indemnity is paid amounting to:

- **EUR 40.00** per day for hospitalisation with surgery;
- **EUR 30.00** per day for hospitalisation without surgery.

The daily indemnities of this paragraph are paid within the maximum limit of 180 days per person and per year and they are not envisaged for the services regulated in Clause 9.5 "Accessory services area" below under letter G.

In any case, the Company will reimburse the services incurred before and after the hospitalisation – indemnifiable under the contract terms – in compliance with the provisions of letter A above, without applying any percentage excess or deductible sum.

If the hospitalisation takes place under the private services in a public hospital scheme, the expenses incurred are reimbursed according to the indications in letter A, with application of the percentage excesses referring to the items concerning hospitalisations made in indirect form.

D- ACCOMPANYING PERSON

As regards the services referred to in letter A, points 1), 2), 3), 4), 5), 6), 7), 10), 11) and 12), the Company reimburses the expenses related to the board and overnight stay in a medical institute or hotel and the transport expenses for the Insured's accompanying person, with the daily limit of **EUR 60.00** and for a maximum of **30 days** per nucleus and per year.
This guarantee is not valid in the event of hospitalisations paid in full by the National Health Service regulated under letter C above.

E- MEDICAL TRANSPORT

The Company reimburses the Insured's expenses for transport to the medical institute, for transfer from one medical institute to another and for return to his or her home, with medical transport if in Italy, with any means of transport, including non-medical ones, if the Insured is abroad. In the latter case, if a private car is used, the costs incurred for tolls and fuel consumption are reimbursed against submission of the related supporting expense receipts.
The reimbursement of the expenses incurred for this purpose is made within the limit of **EUR 2,000.00** per nucleus and per year. This service is reimbursed only in the cases regulated in letters A (excluding points 5), 8) and 9) and C above.

9.4 NON-HOSPITAL SPECIALIST AND/OR OUTPATIENT SERVICES AREA

A.1 HIGH SPECIALISATION TREATMENTS AND DIAGNOSTICS

The Company reimburses, within the maximum limit of **EUR 5,000.00** per nucleus and per year, the "high specialisation" services set out in the following list.

High Specialisation Diagnostics

- Amniocentesis after the age of 35 or if prescribed due to a suspected foetal malformation
- Digital angiography
- Arthrography
- Bronchography
- Cisternogram
- Cystography
- Cholangiography
- Percutaneous cholangiography
- Gallbladder X-ray exam
- Coronary arteriography
- Dacryocystography
- Fistulography
- Phlebography
- Fluorescein angiography
- Galactography
- Hysterosalpingography
- Lymphography
- Myelography
- Pneumoencephalography
- Retinography
- Nuclear Magnetic Resonance with or without contrast agent
- Sialography

- Scintigraphy
- Computerized Axial Tomography (CAT) with or without contrast agent
- Urography
- Vesiculo-deferentography

Cancer therapies

- Chemotherapy
- Cobalt radiation therapy
- Radiotherapy

Treatments

- Alcoholisation
- Dialysis
- Laser therapy (excluded if performed for surgical and rehabilitation purposes; for the latter two, laser therapy for acute diseases is however included within the maximum limit of **18** sessions).

Endoscopic investigations

- Bronchoscopy
- Colonoscopy
- Duodenoscopy
- Oesophagoscopy
- Gastroscopy
- Rectoscopy

This guarantee is valid also if the endoscopic investigation requires concurrently – upon completion of the analysis – a biopsy.

However, the procedures carried out through endoscopy will be reimbursed only within the context and within the deadlines set for "outpatient surgeries".

A.2 NON-INVASIVE PRENATAL GENETIC TESTS ON FOETAL DNA

The Company reimburses, within the limit per nucleus and per year referred to in letter A.1, the expenses incurred for non-invasive prenatal genetic tests that, by analysing the circulating free foetal DNA isolated from a maternal blood sample, evaluate the presence of foetal aneuploidies common in pregnancies, such as those related to the chromosomes 21, 18, 13 and the X and Y sex chromosomes (e.g. Harmony Test, Prenatal Safe, etc.). The present guarantee will be recognised if carried out starting from 30 years of age or if prescribed due to a suspected foetal malformation.

B- ORDINARY DIAGNOSTICS AND SPECIALIST EXAMINATIONS

The Company also reimburses up to maximum amount of **EUR 3,000.00** per nucleus and per year:

1. diagnostic examinations and tests, excluding those listed in letters A.1 and A.2 of this Clause 9.4 "Non-hospital specialist and/or outpatient services area" and the dental and orthodontic examinations not made necessary due to accident. In the latter case, the aforementioned examinations are reimbursed provided they result from an accident, documented by an Emergency Room certificate drawn up within 24 hours of the event and provided it occurred within the 24 months before the examination was performed;
2. physicians fees for specialist examinations, with the exclusion of paediatric examinations and of dental and orthodontic check-ups not made necessary due to accident. In the latter case, the aforementioned examinations are reimbursed provided they result from an accident, documented by an Emergency Room certificate drawn up within 24 hours of the event and provided it occurred within the 24 months before the examination was performed.

For the purposes of reimbursement of the aforementioned specialist examinations, these services must be performed by a physician specialising in the reported disease.

The services referred to in letters A.1, A.2 and B above are reimbursed on prescription by a physician or specialist and with the application:

- of a deductible sum of **EUR 10.00** per invoice (even if it includes multiple paid services and provided they relate to the same working diagnosis or disease) if performed in affiliated healthcare facilities;
- of a percentage excess of **20%** with a minimum of **EUR 60.00** per invoice (even if it includes multiple paid services and related to the same working diagnosis or disease) if not performed in affiliated healthcare facilities;
- of a percentage excess of **30%** with a minimum of **EUR 90.00** per invoice (even if it includes multiple paid services and related to the same working diagnosis or disease) if performed in affiliated healthcare facilities without activating the direct form;
- of a percentage excess of **40%** with a minimum of **EUR 120.00** per invoice (even if it includes multiple paid services and related to the same working diagnosis or disease) if performed in affiliated healthcare facilities indicated in the "List of TOP Clinics" without activating the direct form;

Examples for letter A.1:
Direct assistance scheme
Coverage cap EUR 5,000.00
Knee MRI cost EUR 245.00
Deductible sum EUR 10.00
Authorised service EUR 245.00 of which EUR 235.00 bearing on the Company and EUR 10.00 bearing on the Insured
Reimbursement scheme in TOP Clinics without activation of direct assistance
Coverage cap EUR 5,000.00
Reimbursement request for knee MRI EUR 245.00
Percentage excess 40% minimum EUR 120.00
Indemnity EUR 125.00 (EUR 245.00 - EUR 120.00, because the percentage excess of 20% of the damage is less than the non-indemnifiable minimum)

C- CANCER TREATMENTS

The Company reimburses, up to a maximum amount of EUR 10,000.00 per nucleus and per year, the services related to cancer diseases incurred:

- for home nursing care;
- for chemotherapy;
- for radiotherapy;
- for other cancer therapies;
- for specialist examinations.

For the purposes of reimbursement of the aforementioned treatments and specialist examinations, these services must be performed by a physician specialising in the reported disease.

If the aforementioned services are also contemplated in letters A and B above of this Clause 9.4 "Non-hospital specialist and/or outpatient services area", in the event of reimbursement of the services, the Company will pay – in first instance – the coverage cap envisaged for this "Cancer treatments" guarantee. Once the aforementioned coverage cap has been reached, the coverage cap envisaged for letters A and B above will be used.

This guarantee is not valid if the cancer treatments are performed under the hospitalisation scheme, even if in a day hospital.

D- Physiotherapy services

The Company reimburses, up to the maximum amount of **EUR 1,400.00** per nucleus and per year, the expenses incurred for physiotherapy exclusively at Medical Centres, performed by a specialist physician or a professional with a degree in physiotherapy or equivalent qualification recognised in Italy, together with a prescription of the specialist physician with indication of the rehabilitation treatment plan following:

- an accident, documented by an Emergency Room certificate drawn up within 24 hours of the event and that occurred within the 24 months before the physiotherapy service was performed;
- a brain stroke;
- neoplasms;
- degenerative and homoplastic neurological forms; as an example: multiple sclerosis, amyotrophic lateral sclerosis (ALS) and all chronic neurological forms due to degenerative processes affecting the central nervous system;
- neuromyopathic forms: mixed morbid forms affecting the neuromuscular system;
- cardiac surgery, thoracic surgery and limb amputation.

Only where there is a documented impossibility of reaching a Medical Centre, invoices issued by the professional who performed the services (in any case with a degree in physiotherapy or equivalent qualification recognised in Italy) may also be recognised, together with a prescription of the specialist physician with indication of the rehabilitation treatment plan.

D.1- HOME PHYSIOTHERAPY

With reference to the following cases:

- accident, documented by an Emergency Room certificate drawn up within 24 hours of the event and that occurred within the 24 months before the physiotherapy service;
- brain stroke, neoplasms, degenerative, neuromyopathic and homoplastic neurological forms;
- cardiac surgery, thoracic surgery and limb amputation

subject to medical prescription, instead of the provision at an affiliated Healthcare Facility, the Insured may request through the Operational Centre to benefit from the service directly at his or her home.

The services listed above are reimbursed on prescription of the specialist physician and with the application:

- of a deductible sum of **EUR 40.00** for each treatment cycle, if performed in affiliated healthcare facilities;
- of a percentage excess of **20%** with a minimum of **EUR 60.00** for each treatment cycle, if not performed in affiliated healthcare facilities;
- of a percentage excess of **30%** with a minimum of **EUR 90.00** for each treatment cycle, if performed in affiliated healthcare facilities without activating the direct form;
- of a percentage excess of **40%** with a minimum of **EUR 120.00** for each treatment cycle, if performed in affiliated healthcare facilities indicated in the "List of TOP Clinics" without activating the direct form.

In order to apply a single percentage excess or deductible sum, the Insured must submit the reimbursement request at the end of the treatment cycle.

The services referred to in letter D.1 are reimbursed on prescription of the specialist physician and with the application of a deductible sum of **EUR 20.00** per access.

Treatments performed in fitness or beauty centres are excluded from the coverage in any case.

Examples for letter D.1:
Direct home assistance scheme
Coverage cap EUR 1,400.00
Massage therapy cost (three sessions) EUR 240.00
Deductible sum EUR 20.00 per access
Authorised service EUR 240.00 of which EUR 180.00 bearing on the Company and EUR 60.00 bearing on the Insured

E- SPEECH THERAPY

The Company reimburses, up to a maximum amount of **EUR 1,000.00** per nucleus and per year, the expenses incurred for speech therapy following an accident (documented by an Emergency Room certificate drawn up within 24 hours of the event and that occurred within the 24 months before the speech therapy was performed) or a disease, provided it is carried out by a specialist physician or a graduate speech therapist.

The services listed above are reimbursed on prescription of the physician or specialist and with the application:

- of a deductible sum of **EUR 40.00** per invoice, if performed in affiliated healthcare facilities;
- of a percentage excess of **20%** with a minimum of **EUR 60.00** per invoice, if performed in non-affiliated healthcare facilities;
- of a percentage excess of **30%** with a minimum of **EUR 90.00** per invoice, if performed in affiliated healthcare facilities without activating the direct form;
- of a percentage excess of **40%** with a minimum of **EUR 120.00** per invoice, if performed in affiliated healthcare facilities indicated in the "List of TOP Clinics" without activating the direct form.

Examples:
Direct assistance scheme
Coverage cap EUR 1,000.00
Speech therapy cost (10 sessions) EUR 400.00
Deductible sum EUR 40.00
Authorised service EUR 400.00 of which EUR 360.00 bearing on the Company and EUR 40.00 bearing on the Insured
Reimbursement scheme in TOP Clinics without activation of direct assistance
Coverage cap EUR 1,000.00
Reimbursement request for speech therapy (10 sessions) EUR 400.00
Percentage excess 40% minimum EUR 120.00
Indemnity EUR 240.00 (EUR 400.00 - 40%)

F- SPECIFIC CHILD LEARNING DISABILITIES

The Company reimburses, up to a maximum amount of **EUR 1,500.00** per nucleus and per year for the cases defined as moderate or severe, according to DSM – 5, or up to a maximum amount of **EUR 500.00** per nucleus and per year for the cases defined as mild, according to DSM – 5, the expenses incurred for the treatment and care of specific learning disabilities, according to DSM – 5, provided the diagnosis is certified by a child neuropsychiatry specialist of the National Health Service.

The services listed above are reimbursed on prescription of the physician or specialist and with the application:

- of a deductible sum of **EUR 40.00** per invoice, if performed in affiliated healthcare facilities;
- of a percentage excess of **20%** with a minimum of **EUR 60.00** per invoice, if performed in non-affiliated healthcare facilities;
- of a percentage excess of **30%** with a minimum of **EUR 90.00** per invoice, if performed in affiliated healthcare facilities without activating the direct form;
- of a percentage excess of **40%** with a minimum of **EUR 120.00** per invoice, if performed in affiliated healthcare facilities indicated in the "List of TOP Clinics" without activating the direct form.

G- ORTHOPAEDIC AND ACOUSTIC PROSTHESES

The Company reimburses, up to a maximum amount of **EUR 3,000.00** per nucleus and per year, the expenses to purchase, repair and replace orthopaedic and acoustic prostheses.

H- DENTAL CARE DUE TO ACCIDENT

The Company reimburses, up to a maximum amount of **EUR 4,000.00** per nucleus and per year, the expenses for dental treatment performed in an outpatient clinic made necessary due to an accident (documented by an Emergency Room certificate drawn up within 24 hours of the event and that occurred within the 24 months before the treatment was performed).

I- CO-PAYMENT (NATIONAL HEALTH SERVICE)

The Company reimburses in full (without applying any percentage excess) the costs incurred as healthcare co-payment for any service regulated in this document, within the maximum limits envisaged for each individual service.

J- ADDITIONAL SERVICES

The Company reimburses, within the limit of **EUR 1,500.00** per year/nucleus and with the sub-limit of **EUR 500.00** per year/person, the expenses incurred for paediatric examinations (up to the age of 14), with application of a percentage excess of 30% of the incurred and documented cost, both in-network and out-of-network.

Examples:
Direct assistance scheme
Coverage cap EUR 1,500.00
Paediatric check-up examination cost EUR 70.00
Percentage excess 30%
Authorised service EUR 70.00 of which EUR 49.00 bearing on the Company and EUR 21.00 bearing on the Insured
Reimbursement scheme
Coverage cap EUR 1,500.00
Paediatric check-up examination cost EUR 70.00
Percentage excess 30%
Indemnity EUR 49.00 (EUR 70.00 - 30%)

K- LENSES

The Company reimburses, up to the maximum limit of **EUR 400.00** per year/nucleus and with the sub-limit of **EUR 150.00** per person/year, the expenses incurred to purchase lenses and glasses (including frames) or corrective contact lenses, without applying any percentage excess.

The reimbursement occurs in the event of a first prescription or a modification of the visus, both certified by the duly qualified ophthalmologist, optician or orthoptist, in order to recover the socialisation activity to favour active lifestyles.

L- COMPARATIVE DIAGNOSIS

In the event of a diagnosis of one of the following diseases:

- Alzheimer's disease
- AIDS
- Blindness
- Malignant neoplastic diseases
- Cardiovascular problems
- Deafness
- Kidney failure
- Loss of speech
- Transplantation of vital organs
- Neuromotor disorders
- Multiple sclerosis
- Paralysis
- Parkinson's disease
- Stroke
- Coma

The Insured may request a re-examination of the case through a diagnostic evaluation by worldwide major specialists with the most useful therapeutic indications to treat the highlighted disease. Moreover, an examination by the specialist who evaluated the case may be requested.

Only the costs incurred by the Insured in relation to the consultation with the physician are reimbursed.

M- MATERNITY PACKAGE

The Company reimburses the expenses incurred for examinations and check-ups in the first 6 months of pregnancy, without applying any percentage excess.

In the event of a spontaneous / natural abortion, the Company reimburses in full one gynaecological check-up and a maximum of three psychological care sessions within three months of the event, both in-network and out-of-network.

The annual insured coverage cap for all aforementioned services is EUR 500.00 per nucleus.

N- PSYCHOTHERAPY

The Company reimburses, up to a maximum amount of **EUR 1,000.00** per year and nucleus, the expenses incurred for psychotherapy services prescribed by a Local Health Authority physician or by a specialist, with the application of a percentage excess of **50%** of the incurred and documented cost, both in-network and out-of-network.

9.5 – ACCESSORY SERVICES AREA

A- EMERGENCY ROOM SERVICES

The Company reimburses, up to a maximum amount of **EUR 1,000.00** per event and per year, the expenses incurred for outpatient services following an accident that did not lead to a hospitalisation.

The reimbursement includes the expenses incurred for the following services (provided they are prescribed by the Emergency Room): application and removal of plaster cast, diagnostic tests, medical care, medicines and transport.

B- TREATMENT FOR DRUG ADDICTS

As contribution to the expenses incurred for the recovery from drug addiction in Local Health Authority affiliated therapeutic communities, the Company pays a sum of **EUR 3,000.00** per person and per year, up to a maximum total annual amount of **EUR 30,000.00** for all persons Insured under this policy.

The relative reimbursement of this guarantee is made in a single instalment at the end of the insurance year.

The deadline for submitting reimbursement requests relating to this service is set at 31 January of each year following the year in which the expense for which reimbursement is requested was incurred. If the total sum of the requests exceeds the aforementioned annual limit, the amount of **EUR 30,000.00** will be divided proportionally among those who submitted a request.

Any requests submitted after 31 January, where reimbursable and subject to verification of the availability, will be reimbursed within the coverage cap of the following year.

C- ADVANCE PAYMENT FOR HEALTHCARE EXPENSES

In cases of hospitalisation for a Major Surgical Procedure (indicated in the specific list set out below) made in indirect form, at the request of the Insured through the Policyholder, the Company will pay an amount up to a maximum of **50%** of the expenses to be incurred, and, in any case, within **50%** of the envisaged hospitalisation coverage cap, subject to the final balance at the end of the treatments.

Together with the request for disbursement of the advance payment, the Policyholder must produce suitable medical documentation for the assessment of the effectiveness of the healthcare coverage.

D- NURSING CARE

The Company reimburses, up to the maximum amount of **EUR 50.00** per day for a maximum of **90 days** per nucleus and per year, the expenses incurred for medical and nursing home care if made necessary by a terminal illness substantiated by suitable medical and/or hospital certification.

E- REPATRIATION OF REMAINS

The Company reimburses, up to a maximum amount of **EUR 2,000.00** per event, the expenses incurred to transport the body to the burial site in Italy, in the event of the Insured's death following hospitalisation (also under the day hospital scheme) in a medical institute abroad due to illness or accident, with or without surgery.

Expenses related to the funeral ceremonies and burial are excluded from reimbursement.

F- HOME HOSPITALISATION

The following expenses related to post-hospitalisation are reimbursed in the event of a hospitalisation included in the "List of major surgical procedures" for:

- home hospitalisation (transfer of the patient's care and take-over by a facility directed by a Health Director), subject to prescription by a Local Health Authority physician or specialist physician;

- supplemental home healthcare (home healthcare intervention, with the development of a medical programme, with medical, nursing and rehabilitation services), subject to prescription by a Local Health Authority physician or specialist physician.

The reimbursement of the expenses incurred for this purpose is made within the limit of **EUR 15,000.00** per nucleus/year and with a maximum of **50 days** per hospitalisation:

- without any application of percentage excess if performed under the direct affiliation scheme;
- with the application of a percentage excess of **10%** with the minimum of **EUR 1,200.00** per event if not performed under the direct affiliation scheme.

G- MEDICALLY ASSISTED PROCREATION

The Company reimburses, up to a maximum amount of **EUR 700.00** per nucleus and per year, without applying deductible sums or percentage excesses, the services incurred:

- for surgical medical services related to the medically assisted procreation technique;

- for pharmacological treatments related to the fertilisation technique used.

Reimbursement is excluded for the expenses related to the travel / transfer of the Insured and the costs of the possible accompanying person if the treatment is carried out abroad.

In any case, the daily hospitalisation confinement indemnity provided for in Clause 9.3 "Hospitalization area", letter C "National Health Service", is not paid for this type of procedures.

H- POST–PARTUM CARE

The Company pays the following services aimed at full recovery following childbirth, **performed in affiliated healthcare facilities** indicated by the Previmedical Operations Centre, subject to booking:

1. Post-partum psychological care

a maximum of three psychological consultations will be covered within three (3) months from the childbirth (in the coverage year).

2. Lower Limbs Check-up

Within six (6) months from the childbirth (occurring in the coverage year), it is possible to make a lower limbs check-up examination in order to establish the presence of pathological alterations of the superficial and deep venous circulation of the lower limbs.

3. Wellness weekend

Within one (1) year from the childbirth (occurring in the coverage year), the following overall package of services is provided:

- dietary consultation;
- meeting with a nutritionist;
- meeting with a personal trainer;
- basic lesson in physical activity training;
- thermal treatment.

I- THERMAL TREATMENTS FOR MINORS

The Company pays, up to a maximum amount of one (1) cycle per year (maximum of 12 consecutive sessions with a break in the middle of the cycle), the services for thermal treatments, inhalation and politzerization treatments made by the minor following an illness or accident, **performed in affiliated healthcare facilities** indicated by the Previmedical Operations Centre, subject to booking.

The expenses for the services provided to the Insured are paid directly by the Company to the facilities for a maximum amount of EUR 35 per session.

Also included is a consultation at the beginning of the treatment and a consultation at the end of the treatment without application of any percentage excess or deductible sum.

The hotel expenses of the minor and any accompanying person are excluded from the coverage in any case.

J- DOWN SYNDROME

In the event of a diagnosis of Trisomy 21 (Down Syndrome) ascertained in the first three years of life, an indemnity of **EUR 1,000.00** per newborn and per year is paid.

The indemnity referred to in this paragraph is paid for a maximum period of **five** years.

K- NEWBORN

The insurance is valid free of charge for newborn provided the Company is notified within **90** days from the childbirth. It is understood that the guarantee is also extended to treatments and surgical procedures resulting from congenital malformations and/or physical defects provided they are performed within one year from the childbirth. However, if the aforementioned congenital malformations and/or physical defects are evident from the first year of life of the newborn and the impossibility of performing surgery in the first year of life is ascertainable and can be documented in medical and clinical terms, the useful period within which the surgery is reimbursable – under the terms of the contract – is raised to the first **10** years of life.

L- HEALTH ACCOUNT

The Health Account is a form of accumulation for healthcare purposes aimed at enabling the family nucleus to accumulate, for the years following the first year, a part of the financial resources for the services not used in an insurance year.

A) Good Health Bonus:

If the Insured has an average ratio between Claims and Contributions for his or her family nucleus equal to or less than **75%** and has performed uninterruptedly the Cassa Uni.C.A. prevention protocols during the coverage period, an amount equal to **20%** of the total contribution of the last year will be automatically credited to his or her Health Account.

This amount may be used to increase, in any case up to the maximum amount of the expense, the amount of the reimbursements requested by the Family Nucleus and/or to reduce the incidence of any amounts to be borne by the Insured (percentage excesses and deductible sums) in subsequent years.

B) Healthcare Savings:

If the Family Nucleus has not obtained the reimbursement of any healthcare service (with the exception of the Cassa Uni.C.A. prevention protocols that are not included in this calculation), it has the right to request the crediting on its Health Account of the savings achieved in the year to the extent of 10% of the annual contribution.

This amount may be used to increase, in any case up to the maximum amount of the expense, the amount of the reimbursements requested by the Family Nucleus and/or to reduce the incidence of any amounts to be borne by the Insured (percentage excesses and deductible sums) in subsequent years.

M- INDEMNITY FOR HEALTH AND CARE EXPENSES INCURRED FOR PARENTS ADMITTED TO A NURSING HOME

The guarantee provides for the payment of an indemnity paid, as a lump sum, of **EUR 350.00** per year/person, without the application of percentage excesses or deductible sums, for the medical, health and care expenses incurred by the Insured for parents hospitalised at a public or private nursing home because they are not self-sufficient or no longer able to remain at home due to the impairment, also very serious, of their health conditions and autonomy.

The service is accessible for any Family Nucleus that has not received reimbursement of any health services during the year.

The indemnity will be paid if the hospitalisation in the nursing home has lasted for at least **12** consecutive months.

9.6 – PREVENTION AREA

Before performing the services envisaged by this clause, it is advisable to consult your Local Health Authority or your attending physician for the presence of possible contraindications and significant side effects, in consideration of the age and health condition of the Insured.

A- CHECK-UP EXAMINATIONS

The Company pays in full (without applying any percentage excess or deductible sum to be borne by the Insured) one (1) specialist examination in any specialisation for each Insured performed once a month and on any weekday at the Facilities affiliated with the Previmedical Network, subject to booking.

The services listed above are also paid in the event of consultation / mere check-up and therefore no prescription from a physician or specialist is required during the authorisation phase.

B- INFLUENZA VACCINATION

The Company pays in full (without applying any percentage excess or deductible sum to be borne by the Insured) the services for vaccination against the seasonal influenza risks.

The service is provided exclusively under the indirect scheme following submission of a copy of the purchase invoice or receipt.

C- HERPES ZOSTER PREVENTION

The Company pays the services for the prevention of Herpes Zoster and its complications to all Insured persons over the age of 55, **performed at the Facilities affiliated** with the Previmedical Network, subject to booking.

The services listed above are paid as prevention treatment and therefore no prescription from a physician or specialist is required during the authorisation phase.

The expenses for the services provided to the Insured are paid directly by the Company to the affiliated Facilities with the application of a deductible sum of **EUR 36.15** per service.

D- PAEDIATRIC CHECK-UP

The Company pays the services for specialist paediatric check-ups for children between the ages of six months and six years **performed in the affiliated healthcare facilities** indicated by the Previmedical Operations Centre, subject to booking and under the following conditions:

- one (1) examination between the ages of six months and twelve months;
- one (1) examination at the age of four years;
- one (1) examination at the age of six years.

The services listed above are paid in the event of consultation / mere check-up and therefore no prescription from a physician or specialist is required during the authorisation phase.

The expenses for the services provided to the Insured are paid directly by the Company to the affiliated healthcare facilities with the application of a deductible sum of **EUR 36.15** per service.

E- NUTRITION CONSULTATION AND PERSONALISED DIET

This guarantee envisages the expenses incurred for **one consultation and personalised diet** per two-year insurance period per person.

In the event of use of affiliated healthcare facilities, the annual expenditure limit available for this coverage is unlimited.

In the event of use of non-affiliated Healthcare Facilities, the total annual expenditure limit available for this coverage is **EUR 80.00** per two-year period / person, of which **EUR 50.00** for the consultation and **EUR 30.00** for the diet.

F- STEM CELL PRESERVATION

The Company reimburses, up to a maximum amount of **EUR 500.00** per nucleus and per year, without application of deductible sums or percentage excesses, the expenses incurred for the family and autologous preservation of cord stem cells, both in-network and out-of-network.

Chapter 2 – INSURANCE LIMITATIONS AND EXCLUSIONS

9.7 Excluded services

The following expenses are excluded from reimbursement:

1. myopia correction or elimination surgery, except as provided for in Clause 9.3 “Hospitalisation”, letter A), point 9;
2. dental prostheses, treatment of periodontal diseases, dental care and dental examinations, except as provided for in Clause 9.3 “Hospitalisation area” letter A), point 8 and in Clause 9.4 “Non-hospital specialist and/or outpatient services area”, letter H;
3. medical services for aesthetic purposes, except for reconstructive plastic surgery required due to accidents or destructive surgical procedures or cancer surgery (limited to the anatomical site of the injury) and those for children under three years of age;
4. hospitalisations solely for physical examinations or therapies that, due to their technical nature, can also be performed in an outpatient clinic, as long as permitted by the Insured’s state of health;
5. hospitalisations caused by the Insured Person’s need for assistance from third parties to carry out the basic acts of everyday life and long-term stays, determined by the Insured’s physical conditions that no longer allow healing with medical treatments and that make permanence necessary in a medical institute for maintenance care or physiotherapy interventions;
6. intoxications and accidents resulting from:

- alcohol abuse;
- use of hallucinogens;
- non-therapeutic use of psychotropic drugs and narcotics;

7. voluntary non-therapeutic abortion;
8. correction or elimination of malformations or physical defects, unless they lead to a disease or are the result of an accident and without prejudice to the provisions in Clause 9.5 “Accessory services area”, letter K “Newborn”;
9. all procedures and operations for assisted fertilisation, except as provided for by the guarantee in Clause 9.5 “Accessory services area”, letter G “Medically assisted procreation”. In any case, the daily hospitalisation confinement indemnity provided for in Clause 9.3 “Hospitalization area”, letter C “National Health Service”, is not paid for this type of procedures;
10. accidents suffered as a result of criminal actions intentionally committed or attempted by the Insured, as well as intentionally carried out or permitted by the Insured against him or herself;
11. clinical check-ups;
12. acupuncture;
13. physiotherapy services (where envisaged) not carried out by a specialist physician or a professional with a degree in physiotherapy or equivalent qualification recognised in Italy, or carried out at beauty or fitness centres;
14. direct or indirect consequences of the transmutation of the atom nucleus, as well as of radiation caused by the artificial acceleration of atomic particles;
15. consequences of wars, insurrections, earthquakes and volcanic eruptions;
16. accidents resulting from exercising air sports in general or from any professionally exercised sport;
17. accidents resulting from participating in non-pure regularity motorcar, motorcycle and motorboat competitions or races, and related tests and training sessions;
18. accidents suffered and illnesses that occurred during performance of the military service or the substitute service thereof, voluntary recruitment, call for mobilisation or for reasons of an exceptional nature;
19. expenses incurred as a result of the following mental illnesses: psychoses, neurotic personality disorders and other non-psychotic mental disorders, mental retardation and in any case all illnesses included in chapter 5 (PSYCHIC DISORDERS) of the 9th revision of the International Classification of Diseases (ICD9-CM) of the World Health Organisation and/or of the intake of psychotropic drugs for therapeutic purposes;3
20. services performed at convalescent and residential care facilities, health camps and care facilities with dietary and aesthetic purposes or intended for long-term stays (nursing homes), since they are not considered “Medical Institutes”, as well as gyms, sports clubs, beauty centres, health hotels, medical hotels, wellness centres even if they have an attached medical centre.

3 Please note that the clarifications introduced regarding the exclusion in question are the result of the instructions given to the Companies by the IVASS (formerly ISVAP) following the transposition by Italy with Law No. 18 of 3 March 2009 of the UN Convention on the Rights of Persons with Disabilities. These indications required the Companies to specify – in the field of mental disorders – which healthcare services were eligible for reimbursement as a result of permanent mental illnesses that existed before being included in the coverage.

9.8 Territorial validity

The insurance is valid worldwide.

9.9 Age limits

Inclusion in the policy of new policyholders who have already reached the age of 85 on 31 December 2019 is not allowed.

However, the right is granted to maintain until 31 December 2021 persons already covered in the previous healthcare plan who turn 85 years during the contract term.

Up to the age limit set by this coverage, the possibility to access the coverage is also given to mentally handicapped persons, or persons who take psychotropic drugs for therapeutic purposes, within the limits of the provisions of Clause 9.7 "Excluded services".

CHAPTER 3 – SETTLEMENT OF THE INDEMNITY

10 Obligations in the event of a Claim

The Policyholder, the Insured or his or her beneficiaries must report the claim to the Company as soon as possible and in any case by and no later than the period of limitation of the right. **Failure to comply with this obligation may result in the total or partial loss of the right to reimbursement of the expenses incurred, in accordance with Article 1915 of the Civil Code.**

For hospital services, the date of the claim is the date on which the hospitalisation occurred, or if there was no hospitalisation, the surgical procedure in the outpatient clinic; for non-hospital services, the date of the claim is the date on which the first healthcare service relating to the specific event is provided. For physiotherapy and dental services, the date of the event is the date on which the single service relating to the specific event is performed.

If the Insured receives reimbursement from Funds or Entities, **the settlement documentation of these Entities must be sent together with photocopies of the invoices relating to the aforementioned reimbursement**.

Any documentation written in a language other than Italian, English, French or German must be accompanied by an Italian translation. Failing this, any translation costs will be borne by the Insured.

The Insured, his or her relatives, or his or her beneficiaries must allow an examination by physicians of the Company and any inquiry or investigation that the Company deems necessary, releasing to this end the physicians who examined and treated the Insured from the professional secrecy.

The investigation can be ordered within a minimum period of 48 hours from the report of the claim and in any case within a maximum period of six months.

Should the death of the Insured covered by the insurance policy occur during the term of validity of the policy, his or her legitimate heirs must immediately notify the Company thereof and the obligations referred to in this clause must be fulfilled by the entitled heirs.
In the aforementioned event, it will be necessary to submit further documents such as:

- the death certificate of the Insured;
- an authenticated copy of any will, or a Self-executed Affidavit reporting its details and stating that the said will is the last will that must be considered valid and that it has not been challenged; moreover, the aforementioned Affidavit must indicate the identity of the heirs, their ages and relative capacity to act);
- in the absence of a will, a Self-executed Affidavit (in original or in authenticated copy) made by the person concerned before a public official indicating that the insured died without leaving a will as well as the personal details, age and capacity to act of the legitimate heirs and that there are no other persons to whom the law attributes right to or shares of the inheritance;

- a possible authenticated copy of the Probate Judge's order authorising the Company to liquidate the capital and, at the same time, allowing the collection of the shares destined for beneficiaries who are underage or who lack the capacity to act;
- a photocopy of a valid identity document and the taxpayer's card of each heir;
- a statement signed by all heirs, indicating the IBAN code of a single current account into which the transfers are to be made that relate to the reimbursement of the claims submitted or still to be submitted until the expiry of the coverage as regulated in the Conditions of Insurance.

The services provided under the private services in a public hospital scheme are considered private services, even if performed in public facilities.

Please note that if the Insured intends to use an affiliated facility and/or an affiliated physician and/or an affiliated dentist, he or she must always use them under the direct assistance scheme.

There is no provision for mixed form, i.e. the possibility of having certain services authorised in direct form and other services in indirect form within the same claim.

Operational procedure – Direct assistance scheme

a) ***Before the service***

To receive services under the direct assistance scheme, the Insured **must request prior authorisation from the Operations Centre** (active **24 hours a day, 365 days a year), attaching the necessary supporting documentation, with a notice of at least 48 working hours**.

Please note that the Insured must request the authorisation individually on each occasion for each service that he or she must perform also for dental and physiotherapy services, and that requests for authorisations received directly from the Dental Practices will not be taken into consideration.

The issue of the authorisation can be requested through:

- the mobile app;
- the website portal;
- the designated telephone numbers:
  - **800. 90.12.23** from landline and mobile phones (toll-free number);
  - **+39 0422.17.44.023** for calls from abroad.

The Insured must provide the following information to the Operations Centre:

- the surname and name of the person who must have the service performed;
- the selected affiliated healthcare facility;
- the service to be performed;
- the diagnosis / working diagnosis;
- the appointment date.

The Insured **must send** the following documentation **to the Operations Centre – via the website portal or mobile app or by fax** to the number **+39 0422.17.44.523 or by replying to the e-mail received from the Operations Centre**:

- **medical prescription** (including the electronic medical prescription) valid under the regional regulations in force at the time, **containing the working diagnosis / diagnosis and the disease for which the specified service is requested**. **No prescription is required for the (health and dental) prevention services.**

The prescription must be drawn up by another physician than the specialised physician who will perform (directly or indirectly) the service, or, if the prescribing physician is also the provider of the services performed, the services must be attested by transmission of the relative medical report.

For services other than the hospitalisation guarantee, the Operations Centre may consider sufficient the reading of the prescription alone, not requiring also its transmission at that stage.

- **in the event of an accident, the following documents must also be submitted:**
  - ⇨ **the Emergency Room medical report**, drawn up in the 24 hours following the event, since the accident must be objectively documentable. **In the event of dental treatment due to accident, such treatment must be consistent with the injuries suffered and the accident must be objectively proven with suitable supporting documentation (Emergency Room medical report, orthopantomogram, X-rays and photographs)**;
  - ⇨ **if the damaging event is attributable to the liability of a third party, also the name and address of the liable third party. In the event of a road accident** – in conjunction with the first request for activation of health care in direct form concerning healthcare services that became necessary as a result thereof – **the Insured is required to send also the report relating to the accident drawn up by the police, or the CID [Amicable Accident Description) Form to the Company**.

Where the Operations Centre has successfully completed the administrative and medical insurance verifications of the request made, the authorisation for the services in direct form is transmitted to the Insured **by e-mail or text message** and simultaneously also to the identified affiliated facility. The Insured must indicate whether to receive the authorisation by text message or by e-mail at the time he or she requests the health service. If the Insured does not have a smartphone, he or she must choose e-mail for receipt of the authorisation and then print it from any PC to access the healthcare facility.

The text message or e-mail will contain a short website link (so-called "tiny link") that will enable the display of the authorisation on the device screen.

Subject to a minimum notice of two working days (48 hours), the Operations Centre guarantees the reply (authorisation / denial) upon the outcome of the assessment of the request for direct assistance:

For hospital services

- if the request is received at least seven working days before the date of the event, the Operations Centre guarantees the reply within two working days from the Insured's request;
- if the request is received between six and four working days before the date of the event, the Operations Centre guarantees the reply within two working days before the date of the event;
- if the request is received between three and two working days before the date of the event, the Operations Centre guarantees the reply within one working day before the date of the event.

For non-hospital services

- if the request is received at least four working days before the date of the event, the Operations Centre guarantees the reply within two working days before the date of the event;
- if the request is received between three and two working days before the date of the event, the Operations Centre guarantees the reply within one working day before the date of the event.

Without prejudice to the right of the Insured to a notice of at least two working days (48 hours); in this event, however, this minimum notice could lead, in case of refusal of the authorisation, to a communication from the Operations Centre very close to the expected time of use of the service.

In any case, please note that during the start-up phase of the Health Plans it might not be possible to comply with the aforementioned service levels until the process of acquiring the personal data master record will be completed. To this end, we invite all Insured persons intending to use a service under the direct scheme to contact the Operations Centre as far in advance as possible.

Upon arrival at the affiliated Healthcare Facility, the Insured must submit the authorisation received from the Operations Centre and hand over the medical prescription in order to receive the authorised service.

The Insured must notify the Operations Centre in advance of any changes in and/or additions to the authorised service for the issue of the new authorisation once the relevant administrative and technical-medical checks have been successfully completed.

The exception to the necessary prior request for authorisation to the Operations Centre for the activation of the direct assistance scheme and in any case for access to affiliated healthcare facilities is envisaged only for the emergencies listed in point b) below.

The Insured will bear any amounts not recognized by these conditions of insurance (for example, deductible sums and percentage excesses).

The Company makes direct payment of the expenses indemnifiable under the policy according to the conditions of the agreement entered into by the Services Company Previmedical with the Medical Facilities, the professionals and the affiliated clinical centres.

The Insured persons are given the opportunity, if they are interested in a healthcare facility that is not currently part of the available Network, to report this facility, so that the possibility of an affiliation agreement can be assessed; to this end, it will be sufficient to propose the candidacy to Previmedical, sending the request to the following e-mail address: ufficio.convenzioni@previmedical.it

b) ***Exception: cases of medical-health emergency (only for hospitalisation)***

Exclusively for the hospitalisation guarantee, where it is absolutely impossible to contact the Operations Centre in advance and limited to acute illnesses / diseases or in the case of objectively ascertainable physical injuries produced by an event due to a fortuitous, violent and external cause, the Insured can request the issue of the authorisation **within five days from the beginning of the hospitalisation and in any case before his or her discharge** from the affiliated facility if fewer days have passed.

The Operations Centre must be contacted and it will request the Insured to send the medical report of the physician who ordered the emergency hospitalisation or, in the event of an accident, the Emergency Room medical report, drawn up in the 24 hours following the event.

It is understood that the final assessment on the actual existence of the severity requirement with respect to the individual case is in any case subject to the evaluation of the Operations Centre; the activation of the urgency procedure is contingent on this assessment.

The urgency procedure cannot be activated for hospitalisations provided abroad under the direct assistance scheme, for which the Insured must in any case receive the prior authorisation of the Operations Centre.

c) ***Non-activation of the Operations Centre***

If the Insured accesses affiliated healthcare facilities without complying with the obligations to activate first the Operations Centre, the service will be considered received under the health care regime with reimbursement, with advance payment by and reimbursement to the Insured, where envisaged by his or her Health Plan, within its established deadlines and limits.

d) ***After the performance of the service***

Once the service has been performed, the Insured must countersign the invoice issued by the Affiliated Facility; the invoice must indicate the possible share to be borne by the Insured (for any percentage excess, deductible sums, services not covered by the Conditions of Insurance), as well as, in the event of a hospitalisation, the expenses not strictly related to the stay (for example telephone, television, bar service, medical record, administrative fees, etc.).

The direct payment of the expenses, within the deadlines established by the Conditions of Insurance, is made subject to receipt by the healthcare facility of the invoice and the medical documentation requested from the Insured and/or the Healthcare Facility at the time of authorisation (medical prescription, diagnosis and/or working diagnosis, medical record also containing also the recent and past medical history in the event of hospitalisation, X-rays, X-ray medical reports and histological medical reports, photographs, etc.).

Operating procedure - Reimbursement scheme

a) Hardcopy reimbursement request

To obtain reimbursement, at the end of the treatment cycle and as soon as all the complete medical documentation is available, the Insured must fill out all parts of the Reimbursement request form available on the website www.unica.previmedical.it (Forms and documents section) and attach the following photocopied supporting documentation, also in the event of services provided under the National Health Service scheme:

1) **the receipted expense documentation** (invoices, bills, receipts), issued by the healthcare institute or medical centre. The invoice issued by a physician or specialist physician must clearly and legibly report the professional's specialisation, which must be consistent with the diagnosis. **All the documentation must comply fiscally with the legal provisions in force. The reimbursement of expenses incurred for healthcare services under the National Health Service scheme requires the invoice or receipt issued at the time of payment by the Local Health Authority or healthcare facility accredited with the National Health Service, with indication of the service performed or the payment receipt issued by Punto Giallo with the booking document issued by the Local Health Authority at the time of booking or provision of the service. The provider will verify that the service (identifiable by a specific code contained in the aforementioned documents) is a service envisaged by the Health Plan (for example, the costs incurred for prevention and/or check-up services are excluded). In order to be able to consider the services as performed under the National Health Service co-payment scheme, with the application of the relative settlement conditions, the provision scheme must be unequivocally inferable from the expense document.**
2) **the complete medical record and the hospital discharge sheet, in the event of hospitalisation, also in Day Hospital. Please note that a stay in the Emergency Room is considered neither Hospitalisation nor Day Hospital;**
3) **the medical prescription (including the electronic prescription) valid under the regional regulations in force at the time, attesting to the nature of the disease and the services performed, in the event of guarantees other than hospital guarantees;**
4) **the detailed medical report stating the nature of the disease and the services performed, in the case of Outpatient surgery, with a possible histological report, if performed;**
5) **the certificate of the duly qualified ophthalmologist or optometrist, attesting to the modification of the visus, for the purchase of lenses, in any case excluding disposable lenses. Please note that it must be specified whether it is a prescription for first lenses; please note as well that it is necessary to submit the certificate of conformity issued by the optician, as per Legislative Decree No. 46 of 24 February 1997;**
6) **reimbursement requests for dental care must be submitted at the end of the treatment plan**, unless the plan is for more than one year. In this event, the cost estimate must be sent together with the first reimbursement request;
7) **in the event of physiotherapy treatments:**
   - **I.** the prescription of the specialist physician whose specialisation pertains to the reported disease;
   - **II.** the indication of the specialisation of the physician, or of the qualification of the professional, who performed the service.

   Reimbursement requests for physiotherapy treatments must be submitted at the end of the treatment.
8) **in the event of an accident, the following documents must also be submitted:**
   - ⇨ **the Emergency Room medical report drawn up in the 24 hours following the event**, since the accident must be objectively documentable. **In the event of dental treatment due to accident, such treatment must be consistent with the injuries suffered and the accident must be objectively proven with suitable supporting documentation (Emergency Room medical report, orthopantomogram, X-rays and photographs)**;
   - ⇨ **if the damaging event is attributable to the liability of a third party, also the name and address of the liable third party. In the event of a road accident** – in conjunction with the first reimbursement request concerning healthcare services that became necessary as a result thereof – **the Insured is required to send the report relating to the accident drawn up by the police, or the CID [Amicable Accident Description) Form to the Company**;
9) **anything else required for the correct settlement of the claims.**

The form and the relative attachments must be sent to the following address:

PREVIMEDICAL C/O CSU – BOLOGNA (POSTA INTERNA)
or to

Ufficio Liquidazioni UNI.C.A. - PREVIMEDICAL
Casella Postale n. 142
31021 Mogliano Veneto (TV)

The documentation must be made out in the name of the Insured and the reimbursement will be made in favour of the Insured covered by the policy.

For the purposes of the reimbursement owed, all insured services must be prescribed by another physician than the physician who will perform – whether directly or indirectly – the aforementioned services.

If the prescribing physician is also – whether directly or indirectly – the provider of the services performed, the services must be attested by transmission of the relative medical report.

The services must be performed by specialised personnel (physician, nurse), accompanied by the relative diagnosis (indication of the disease or suspected disease), and invoiced by the Medical Institute or Medical Centre. The invoice issued by a physician or specialist physician must clearly and legibly report the professional's specialisation, which must be consistent with the diagnosis.

In order to properly assess the claim or verify the truthfulness of the documentation produced in copy, the Company will always have the right to request the submission of the original documents of the aforementioned documentation.

b) On-line reimbursement request

As an alternative to the hardcopy reimbursement procedure, the Insured may submit his or her reimbursement request online, together with the relative supporting medical and expense documentation. To this end, the Insured must access his or her Reserved Area from the website www.unica.previmedical.it (Reserved area) or through the Mobile App.

The documentation is transmitted via an optical scanning system that the Company considers legally equivalent to the original for the purposes of applying this coverage. The Company reserves the right to carry out all necessary checks with the physicians and Healthcare Facilities in order to prevent possible abuse of this channel.

Persons who do not have Internet access can submit reimbursement requests through the conventional (hardcopy) channel as described in the previous paragraph.

Restitution of amounts unduly paid

In the event of hospitalisation in a medical institute under the direct assistance scheme, if, either during or after the hospitalisation, it becomes clear that the policy is not valid or that there are conditions or elements that determine the invalidity of the guarantee or the ineffectiveness of the insurance, the Company will send written notification thereof to the Insured, who will be required either to return to the Company all amounts it has unduly paid to the medical institute if they have already been paid by the Company to the affiliated facility and/or physicians, or to pay directly both the affiliated facility and the physicians.

Re-settlement of the case files following a change in the classification at the time of subscription or in the second coverage year

Should it emerge, by the deadline of 30 April, that the Insured is entitled to use, as of the beginning of the reference calendar year, a policy other than the policy initially assigned to him or her, the claim already settled (whether in direct or indirect form) by virtue of the policy initially assigned to him or her will be re-settled if the provisions of the policy to which he or she is entitled as of the beginning of the reference calendar year are different, for the claim in question, than the provisions of the initially assigned policy.

In this event:

- any credit differences in favour of the Insured will be paid by the Company to the Insured;
- any credit differences in favour of the Company must be returned by the Insured.

The Company or the Insured will settle the aforementioned possible differences by 30 June of the reference year.

Section III

CHAPTER 1 – ADDITIONAL INFORMATION

Mobile App

The Insured can access the "EasyUnica" Mobile App made available by the Company to access the following functions:

- display of the personal and contact data;
- display of the useful contact details for contacting the Operations Centre;
- search for facilities affiliated with the Network;
- display of the status and details of his or her case files;
- pre-activation of the services under the direct assistance scheme.

The Insured who is already registered in the Reserved Area – Claims will use the same credentials (login and password) to access the services through the Mobile APP. Otherwise, the Insured must register with the Reserved Area. For all web features, please refer to the specific documentation published on the websites www.unica.unicredit.it and www.unica.previmedical.it).

Preganziol, ... 2019

RBM Assicurazione Salute S.p.A. Cassa Uni.C.A.

For the purposes of Article 1341 of the Civil Code, the Policyholder declares that it expressly approves the provisions of the following clauses:

CONDITIONS OF INSURANCE

Clause 8.2 Effective date of the Insurance

Clause 8.3 Subscription to the coverage – Changes in the Insured persons

Clause 8.5 Court with jurisdiction

Clause 9.9 Age limits

Clause 10 Obligations in the event of a Claim

Cassa Uni.C.A.

Annex 1 – List of surgical procedures with ceilings

TYPE OF SURGERY	CEILING
Vein (including varicocele) ligation and stripping	EUR 3,500
Functional septoplasty, including possible surgery on turbinates	EUR 3,500
Surgery for reduction and synthesis of fractures of large segments (femur, humerus, tibia)	EUR 9,000
Surgery for reduction and synthesis of fractures of medium segments (clavicle, sternum, patella, radius, ulna, fibula)	EUR 6,000
Surgery for reduction and synthesis of fractures of small segments (all others)	EUR 3,000
Surgery for removal of synthesis media (for example, nails, plates, screws)	EUR 3,000
Tonsillectomy / adenotonsillectomy	EUR 3,000
Surgery for hernias and/or incisional hernias of the abdominal wall	EUR 5,000
Hemorrhoidectomy and/or surgery for the removal of fissures and/or fistulas and/or rectal prolapse	EUR 4,500
Surgery for hallux valgus with or without metatarsophalangeal realignment, hammer toe, stiff toe	EUR 4,000
Knee surgery (other than on ligaments)	EUR 7,000
Surgical hysteroscopy	EUR 4,000
Ligament reconstruction surgery	EUR 8,500
Rotator cuff surgery	EUR 7,500
Ovarian cyst removal surgery	EUR 8,500
Thyroidectomy (excluding radical surgery for malignant cancer)	EUR 10,000
Cholecystectomy	EUR 8,500
Herniated disc and/or vertebral stabilisation surgery	EUR 11,000
Arthrodesis and/or vertebral stabilisation surgery (any method), including possible excision of intervertebral herniated disc (any method)	EUR 14,000
Endoscopic prostatectomy for adenoma (transurethral resection of the prostate)	EUR 9,000
Radical prostatectomy for malignant cancer including lymphadenectomy (any method, including robot)	EUR 18,000
Hysterectomy	EUR 10,000
Hysterectomy for malignant cancer (including possible removal of uterine adnexa and lymphadenectomy)	EUR 15,000
Hip replacement surgery	EUR 20,000
Excision of skin neoformations (cysts in general, lipomas and nevi)	EUR 1,000
Knee replacement surgery	EUR 15,000
Surgery for Dupuytren's disease, Guyon's syndrome	EUR 2,000
Carpal tunnel surgery	EUR 1,500
Surgery for snap finger and entrapment of the ulnar nerve at the elbow	EUR 2,500
Cataract surgery (with or without intraocular lens implantation) - per eye	EUR 2,000
Surgery for removal of benign breast cysts and nodules (nodulectomies)	EUR 3,500
Appendectomy	EUR 4,000
Paranasal, frontal and maxillary sinus surgery and/or functional endoscopic sinus surgery	EUR 3,500

Annex 2 – List of Major Surgical Procedures

OESOPHAGUS SURGERY

- Cervical oesophagus: resection with reconstruction with intestinal loop auto transplantation
- Median oesophagectomy with two- or three-field access (thoraco-laparotomic or thoraco-laparoscopic-cervicotomic) with intrathoracic or cervical oesophagoplasty and lymphadenectomy
- Osophagogastroplasty, oesophagojejunalplasty, oesophagocolonplasty
- Closed-chest oesophagectomy with neck oesophagoplasty and lymphadenectomy
- Oesophagectomy by thoracoscopic route
- Enucleation of leiomyomas of the thoracic oesophagus by conventional route WITH THORACOTOMY
- Azygos-portal disconnections by abdominal and/or transthoracic route for oesophageal varices.

STOMACH-DUODENUM-SMALL INTESTINE SURGERY

- Total gastrectomy with lymphadenectomy
- Proximal gastrectomy and subtotal oesophagectomy for carcinoma of the cardia
- Total gastrectomy and distal oesophagectomy for carcinoma of the cardia

COLON SURGERY

- Right hemicolectomy and lymphadenectomy
- Total colectomy with ileum-rectum-anastomosis without or with ileostomy
- Anterior resection of the rectum and colon and lymphadenectomy by conventional route
- Resection of the rectum and colon with coloanal anastomosis by conventional route
- Proctocolectomy with ileo-anal anastomosis and ileal reservoir by conventional route
- Amputation of the rectum by the abdomino-perineal route

LIVER AND BILIARY TRACT SURGERY

- Liver resections for biliary tract cancer
- Portal hypertension surgery:

a) Derivation procedures

- portacaval anastomosis
- splenorenal anastomosis
- mesenteric-caval anastomosis

b) Devascularisation procedures

- ligation of varicose veins by thoracic and/or abdominal route
- oesophageal transection by thoracic route
- oesophageal transection by abdominal route
- azygos-portal disconnection with gastrojejunal anastomosis
- oesophageal transection with paraoesophageal-gastric devascularisation

PANCREAS SURGERY

- Pancreaticoduodenectomy with or without lymphadenectomy
- Total pancreatectomy with or without lymphadenectomy
- Surgery for functional endocrine tumours and malignant neoplasms of the pancreas

NECK SURGERY

- Total thyroidectomy for malignant neoplasms without or with mono or bilateral laterocervical emptying
- Tracheal resections and plastic surgery
- Total pharyngo-laryngo-oesophagectomy with pharyngoplasty for hypopharynx and cervical oesophageal carcinoma

THORACIC SURGERY

- Surgical excision of cysts and tumours of the mediastinum
- Lobectomies, bilobectomies and pneumonectomies
- Pleurectomies and pleuropneumonectomies
- Lobectomies and segmental or atypical resections by thoracoscopic route
- Bronchial resections with replantation
- Thoracoplasty: 1st and 2nd stage

HEART SURGERY

- Aortocoronary bypass
- Surgery for congenital heart disease or malformations of large vessels (not excluded from the guarantee)
- Cardiac resection
- Valve replacement with prosthesis
- Valvuloplasty

VASCULAR SURGERY

- Thoracic and/or abdominal aorta surgery BY THORACOABDOMINAL ROUTE
- Abdominal aorta and iliac arteries (mono or bilateral) surgery BY LAPAROTOMY
- Treatment of traumatic aortic lesions
- Treatment of traumatic lesions of the limb and neck arteries
- Aortoenteric fistula surgery
- Superior or inferior vena cava surgery

NEUROSURGERY

- Craniotomy for vascular malformations (not excluded from the guarantee)
- Craniotomy for spontaneous intracerebral hematoma
- Craniotomy for intracerebral hematoma due to vascular malformation rupture (not excluded from the guarantee)

- Craniotomy for endocranial neoplasms above and below the tentorium cerebelli
- Craniotomy for intraventricular neoplasms
- Transsphenoidal approach for neoplasms of the pituitary region
- Brain biopsy by stereotaxic route
- Orbital tumour excision by intracranial route
- Internal and external ventricular derivation
- Craniotomy for cerebral access
- Surgery for cervical disc herniation or cervical myelopathy and radiculopathy by anterior route
- Surgery for malignant neoplasms of peripheral nerves

UROLOGICAL SURGERY

- Expanded nephrectomy
- Nephroureterectomy
- Urinary diversion with intestinal interposition
- Total cystectomy with urinary diversion and orthotopic or heterotopic neobladder with intestinal segment
- Augmentation enterocystoplasty
- Orchiectomy with pelvic and/or lumbar aortic lymphadenectomy
- Total amputation of the penis and lymphadenectomy total emasculation, for malignant neoplasm
-

GYNAECOLOGICAL SURGERY

- Extended vulvectomy with lymphadenectomy
- Radical hysterectomy by abdominal route with lymphadenectomy

EYE SURGERY

- Full thickness corneal transplant
- Eyeball neoplasm surgery

EAR, NOSE AND THROAT SURGERY

- Parotid excision for malignant neoplasms with emptying
- Extensive demolition surgery for malignant neoplasms of the tongue, oral cavity floor and tonsil with ganglion emptying
- Surgery for functional recovery of the VII cranial nerve
- Excision of neurinoma of the eighth cranial nerve.
- Petrosectomy

ORTHOPAEDIC SURGERY

- Vertebral arthrodesis by anterior route
- Shoulder replacement surgery
- Hemi-pelvic fracture reconstruction-osteosynthesis

- Hemipelvectomy
- Surgical reduction and stabilisation of spondylolisthesis
- Surgical treatment of bone tumours
- Major limb amputations exceeding one third

MAXILLOFACIAL SURGERY

- Resection of the maxilla due to neoplasm
- Resection of the mandible due to neoplasm

PAEDIATRIC SURGERY (NOT EXCLUDED FROM THE GUARANTEE)

- Bifid skull with meningoencephalocele
- Hypersecretory hydrocephalus
- Cystic and polycystic lung (lobectomy, pneumonectomy)
- Typical child cysts and tumours of enterogenic bronchial and nervous origin (neuroblastoma)
- Congenital oesophageal atresia
- Congenital oesophageal fistula
- Funnel chest and pigeon chest
- Congenital pyloric stenosis
- Intestinal obstruction of the newborn due to meconium ileus: resection with primary anastomosis
- Simple anal atresia: abdominoperineal lowering
- Anal atresia with recto-urethral or recto-vulvar fistula: abdominoperineal lowering
- Megaureter: resection with reimplantation, resection with intestinal loop replacement
- Megacolon: Buhamel's or Swenson's abdominoperineal surgery
- Nephrectomy due to Wilms' tumour
- Spina bifida: meningocele or myelomeningocele

OTHER ITEMS

The following are also considered "major surgical procedures":

- organ transplantation with donor organ removal;
- admission to the intensive care unit (so-called resuscitation), provided it exceeds three days.

Annex 3 – List of Severe Morbid Events

a) Acute myocardial infarction
b) Cardiac or respiratory failure with at least two of the following concurrent symptoms: - dyspnoea - peripheral oedema - arrhythmia - unstable angina - pulmonary oedema or stasis - hypoxaemia
c) Histologically documented malign neoplasm
d) Complicated diabetes characterized by at least two of the following events: - torpid ulcers - decubitus - neuropathies - peripheral vasculopathies - urogenital infections or superinfections - retinopathy - ketoacidosis - diabetic coma
e) Severe trauma - with or without surgery - involving immobilisation exceeding 40 days. The immobilisation consists in the application of a device that cannot be removed by the patient and/or to prevent loading the limb.
f) Second degree burns covering at least 20% of the body
g) Acute vasculopathy of cerebral ischemic or hemorrhagic nature
h) Multiple sclerosis with significant functional deficit (3-4 on the Expanded Disability Status Scale)
i) Amyotrophic Lateral Sclerosis (ALS)
j) Comatose state
k) Paraplegia and/or Quadriplegia
l) Alzheimer's disease at stage 5 or higher of the Reisberg Scale certified by the UVA (Unità Valutativa Alzheimer) [Alzheimer's Assessment Unit] of a public neurological facility
m) Parkinson's disease at stage three or higher on the Hoehn & Yahr Scale, certified by a public neurological facility
n) Osteomyelitis
o) Severe, post-surgery or post-traumatic infections
p) Severe morbid events that are "similar" by type, event, diagnosis and treatment to those indicated in letters a) to h).

Annex 4 – List of TOP Clinics

ROME

- Casa di Cura Paideia S.p.A.
- Casa di Cura Mater Dei S.p.A.
- Casa di Cura Quisisana
- Casa di Cura Villa Stuart
- Casa di Cura Villa Flaminia
- Casa di Cura Villa Margherita

MILAN

- Casa di Cura La Madonnina S.p.A..
- Istituto Nazionale Tumori
- Ospedale San Raffaele S.r.l.
- Humanitas Mirasole S.p.A.. (Istituto Clinico Humanitas)
- Casa di Cura Capitanio

TURIN

- Clinica Fornaca di Sessant
- Casa di Cura Sedes Sapientiae
- Casa di Cura Cellini S.p.A.

BERGAMO

- Humanitas Gavazzeni

VARESE

- Istituto Clinico Humanitas Mater Domini Casa di Cura Privata S.p.A.

Annex 5: Summary Data Sheet

The coverage caps/insured sums, percentage excesses and deductible sums referring to the various guarantees are shown below. Unless otherwise indicated, the coverage caps are intended per Year/Nucleus and the percentage excesses and deductible sums per event.

HOSPITALISATION AREA	
Hospitalisation with/without surgery, Day Hospital with/without surgery, Outpatient surgery, Childbirth / Therapeutic abortion, Dental surgery, Major Surgical Procedures (MSP), Transplantations, Post-surgical rehabilitation, Severe Morbid Events (SME)	extended list for Surgical procedures with ceiling (Int_PLAFONATI), Major Surgical Procedures and Dental surgery (Int_ODONTOIATRICI)
Coverage cap	EUR 150,000; EUR 300,000 per Major Surgical Procedure
Conditions:	
In-network	deductible sum EUR 200 per event; EUR 100 for outpatient surgery; not envisaged for Major Surgical Procedures
In-network not in direct form (no TOP Clinics)	percentage excess 15%, min. EUR 2,250 per event (EUR 1,500 for Day Hospital with/without surgery; EUR 750 for outpatient surgery); not envisaged for Major Surgical Procedures
in TOP Clinics not in direct form, Major Surgical Procedures included	percentage excess 20%, min. EUR 3,000 per event (EUR 2,000 for Day Hospital with/without surgery; EUR 1,000 for outpatient surgery);
Out-of-network and with Physician working privately in a public hospital	percentage excess 10%, min. EUR 1,500 per event (EUR 1,000 for Day Hospital with/without surgery; EUR 500 for outpatient surgery); not envisaged for Major Surgical Procedures
Hospitalisation without surgery	maximum limit of five days for hospitalisation and up to three hospitalisations per year excluded if for diagnostic purposes and for pre-surgery diagnosis
Hospitalisation without surgery for long-term stay	for hospitalisation exceeding 30 days
Caesarean section / Therapeutic abortion (Pre/Post excluded)	
Sub coverage cap:	EUR 6,000
Newborn expenses (sub-limit)	EUR 1,000
Obstetric assistance (sub-limit)	EUR 1,500
Conditions:	100%
Natural childbirth (Pre/Post excluded)	
Sub coverage cap:	EUR 3,000
Newborn expenses (sub-limit)	EUR 1,000
Conditions:	100%
Dental surgery	extended list (Int_ODONTOIATRICI)
Sub coverage cap:	EUR 10,000
Conditions:	
In-network	deductible sum EUR 200 per event
In-network not in direct form (no TOP Clinics)	percentage excess 30% min. EUR 1,500
in TOP Clinics not in direct form, Major Surgical Procedures included	percentage excess 40% min. EUR 2,000
Out-of-network and with Physician working privately in a public hospital	percentage excess 20% min. EUR 1,000
Myopia	with differential greater than 4 dioptres (not caused by previous corrective surgery) or visual defect of an eye equal to or greater than 8 dioptres
Conditions:	
In-network	deductible sum EUR 200 per event
In-network not in direct form (no TOP Clinics)	percentage excess 15% min. EUR 1,500

in TOP Clinics not in direct form, Major Surgical Procedures included	percentage excess 20% min. EUR 2,000
Out-of-network and with Physician working privately in a public hospital	percentage excess 10% min. EUR 1,000
Reconstructive dental surgery	mastectomy or quadrantectomy
Coverage cap	EUR 5,000
Pre/Post	90 days/90 days
Conditions:	
In-network	deductible sum EUR 1,000 per event
In-network not in direct form (no TOP Clinics)	percentage excess 30% min. EUR 1,500
in TOP Clinics not in direct form, Major Surgical Procedures included	percentage excess 40% min. EUR 2,000
Out-of-network and with Physician working privately in a public hospital	percentage excess 20% min. EUR 1,000
Newborn Correction Congenital Malformations	in the first year of life, raised to the first 10 years of life due to the impossibility of performing surgery in the first year of life
Surgical procedures with ceiling	extended list (Int_PLAFONATI)
Conditions:	100% for the main surgery, 70% for the secondary surgeries
Stay charge limit only Out-of-network	EUR 300 per day; EUR 250 for Day Hospital with/without surgery; not envisaged for Childbirth / Therapeutic Abortion
Pre/Post	100 days/100 days
Post-surgery physiotherapy / rehabilitation treatments	120 days, not envisaged for Natural childbirth, Myopia and Dental surgery
Charge for accompanying person	EUR 60 per day, max. 30 days, not envisaged for Dental surgery and Myopia
Nursing Care Limit for hospitalisation without surgery	EUR 50 per day, max. 5 days per event; raised to 30 days for post-surgical rehabilitation and SME
Nursing Care for Day Hospital without surgery, Outpatient surgery, Childbirth / Therapeutic abortion, Dental surgery	NOT ENVISAGED
Transport	EUR 2,000, not envisaged for Outpatient surgery, Dental surgery, Myopia and National Health Service (NHS)
Hospital confinement indemnity	
Coverage cap	180 days per person / year
Hospitalisation with surgery	EUR 80 per day
Hospitalisation without surgery	EUR 60 per day
Major Surgical Procedures	EUR 100 per day
Day Hospital with surgery	EUR 40 per day
Day Hospital without surgery	EUR 30 per day
Pre/Post	100 days/100 days, 100% (excluding the case of hospitalisation under the private services in a public hospital scheme)
Post-surgery physiotherapy / rehabilitation treatments	100%, 120 days, not envisaged for Natural childbirth, Myopia and Dental surgery, 100% (excluding the case of hospitalisation under the private services in a public hospital scheme)
NON-HOSPITAL SPECIALIST AND/OR OUTPATIENT SERVICES AREA	
HIGH SPECIALISATION (HS) CARE AND DIAGNOSTICS	extended list (ALTA_D)
Coverage cap	EUR 5,000
Conditions:	
In-network	deductible sum EUR 10 per invoice
In-network not in direct form	percentage excess 30% min. EUR 90 per invoice
In TOP Clinics not in direct form	percentage excess 40% min. EUR 120 per invoice
Out-of-network	percentage excess 20% min. EUR 60 per invoice

Co-payment	100%
Non-invasive prenatal genetic tests on foetal DNA	included in the HS coverage cap
Ordinary Diagnostics and Specialist Examinations (SE)	excluding the investigations envisaged in the HS and the dental and orthodontic investigations not due to accident; including the specialist examinations / dental and orthodontics investigations due to accident with Emergency Room certificate within 24 months from the event
Coverage cap	EUR 3,000
Conditions:	
In-network	deductible sum EUR 10 per invoice
In-network not in direct form	percentage excess 30% min. EUR 90 per invoice
In TOP Clinics not in direct form	percentage excess 40% min. EUR 120 per invoice
Out-of-network	percentage excess 20% min. EUR 60 per invoice
Co-payment	100%
Cancer treatment	services for cancer diseases for home nursing care, chemotherapy, radiotherapy, other cancer therapies, specialist examinations; once this coverage cap has been reached, those of HS and SE will be used
Coverage cap	EUR 10,000
Conditions:	100%
Physiotherapy services	only due to accident with Emergency Room certificate within 24 of the event; brain stroke; neoplasms; degenerative and homoplastic neurological forms (multiple sclerosis, ALS, etc.); neuromyopathic forms: mixed morbid forms affecting the neuromuscular system; cardiac surgery, thoracic surgery and limb amputation
Coverage cap	EUR 1,400
Conditions:	
In-network	deductible sum EUR 40 per treatment cycle
Direct at home	deductible sum EUR 20 per use
In-network not in direct form	percentage excess 30% min. EUR 90 per treatment cycle
In TOP Clinics not in direct form	percentage excess 40% min. EUR 120 per treatment cycle
Out-of-network	percentage excess 20% min. EUR 60 per treatment cycle
Co-payment	100%
Speech therapy	due to accident with Emergency Room certificate within 24 months of the event or due to illness if carried out by a specialist physician or graduate speech therapist
Coverage cap	EUR 1,000
Conditions:	
In-network	deductible sum EUR 40 per invoice
In-network not in direct form	percentage excess 30% min. EUR 90 per invoice
In TOP Clinics not in direct form	percentage excess 40% min. EUR 120 per invoice
Out-of-network	percentage excess 20% min. EUR 60 per invoice
Co-payment	100%
Specific child learning disabilities	as set forth in DSM - 5, provided the diagnosis is certified by a child neuropsychiatry specialist of the National Health Service
Coverage cap	EUR 1,500.00 per nucleus and per year for moderate or severe cases or up to € 500.00 per nucleus and per year for mild cases
Conditions:	
In-network	deductible sum EUR 40 per invoice
In-network not in direct form	percentage excess 30% min. EUR 90 per invoice
In TOP Clinics not in direct form	percentage excess 40% min. EUR 120 per invoice

Out-of-network	percentage excess 20% min. EUR 60 per invoice
Co-payment	100%
Orthopaedic and acoustic prostheses	
Coverage cap	EUR 3,000
Conditions:	100%
Dental care due to accident	with Emergency Room certificate within 24 months from the event
Coverage cap	EUR 4,000
Conditions:	100%
Additional services	paediatric examinations (up to 14 years old)
Coverage cap	EUR 1,500, sub-limit EUR 500 per year / person
Conditions:	percentage excess 30%
Lenses	
Coverage cap	EUR 400, sub-limit EUR 150 per year / person
Conditions:	100%
Comparative diagnosis	ENVISAGED
Maternity package	check-up examinations and investigations during the first six months of pregnancy; in the event of miscarriage, within three months, one gynaecological examination and 3 psychological examinations
Coverage cap	EUR 500
Conditions:	100%
Psychotherapy	
Coverage cap	EUR 1,000
Conditions:	percentage excess 50%
ACCESSORY SERVICES AREA	
Emergency room services	outpatient services following an accident without hospitalisation; the following services are also included when there is an Emergency Room prescription: plaster cast application and removal, diagnostic tests, medical assistance, medicines and transport
Coverage cap	EUR 1,000 per event and per year
Treatment for drug addicts	for recovery from drug addiction in Local Health Authority affiliated rehabilitation communities
Coverage cap	EUR 3,000 per person and year, maximum of EUR 30,000 for all the Insured
Conditions:	if the total requests of the Insured exceed the amount of EUR 30,000, the contribution will be distributed proportionately among the applicants
Advance payment for healthcare expenses	per Major Surgical Procedure, maximum of 50% of the expense to be incurred within 50% of the Hospitalisation Area coverage cap
Nursing Care	for terminal illness with appropriate medical / hospital certification
Conditions:	EUR 50 per day up to 90 days
Repatriation of remains	in the event of the death of the Insured following a hospitalisation (also under the Day Hospital scheme) in a healthcare facility abroad for illness or accident, with or without surgery
Coverage cap	EUR 2,000
Conditions:	excluding expenses for funeral ceremonies and burial
Home hospitalisation	post-hospitalisation expenses per Major Surgical Procedure
Coverage cap	EUR 15,000, maximum 50 days per hospitalisation
Conditions:	
In-network	100%

Out-of-network	percentage excess 10% min. EUR 1,200 per event

Medically assisted procreation	
Coverage cap	EUR 700 per nucleus and per year
Conditions:	excluding the expenses related to the travel / transfer of the insured and the costs of the possible accompanying person if the treatment is carried out abroad
Post-partum care	
Coverage cap	Unlimited
Conditions:	extended list (POST_P), within one year from the childbirth
Thermal treatments for minors	
Coverage cap	Unlimited
Conditions:	max. one cycle per year, max. EUR 35.00 per session
Down Syndrome (children of insured)	
Coverage cap	EUR 1,000 per year, max. five years
Conditions:	for diagnosis of Trisomy 21 within the first three years of life
Health Account	ENVISAGED
Indemnity for Parents in Nursing Home	for stays in Nursing Home lasting at least 12 consecutive months
Coverage cap	EUR 350 per person / year
Conditions:	in the absence of healthcare reimbursements during the insurance year
PREVENTION AREA	
Check-up examinations	Carried out at affiliated facilities
Coverage cap	Unlimited
Conditions:	100% - one examination per month per Insured
Influenza vaccination	Made out-of-network
Coverage cap	Unlimited
Conditions:	one annual vaccination per Insured
Herpes zoster prevention	Carried out at affiliated facilities
Coverage cap	Unlimited
Conditions:	age > 55 years, deductible sum EUR 36.15 per service
Paediatric check-up	Carried out at affiliated facilities
Coverage cap	Unlimited
Conditions:	deductible sum EUR 36.15 per service – as per list, between six months and six years of life
Nutrition consultation and personalised diet	One nutrition consultation and personalised diet per two-year period and per person
Coverage cap	
In-network	Unlimited
Out-of-network	EUR 80,00 two-year period / person (EUR 50.00 for the consultation and EUR 30.00 for the diet)
Stem cell preservation	
Coverage cap	EUR 500 per nucleus and per year

ANNEX 6

POLICY ON THE COLLECTION AND USE OF PERSONAL DATA GIVEN TO THE DATA SUBJECT IN ACCORDANCE WITH REGULATION (EU) 2016/679

Rev. 3 of 7 February 2019

In accordance with Articles 13 and 14 of Regulation (EU) 2016/679 (hereinafter referred to as the "GDPR") on the protection of natural persons and other parties with regard to the processing of personal data, we wish to inform you that the personal data you provide, referring both to you and to any other Insured Persons, will be processed in compliance with the aforementioned regulation and the confidentiality obligations bearing on RBM Assicurazione Salute S.p.A. (hereinafter referred to as "RBM").

1. Purpose of the processing

a) Processing of personal data for insurance purposes

In compliance with current legislation on the protection of personal data, we inform you that our Company intends to acquire or already holds personal data, including sensitive data[1], concerning you and/or other Insured Persons in order to provide the insurance services and/or products you requested or in your favour. With reference to such personal data, we specify that:

- certain data (e.g. name, surname, address, tax code) must necessarily be provided to perform any insurance contracts to which you are a party or pre-contractual measures adopted at your request;
- certain data must be provided to fulfil legal obligations related to the performance of any insurance contracts to which you are a party[2];
- certain data may be provided, also via electronic devices (smart-IOT), to be able to use the various services related to the insurance contracts;
- certain data (e.g. e-mail address) will be requested to facilitate the transmission of notices and service communications relating to the relationship between you and RBM, but their provision – always related to the purpose of performing any insurance contracts – will be optional.

By registering yourself in the "Area riservata" [Reserved Area] of our website and/or downloading our Apps for mobile devices (FeelUp and Citrus), these data will be used to identify you as our insured, to provide you with the services envisaged by your policy and to send you the communications required to manage the guaranteed services. The provision of these data is necessary to allow you to obtain the online services through the "Area riservata" [Reserved Area] of our website or directly through the Apps on your smartphone, and to provide you information on the status of your bookings, appointment reminders or confirmations, feedback on the settlement of claims and periodic account statements of the claims, by e-mail, text messages or, limited to the Apps, by push notifications.

We also collect special categories of data (so-called sensitive data, meaning data that can reveal your health conditions, such as those reported in prescriptions, medical reports, invoices of specialists, receipts for the purchase of medicines and medical devices, etc., sent to us in paper format or uploaded in digital format in the "Area riservata" [Reserved Area] of our website, or through the App using the smartphone camera) to perform the services envisaged by your policy and to provide you with the requested services, as well as for regulatory compliance. The provision of these data is necessary to be able to provide the insurance services to you, but they can only be processed subject to prior explicit consent given by you or any other Insured Persons concerned, if provided for by the insurance contract.

For the purposes of extending the insurance coverage in favour of other Insured Persons – where provided for in the insurance contract – you will gain knowledge of certain data, including those belonging to the category of special data, relating to the insurance services provided in their favour if required to manage the existing policy and to verify the relative coverages and the guaranteed coverage caps.

[1] "sensitive" data refers to personal data revealing racial or ethnic origin, religious, philosophical or other beliefs, political opinions, membership in parties, trade unions, associations or organisations of a religious, philosophical, political or trade union nature as well as to data relating to health and sexual life or sexual orientation of the person, which the GDPR indicates in Article 9 as "special categories of personal data".

[2] For example, due to provisions of the IVASS [Insurance Supervisory Authority] and the Privacy Authority or for fulfilments with regard to tax assessments.

2. Processing and storage methods

The data provided by you or other parties[3] are only those strictly required to achieve the aforementioned purposes. The data are processed, also with the aid of electronic and automated tools, in such a way as to guarantee an adequate level of security, with the methods and procedures strictly necessary for the purposes described in this policy, also when they are disclosed to other parties related to the insurance and reinsurance industry.

The data are processed in Italy; where necessary for the provision of the services requested, they may possibly be disclosed in both EU and non-EU countries, in compliance with the legislation on the protection of personal data, to other parties with technical, organisational and operational functions that are part of the so-called insurance chain[4]. These parties will process the data in the context of their respective functions and in accordance with the instructions received, in their capacity as Processors or Appointees or as independent Controllers.

The data can become known to our collaborators specifically authorised to process them, in their capacity as Appointees, for the pursuit of the aforementioned purposes.

The personal data are stored for the time strictly required to achieve the purposes for which they were collected and processed, and they are not subject to dissemination.

The personal data will be stored for the entire term of the contractual relationship and, at its termination, for the time required by the legislation on the storage of documents for administrative, accounting, tax, contractual and insurance purposes (10 years as a rule).

3 Data subject's rights

The Controller is RBM Assicurazione Salute S.p.A.. In accordance with and within the limits of Chapter III of the GDPR, you may exercise the following rights:

a. access to your personal data;
b. rectification of your personal data (upon your notification, we will rectify your incorrect data also when they have become incorrect inasmuch as not updated);
c. revocation of the consent;
d. erasure of the data (right to be forgotten) (for example, in the event of withdrawal of consent, if there is no other legal basis for the processing);
e. restriction of the processing;
f. objection to the processing for legitimate reasons;
g. data portability (upon your request, the data will be transmitted to the party you indicate in a format that facilitates their consultation and use);
h. lodge a complaint with the supervisory authority (Privacy Authority).

To exercise your rights in accordance with Chapter III of the GDPR and for detailed information about the parties or categories of parties to whom the data is disclosed or who become aware thereof as Processors or Appointees, you can contact the Data Protection Officer (DPO) by sending an e-mail to privacy@rbmsalute.it, or by writing to the Privacy Office at the registered office of RBM Assicurazione Salute S.p.A., Via Forlanini 24 – 31022 Preganziol (TV).

4. Controller and Data Protection Officer

RBM Assicurazione Salute S.p.A., with registered office at Via Forlanini 24 - 31022 Loc. Borgo Verde di Preganziol (TV), is the Controller you may address to assert your rights as provided for by Chapter III of the GDPR by writing to privacy@rbmsalute.it / rbmsalutespa@pec.rbmsalute.it.

The Data Protection Officer may be contacted at the address privacy@rbmsalute.it.

[3] For example: policyholders of collective or individual policies that qualify you as insured, beneficiary or injured person; co-obligors; other insurance operators (agents, insurance brokers, insurers, etc.); parties that, to satisfy your requests (such as insurance coverage, settlement of a claim, etc.), provide information; associations and consortia of the insurance industry; other public entities.

[4] These are in particular agents, agency-producing sub-agents, insurance brokers, banks, stock broking companies and other insurance contract acquisition channels; insurers, co-insurers and reinsurers; lawyers; healthcare facilities and other conventional service providers; companies of the Group to which our company belongs and other service companies, including companies entrusted with the management, settlement and payment of claims; IT, telematic, financial, administrative, archiving, printing, postal, auditing and financial statement certification services companies; or companies entrusted with other technical/organisational services. Then there are association bodies (ANIA) [National Association of Insurance Companies] and consortia of the insurance sector in respect of which the disclosure of the data is essential for providing the services indicated above or for protecting the rights of the insurance industry; other institutional bodies such as the IVASS [Insurance Supervisory Authority], the Ministry of Economy and Finance, the Ministry of Labour and Social Security, the CONSAP [Public Insurance Services Concessionaire], the UCI [Central Office], the Entities operating compulsory social insurances, the Tax Registry, the Law Enforcement Forces, the Judiciary and other databases in respect of which the disclosure of data is mandatory (for example, the Financial Information Unit at the Bank of Italy, the Casellario Centrale Infortuni [Central Accident Registry]).

RBM ASSICURAZIONE SALUTE S.p.A.
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RBM ASSICURAZIONE SALUTE S.p.A. - Sole Shareholder
Fully paid-up Share Capital EUR 160,000,000 - Chamber of Commerce of Treviso Tax Code/VAT Number 05796440963 - Economic Administrative Index 360145
Company registered under number 1.00161 of the Register of Insurance Companies, authorized to exercise Insurance activities by the ISVAP Provision No. 2556 of 17 October 2007 (O.J. No. 255 of 2 November 2007).