Health Plans 2022 – 2023

Base p - Base+ p - Standard p
Plus p - Extra p

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People with visual impairments who use screen readers (e.g. Jaws) can use the keys CTRL + ALT + direction arrows to read the information found in the tables, or may use the guide on the screen reader accessed using the “hot keys” + F1 F1 (e.g. for Jaws, use Insert + F1 F1) to obtain information on how to read the document.

The plans described herein are **healthcare/personal injury policies**, whose aim is to indemnify the insured parties from expenses that may be incurred to treat or diagnose a presumed or confirmed health condition.
Every claim for reimbursement must be accompanied by supporting medical documentation that confirms the diagnosis, or suspected diagnosis, to which the service pertains (indication of symptoms is not sufficient). Preventive services are excluded from this clause.

The services described in the document may be used by Policyholders according to different conditions and by the following methods:

DIRECT/IN NETWORK	INDIRECT/OUT OF NETWORK	MIXED	PUBLIC HEALTH AUTHORITY
at facilities/specialists that are part of the Affiliated Network and on authorisation by the Operations Centre	at other facilities/specialists that are not part of the Affiliated Network or for non-affiliated services	at other facilities/specialists that are not part of the Affiliated Network or for non-affiliated services	in public health service facilities with payment of co-payment, where applicable

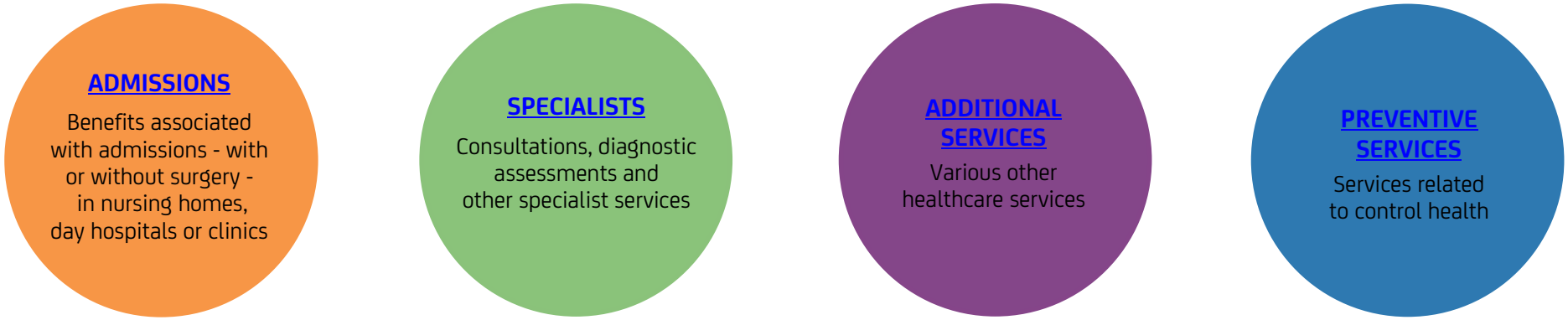
Before accessing healthcare services, in addition to the terms of policy, always consult:

- the "**Policyholder's Guide**" that offers information about methods and conditions for accessing services;
- the final section of this document, "Insurance Policies: **Interpretations**", which provides interpretations relative to certain services shared with the insurer.

This document **does not replace the contractual legal source of health guarantees which is constituted by the Policy**, to be consulted prior to subscribing to the benefits, paying special attention to any **"exclusions".**
Please note that the **Subscription Regulations** specify the policies to which you are entitled.

The present document is a translation of the official Italian version. Please note that in case of discrepancies the Italian version will prevail

The benefits included in the Health Plans are grouped into 4 categories:



The following tables highlight the characteristics of the five covers reserved for retired staff (to be consulted on the basis of the individual choice of membership); equal forecasts are shown once, while differences are specified.

PENALTIES:

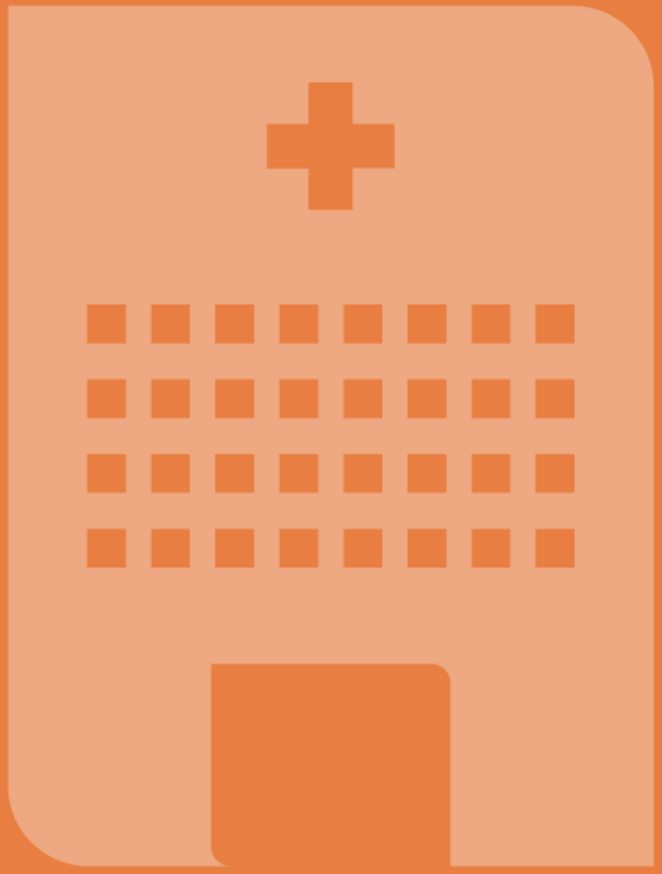
A penalty applies in the event of indirect access to affiliated healthcare facilities/professionals eligible for direct access: in this case the excess/deductible shall be increased by 50%; in the case of TOP clinics, the increase is 100%. (See list of TOP clinics on page 69)

Penalties do not apply to Admissions.

During the "transition period", this surcharge shall not apply to services that cannot already be directly accessed from 01/01/2022

Admissions

Benefits associated with admissions - with or without surgery - in nursing homes, day hospitals or clinics



Admission

ADMISSIONS WITH SURGERY	BASIC p	BASIC+ p	STANDARD p	PLUS p	EXTRA p
BENEFITS DURING TREATMENT	Doctors' fees; operating theatre fees; materials and endoprostheses; medicines, diagnostic assessments, physiotherapy and rehabilitative interventions, treatments Accompanying person (see "Accompanying person" section) Individual nursing care: unlimited	Doctors' fees; operating theatre fees; materials and endoprostheses; medicines, diagnostic assessments, physiotherapy and rehabilitative interventions, treatments Accompanying person (see "Accompanying person" section) Individual nursing care: max. 30 days per event / € 50 per day.	Doctors' fees; operating theatre fees; materials and endoprostheses; medicines, diagnostic assessments, physiotherapy and rehabilitative interventions, treatments Accompanying person (see "Accompanying person" section) Individual nursing care: unlimited	Doctors' fees; operating theatre fees; materials and endoprostheses; medicines, diagnostic assessments, physiotherapy and rehabilitative interventions, treatments Accompanying person (see "Accompanying person" section) Individual nursing care: unlimited	Doctors' fees; operating theatre fees; materials and endoprostheses; medicines, diagnostic assessments, physiotherapy and rehabilitative interventions, treatments Accompanying person (see "Accompanying person" section) Individual nursing care: unlimited
PRE-TREATMENT BENEFITS	Diagnostic assessments and specialist consultations in the 100 day period.				
POST-TREATMENT BENEFITS	Diagnostic assessments, medication, medical, surgical and nursing services, treatments (including hydrotherapeutic, excluding hotel costs) in the 100 day period. physiotherapy and rehabilitation treatments[(1)] within a 120 day period				
CHARGES PER INPATIENT DAY (admissions outside the national health service)	In-Network: no daily limits; Out-of-network: € 200 per day. (does not include expenditure on unnecessary luxuries)	In-Network: no daily limits; Out-of-network: € 250 per day. (does not include expenditure on unnecessary luxuries)	Network: no daily limits; Out-of-Network: € 300 per day. (does not include expenditure on unnecessary luxuries)	Network: no daily limits; Out-of-Network: € 300 per day. (does not include expenditure on unnecessary luxuries)	Network: no daily limits; Out-of-Network: € 300 per day. (does not include expenditure on unnecessary luxuries)
LIMIT	€ 100,000 per household/year	€ 150,000 per household/year	€ 150,000 per household/year	€ 150,000 per household/year	€ 500,000 per household/year
EXCESS DEDUCTIBLE	In-Network: € 1,500 Out-of-network: 25%, minimum € 2000				
NOTES	In the case of transplantation, donor removal expenses incurred are covered PRE services that have already been liquidated relative to the "Specialist Treatments" coverage cannot be reassessed for liquidation relative to the "Admissions" coverage *Physiotherapy and rehabilitation treatments [(1)]: reimbursable only if received exclusively at medical centres equipped with Health Departments - cf. Policy Glossary* *For surgeries with a ceiling, see list on pages 70/71*				

Admission (continued)

ADMISSION WITH SURGERY for reconstructive purposes	BASIC p	BASIC+ p	STANDARD p	PLUS p	EXTRA p
BENEFITS DURING TREATMENT	Admissions expenses following mastectomy or quadrantectomy and relative contralateral adjustment surgery, including psychological support:				
PRE-TREATMENT BENEFITS	Diagnostic assessments and specialist consultations in the 90 day period.				
POST-TREATMENT BENEFITS	Diagnostic assessments, medication, medical, surgical and nursing services, treatments (including hydrotherapeutic, excluding hotel costs) in the 90 day period.				
CHARGES PER INPATIENT DAY (admissions outside the national health service)	no daily limit (does not include expenditure on unnecessary luxuries)				
LIMIT	€ 5,000 per household/year (sublimit)				
EXCESS DEDUCTIBLE	In-Network: € 1,000 Out-of-network: 20%, minimum € 1000				
NOTES	PRE services that have already been liquidated relative to the "Specialist Treatments" coverage cannot be reassessed for liquidation relative to the "Admissions" coverage				

Admission (continued)

ADMISSIONS WITHOUT SURGICAL OPERATION Medical Admission (*)	BASIC p	BASIC+ p	STANDARD p	PLUS p	EXTRA p
BENEFITS DURING TREATMENT	Medical and nursing assistance, specialised medical consulting, treatment, diagnostic examinations, services aimed at recovering health, such as physiotherapy and rehabilitation treatments, medication; Accompanying person (see "Accompanying person" section) Individual nursing care: max. 5 days per event / € 50 per day.				
PRE-TREATMENT BENEFITS	Diagnostic assessments and specialist consultations in the 100 day period.				
POST-TREATMENT BENEFITS	Diagnostic assessments, medication, medical, surgical and nursing services, physiotherapy and rehabilitation treatments[(1)], treatments (including hydrotherapeutic, excluding hotel costs) in the 100 day period.				
CHARGES PER INPATIENT DAY (admissions outside the national health service)	In-Network: no daily limits. Out-of-network: € 200 per day. (does not include expenditure on unnecessary luxuries)	In-Network: no daily limits. Out-of-network: € 250 per day. (does not include expenditure on unnecessary luxuries)	In-Network: no daily limits. Out-of-network: € 300 per day. (does not include expenditure on unnecessary luxuries)	In-Network: no daily limits. Out-of-network: € 300 per day. (does not include expenditure on unnecessary luxuries)	In-Network: no daily limits. Out-of-network: € 300 per day. (does not include expenditure on unnecessary luxuries)
LIMIT	€ 100,000 per household/year	€ 150,000 per household/year	€ 150,000 per household/year	€ 150,000 per household/year	€ 500,000 per household/year
EXCESS DEDUCTIBLE	In-Network: € 500 Out-of-network: 25%, minimum € 1750		In-Network: € 500 Out-of-network: 20%, minimum € 1750		
NOTES	PRE services that have already been liquidated relative to the "Specialist Treatments" coverage cannot be reassessed for liquidation relative to the "Admissions" coverage *Physiotherapy and rehabilitation treatments [(1)]: reimbursable only if received exclusively at medical centres equipped with Health Departments - cf. Policy Glossary* (*) Maximum limit for five days in recovery for a maximum of three occurrences per person per year, after this, the right to compensation does not apply. Furthermore, medical admission is excluded if carried out for diagnostic or pre-operative assessments				

Admission (continued)

ADMISSIONS WITHOUT SURGICAL OPERATION for Serious Pathological Events	BASIC p	BASIC+ p	STANDARD p	PLUS p	EXTRA p
BENEFITS DURING TREATMENT	Medical and nursing assistance, specialised medical consulting, treatment, diagnostic examinations, services aimed at recovering health, such as physiotherapy and rehabilitation treatments, medication; Accompanying person (see "Accompanying person" section) Individual nursing care: max 30 days per event / € 50 per day.				
PRE-TREATMENT BENEFITS	Diagnostic assessments and specialist consultations in the 100 day period.				
POST-TREATMENT BENEFITS	Diagnostic assessments, medication, medical, surgical and nursing services, physiotherapy and rehabilitation treatments(1), treatments (including hydrotherapeutic, excluding hotel costs) in the 100 day period.				
CHARGES PER INPATIENT DAY (admissions outside the national health service)	In-Network: no daily limits. Out-of-network: € 200 per day. (does not include expenditure on unnecessary luxuries)	In-Network: no daily limits. Out-of-network: € 250 per day. (does not include expenditure on unnecessary luxuries)	In-Network: no daily limits. Out-of-network: € 300 per day. (does not include expenditure on unnecessary luxuries)	In-Network: no daily limits. Out-of-network: € 300 per day. (does not include expenditure on unnecessary luxuries)	In-Network: no daily limits. Out-of-network: € 300 per day. (does not include expenditure on unnecessary luxuries)
LIMIT	€ 100,000 per household/year	€ 150,000 per household/year	€ 150,000 per household/year	€ 150,000 per household/year	€ 500,000 per household/year
EXCESS DEDUCTIBLE	In-Network: € 500 Out-of-network: 25%, minimum € 1750		In-Network: € 500 Out-of-network: 20%, minimum € 1750		
NOTES	See “List of Serious Pathological Events” PRE services that have already been liquidated relative to the "Specialist Treatments" coverage cannot be reassessed for liquidation relative to the "Admissions" coverage *Physiotherapy and rehabilitation treatments(1): reimbursable only if received exclusively at medical centres equipped with Health Departments - cf. Policy Glossary*				

List of serious pathological events

A. **ACUTE MYOCARDIAL INFARCTION**
B. **HEART OR RESPIRATORY FAILURE**
presenting, at the same time, at least two of the following conditions:
- dyspnea
- peripheral oedema
- arrhythmia
- unstable angina
- pulmonary stasis or oedema
- hypoxemia

C. **MALIGNANT NEOPLASM**
histologically documented
D. **DIABETES**
complicated characterised by at least two of the following conditions:
- torpid ulcers
- pressure sores
- neuropathy
- peripheral vascular pathologies
- urogenital infections or superinfections
- retinopathy
- ketoacidosis
- diabetic coma

E. **SERIOUS TRAUMA**
- with or without surgical operation - resulting in immobilisations for more than 40 days. Immobilisation consists of the application of a device that cannot be removed by the patient and/or prohibits the loading of the affected limb
F. **SECOND DEGREE BURNS**
over at least 20% of the body
G. **ACUTE VASCULAR PATHOLOGY**
due to ischemic damage or haemorrhage
H. **MULTIPLE SCLEROSIS**
with a significant loss of function (3-4 on the EDSS scale)
I. **AMYOTROPHIC LATERAL SCLEROSIS (ALS)**
J. **COMA**
K. **PARAPLEGIA AND/OR QUADRIPLEGIA**
L. **ALZHEIMER'S DISEASE**
to level 5 or above on the Reisberg scale certified by the UVA (Alzheimer Assessment Unit) of a public neurological facility
M. **PARKINSON'S DISEASE**
to level 3 or above on the Hoehn & Yahr scale, certified by a public neurological facility
N. **OSTEOMYELITIS**
O. **SERIOUS INFECTIONS, POST-OPERATIVE OR POST-TRAUMA INFECTIONS**
P. **SERIOUS PATHOLOGICAL EVENTS "SIMILAR" IN TYPE, EVENT, DIAGNOSIS AND TREATMENT TO THOSE INDICATED IN LETTERS A) TO H).**

Admission (continued)

ADMISSIONS WITHOUT SURGICAL OPERATION for Post-Surgical Rehabilitation	BASIC p	BASIC+ p	STANDARD p	PLUS p	EXTRA p
BENEFITS DURING TREATMENT	Medical and nursing assistance, specialised medical consulting, treatment, diagnostic examinations, services aimed at recovering health, such as physiotherapy and rehabilitation treatments, medication; Accompanying person (see "Accompanying person" section) Individual nursing care: max 30 days per event / € 50 per day.				
PRE-TREATMENT BENEFITS	Diagnostic assessments and specialist consultations in the 100 day period.				
POST-TREATMENT BENEFITS	Diagnostic assessments, medication, medical, surgical and nursing services, physiotherapy and rehabilitation treatments(1), treatments (including hydrotherapeutic, excluding hotel costs) in the 100 day period.				
CHARGES PER INPATIENT DAY (admissions outside the national health service)	In-Network: no daily limits. Out-of-network: € 200 per day. (does not include expenditure on unnecessary luxuries)	In-Network: no daily limits. Out-of-network: € 250 per day. (does not include expenditure on unnecessary luxuries)	In-Network: no daily limits. Out-of-network: € 300 per day. (does not include expenditure on unnecessary luxuries)	In-Network: no daily limits. Out-of-network: € 300per day. (does not include expenditure on unnecessary luxuries)	In-Network: no daily limits. Out-of-network: € 300per day. (does not include expenditure on unnecessary luxuries)
LIMIT	€ 100,000 per household/year	€ 150,000 per household/year	€ 150,000 per household/year	€ 150,000 per household/year	€ 500,000 per household/year
EXCESS DEDUCTIBLE	In-Network: € 500 Out-of-network: 25%, minimum € 1750		In-Network: € 500 Out-of-network: 20%, minimum € 1750		
NOTES	PRE services that have already been liquidated relative to the "Specialist Treatments" coverage cannot be reassessed for liquidation relative to the "Admissions" coverage *Physiotherapy and rehabilitation treatments (1): reimbursable only if received exclusively at medical centres equipped with Health Departments - cf. Policy Glossary* For admissions for Long-Term Post-Surgical Rehabilitation, see the following point.				

Admission (continued)

ADMISSIONS WITHOUT SURGERY Long-Term	BASIC p	BASIC+ p	STANDARD p	PLUS p	EXTRA p
BENEFITS DURING TREATMENT	Long-term admission for rehabilitation for recovery from and/or to improve a physical condition of the Policyholder through medical and/or physiotherapeutic treatments at specialised long-term healthcare facilities (e.g. RSA – residential care homes) or dedicated long-term healthcare departments, in the case of: - admission for surgical operation and post-surgical rehabilitation for the same admission, for a total period of more than 30 day admission for a surgical operation and a later admission for post-surgical rehabilitation, for a total period of more than 30 days;				
PRE-TREATMENT BENEFITS	Medical fees, treatment, diagnostic examinations, services aimed at recovering health, such as physiotherapy and rehabilitation treatments, medication;				
POST-TREATMENT BENEFITS	Not applicable				
CHARGES PER INPATIENT DAY (admissions outside the national health service)	In-Network: unlimited daily limit (in this case, both the healthcare institution and the medical team must be affiliated) Out-of-Network: up to a daily limit of € 200.00 for the first 6 months and € 150.00 for any additional months. This provision applies from the 31st day of the total admission period; until the 30th day of the total admission period, the provisions relative to hospital fees for non-surgical admission for post-surgical rehabilitation shall apply. (does not include expenditure on unnecessary luxuries)				
LIMIT	€ 100,000 per household/year	€ 150,000 per household/year	€ 150,000 per household/year	€ 150,000 per household/year	€ 500,000 per household/year
EXCESS DEDUCTIBLE	In-Network: € 500 Out-of-network: 25%, minimum € 1750		In-Network: € 500 Out-of-network: 20%, minimum € 1750		
NOTES	PRE services that have already been liquidated relative to the "Specialist Treatments" coverage cannot be reassessed for liquidation relative to the "Admissions" coverage If the long-term rehabilitation takes place in healthcare facilities which do not specialise in long-term admission, from the 31st day of the total period hospital fees shall be reimbursed up to the daily limit of € 100.00, for direct and indirect admissions. In the case that dedicated healthcare facilities are not available: - within 50 km from the residence/home of the Policyholder; - or, if the admission for a surgical operation and post-surgical rehabilitation took place in a city other than that of the Policyholder's residence and the Policyholder decides to continue the admission in the same city, within 50 km from the location of the healthcare facility where the admission took place; the provisions pursuant to the "hospital fees" section applicable to long-term admission without surgery shall apply.				

Admission (continued)

MAJOR SURGERY	BASIC p	BASIC+ p	STANDARD p	PLUS p	EXTRA p
BENEFITS DURING TREATMENT	Doctors' fees Operating theatre fees Materials and endoprostheses; medicines, diagnostic assessments, physiotherapy, rehabilitative interventions, treatments Accompanying person (see "Accompanying person" section) Individual nursing care: unlimited	Doctors' fees Operating theatre fees Materials and endoprostheses; medicines, diagnostic assessments, physiotherapy, rehabilitative interventions, treatments Accompanying person (see "Accompanying person" section) Individual nursing care: max. 30 days x event / € 50 per day.	Doctors' fees Operating theatre fees Materials and endoprostheses; medicines, diagnostic assessments, physiotherapy, rehabilitative interventions, treatments Accompanying person (see "Accompanying person" section) Individual nursing care: unlimited	Doctors' fees Operating theatre fees Materials and endoprostheses; medicines, diagnostic assessments, physiotherapy, rehabilitative interventions, treatments Accompanying person (see "Accompanying person" section) Individual nursing care: unlimited	Doctors' fees Operating theatre fees Materials and endoprostheses; medicines, diagnostic assessments, physiotherapy, rehabilitative interventions, treatments Accompanying person (see "Accompanying person" section) Individual nursing care: unlimited
PRE-TREATMENT BENEFITS	Diagnostic assessments and specialist consultations in the 100 day period.				
POST-TREATMENT BENEFITS	Diagnostic assessments, medication, medical, surgical and nursing services, treatments (including hydrotherapeutic, excluding hotel costs) in the 100 day period. physiotherapy and rehabilitation treatments(1) within a 120 day period.				
CHARGES PER INPATIENT DAY (admissions outside the national health service)	In-Network: no daily limits Out-of-network: € 250 per day. (does not include expenditure on unnecessary luxuries)	In-Network: no daily limits Out-of-network: € 250 per day. (does not include expenditure on unnecessary luxuries)	In-Network: no daily limits Out-of-network: € 300 per day. (does not include expenditure on unnecessary luxuries)	In-Network: no daily limits Out-of-network: € 300 per day. (does not include expenditure on unnecessary luxuries)	In-Network: no daily limits Out-of-network: € 300 per day. (does not include expenditure on unnecessary luxuries)
LIMIT	€ 150,000 per household/year for ADMISSIONS	€ 300,000 per household/year for ADMISSIONS	€ 300,000 per household/year for ADMISSIONS	€ 300,000 per household/year for ADMISSIONS	€ 500,000 per household/year for ADMISSIONS
EXCESS DEDUCTIBLE	In-Network: € 1,250 Out-of-network: 25% minimum € 1,750				
NOTES	Transplants: reimbursement of donors' surgical expenses. See List of Major Operations PRE services that have already been liquidated relative to the "Specialist Treatments" coverage cannot be reassessed for liquidation relative to the "Admissions" coverage *Physiotherapy and rehabilitation treatments (1): reimbursable only if received exclusively at medical centres equipped with Health Departments - cf. Policy Glossary*				

List of major surgical procedures

ESOPHAGEAL SURGERY

- Cervical esophagus: resection with reconstruction and autologous transplant of a segment of the intestine
- Median esophagectomy with double or triple access incision (thoraco-laparotomic or thoraco-laparo-cervicotomic) with intra-thoracic or cervical esophagoplasty and lymphadenectomy
- Esophagogastroplasty, esophago-jejunoplasty, esophagocolonoplasty
- Closed-thorax esophagectomy with esophagoplasty at the neck and lymphadenectomy
- Esophagectomy via thoracoscopy
- Enucleation of leiomyoma of the thoracic esophagus by traditional route WITH THORACOTOMY
- Azygos-portal disconnections by abdominal route and/or transthoracically for esophageal varices.

SURGERY OF THE STOMACH, DUODENUM AND SMALL INTESTINE

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

COLON SURGERY

- Right hemicolectomy and lymphadenectomy
- Total colectomy with ileorectal anastomosis, with or without ileostomy
- Anterior rectocolic resection and traditional lymphadenectomy
- Rectocolic resection with colo-anal anastomosis by traditional route
- Proctocolectomy with ileo-anal anastomosis and ileal reservoir, by traditional route
- Amputation of the rectum by abdominoperineal route

LIVER AND BILE DUCT SURGERY

- Liver resections for carcinoma of the principal bile duct
- Portal hypertension surgery:
  a) Derivation surgery
     - portocaval anastomosis
     - splenorenal anastomosis
     - mesenteric-caval anastomosis
  b) Devascularization surgery
     - ligation of the varices by thoracic and/or abdominal route
     - transection of the esophagus by thoracic route
     - transection of the esophagus by abdominal route
     - azygos-portal disconnection with gastrojejunal anastomosis
     - esophageal transection with paraesophageal-gastric devascularisation

PANCREAS SURGERY

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

NECK SURGERY

- Total thyroidectomy for malignant neoplasms with or without uni- or bilateral latero-cervical excavation
- Resections of the trachea and tracheoplasties
- Total pharyngo-laryngo-esophagectomy with pharyngoplasty for carcinoma of the hypopharynx and the cervical esophagus

THORACIC SURGERY

- Surgical removal of cysts and tumours of the mediastinum
- Lobectomies, bilobectomies and pneumonectomies
- Pleurectomies and pleuropneumonectomies
- Lobectomies and segmental or atypical resections via thoracoscopy
- Bronchial resections with reimplantation
- Thoracoplasty: parts I and II

HEART SURGERY

- Aortocoronary bypass
- Surgery for congenital heart diseases or malformations in the large blood vessels (which are not excluded by the guarantee)
- Resection of the heart
- Prosthetic valve replacement
- Valvuloplasty

VASCULAR SURGERY

- Surgery to the thoracic and/or abdominal aorta BY THE THORACOABDOMINAL ROUTE
- Surgery to the abdominal aorta and the iliac arteries (uni- or bilateral) BY THE LAPAROTOMIC ROUTE
- Treatment of traumatic lesions to the aorta
- Treatment of traumatic lesions to the arteries of the limbs and neck
- Aortoenteric fistula surgery
- Surgery to the superior or inferior vena cava

NEUROSURGERY

- Craniotomy for vascular malformations (which are not excluded by the guarantee)
- Craniotomy for spontaneous intracerebral haematoma
- Craniotomy for intracerebral haematoma due to vascular malformation
- Craniotomy for sub- and supratentorial intracranial neoplasms
- Craniotomy for endoventricular neoplasms
- Transsphenoidal approach for neoplasms of the hypophyseal region
- Cerebral biopsy by stereotaxic route

- Removal of orbital tumours by intracranial route
- Internal and external ventricular derivation
- Craniotomy for cerebral abscess
- Surgery for herniated cervical disc or cervical myelopathies and radiculopathies by the anterior route
- Surgical treatment of malignant neoplasms of the peripheral nerves

UROLOGY SURGERY

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

GYNAECOLOGICAL SURGERY

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

EYE SURGERY

- Full-thickness cornea transplant
- Surgery for neoplasm of the eyeball

OTO-RHINO-LARYNGOLOGICAL SURGERY

- Removal of the parotid for malignant neoplasms with excavation
- Radical interventions for malignant neoplasms of the tongue, the floor of the mouth and the tonsils with excavation of ganglia
- Operations to recover function in the VII cranial nerve
- Exeresis of neurinoma of the VIII cranial nerve.
- Petrosectomy

ORTHOPAEDIC SURGERY

- Vertebral arthrodesis by anterior route
- Shoulder replacement
- Osteosynthetic reconstruction of a fracture of the hemipelvis
- Hemipelvectomy
- Invasive reduction and stabilisation of spondylolisthesis
- Invasive treatment of bone tumours
- Major limb amputations exceeding one third

MAXILLOFACIAL SURGERY

- Resection of the upper jaw for neoplasms
- Resection of the lower jaw for neoplasms

PAEDIATRIC SURGERY (THAT IS NOT EXCLUDED BY THE GUARANTEE)

- Cranium bifida with meningoencephalocele.
- Hypersecretory hydrocephalus.
- Cystic and polycystic lung treatment (lobectomy, pneumonectomy).
- Typical children's cysts and tumours of bronchial, enterogenous and nervous origins (sympathoblastoma).
- Congenital atresia of the esophagus.
- Congenital fistula of the esophagus.
- Funnel chest and pigeon chest.
- Congenital stenosis of the pylorus.
- Neonatal intestinal occlusion for meconium ileus: resection with primitive anastomosis.
- Simple atresia of the anus: lowering of the perineal abdomen.
- Atresia of the anus with recto-urethral or recto-vulvar fistula: lowering of the perineal abdomen.
- Megaureter: resection with reimplantation, resection with substitution of a segment of the intestine.
- Megacolon: Duhamel's or Svvenson's abdominoperineal operations.
- Nephrectomy for Wilms' tumour.
- Spina bifida: meningocele or myelomeningocele.

OTHER ITEMS

"Major surgery" is also deemed to include:

- organ transplantation with removal of donor organs;
- admission to an intensive care/resuscitation facility, provided it is for more than 3 days.

Admission (continued)

DAY HOSPITAL WITH SURGERY	BASIC p	BASIC+ p	STANDARD p	PLUS p	EXTRA p
BENEFITS DURING TREATMENT	Team fees; operating theatre fees; surgical materials and endoprostheses, medications, diagnostic assessments, physiotherapy and rehabilitative treatments, medical and nursing care	Team fees; operating theatre fees; surgical materials and endoprostheses, medications, diagnostic assessments, physiotherapy and rehabilitative treatments, medical and nursing care	Team fees; operating theatre fees; surgical materials and endoprostheses, medications, diagnostic assessments, physiotherapy and rehabilitative treatments, medical and nursing care Individual nursing care: unlimited Accompanying person (see "Accompanying person" section)	Team fees; operating theatre fees; surgical materials and endoprostheses, medications, diagnostic assessments, physiotherapy and rehabilitative treatments, medical and nursing care Individual nursing care: unlimited Accompanying person (see "Accompanying person" section)	Team fees; operating theatre fees; surgical materials and endoprostheses, medications, diagnostic assessments, physiotherapy and rehabilitative treatments, medical and nursing care Individual nursing care: unlimited Accompanying person (see "Accompanying person" section)
PRE-TREATMENT BENEFITS	Diagnostic assessments and specialist consultations in the 100 day period.				
POST-TREATMENT BENEFITS	Diagnostic assessments, medication, medical, surgical and nursing services, treatments (including hydrotherapeutic, excluding hotel costs) in the 100 day period. Physiotherapy and rehabilitation treatments(1) within a 120 day period.				
CHARGES PER INPATIENT DAY (admissions outside the national health service)	Network: no daily limits; Out-of-Network: € 200 per day. (does not include expenditure on unnecessary luxuries)	Network: no daily limits; Out-of-Network: € 250 per day. (does not include expenditure on unnecessary luxuries)	Network: no daily limits; Out-of-Network: € 250 per day. (does not include expenditure on unnecessary luxuries)	Network: no daily limits; Out-of-Network: € 250 per day. (does not include expenditure on unnecessary luxuries)	Network: no daily limits; Out-of-Network: € 250 per day. (does not include expenditure on unnecessary luxuries)
LIMIT	€ 100,000 per household/year	€ 150,000 per household/year	€ 150,000 per household/year	€ 150,000 per household/year	€ 500,000 per household/year
EXCESS DEDUCTIBLE	In-Network: € 500 Out-of-network: 20% min. € 1,750				
NOTES	PRE services that have already been liquidated relative to the "Specialist Treatments" coverage cannot be reassessed for liquidation relative to the "Admissions" coverage *Physiotherapy and rehabilitation treatments (1): reimbursable only if received exclusively at medical centres equipped with Health Departments - cf. Policy Glossary* *For surgeries with a ceiling, see list on pages 70/71*				

Admission (continued)

DAY HOSPITAL ADMISSIONS WITHOUT SURGERY	BASIC p	BASIC+ p	STANDARD p	PLUS p	EXTRA p
BENEFITS DURING TREATMENT	Medical care, medicines, diagnostic assessments, treatments and doctors' fees	Medical care, medicines, diagnostic assessments, treatments and doctors' fees	Medical care, medicines, diagnostic assessments, treatments and doctors' fees Accompanying person (see "Accompanying person" section)	Medical care, medicines, diagnostic assessments, treatments and doctors' fees Accompanying person (see "Accompanying person" section)	Medical care, medicines, diagnostic assessments, treatments and doctors' fees Accompanying person (see "Accompanying person" section)
PRE-TREATMENT BENEFITS	Diagnostic assessments and specialist consultations in the 100 day period.				
POST-TREATMENT BENEFITS	Diagnostic assessments, medication, medical, surgical and nursing services, services intended for health recovery, such as physiotherapy and rehabilitation treatments(1), treatments (including hydrotherapeutic, excluding hotel costs) in the 100 day period.				
CHARGES PER INPATIENT DAY (admissions outside the national health service)	In-Network: no daily limits Out-of-network: € 200 per day	In-Network: no daily limits Out-of-network: € 250 per day.	In-Network: no daily limits Out-of-network: € 250 per day.	In-Network: no daily limits Out-of-network: € 250 per day.	In-Network: no daily limits Out-of-network: € 250 per day.
LIMIT	€ 100,000 per household/year	€ 150,000 per household/year	€ 150,000 per household/year	€ 150,000 per household/year	€ 500,000 per household/year
EXCESS DEDUCTIBLE	In-Network: € 500 Out-of-network: 20% min.€ 1,500				
NOTES	PRE services that have already been liquidated relative to the "Specialist Treatments" coverage cannot be reassessed for liquidation relative to the "Admissions" coverage *Physiotherapy and rehabilitation treatments (1): reimbursable only if received exclusively at medical centres equipped with Health Departments - cf. Policy Glossary*				

Admission (continued)

OUTPATIENT SURGERY	BASIC p	BASIC+ p	STANDARD p	PLUS p	EXTRA p
BENEFITS DURING TREATMENT	Doctors' fees; operating theatre fees; surgical materials, medicines, diagnostic assessments, physiotherapy and rehabilitative interventions, treatments, nursing care	Doctors' fees; operating theatre fees; surgical materials, medicines, diagnostic assessments, physiotherapy and rehabilitative interventions, treatments, nursing care	Doctors' fees; operating theatre fees; surgical materials, medicines, diagnostic assessments, physiotherapy and rehabilitative interventions, treatments, nursing care Accompanying person (see "Accompanying person" section)	Doctors' fees; operating theatre fees; surgical materials, medicines, diagnostic assessments, physiotherapy and rehabilitative interventions, treatments, nursing care Accompanying person (see "Accompanying person" section)	Doctors' fees; operating theatre fees; surgical materials, medicines, diagnostic assessments, physiotherapy and rehabilitative interventions, treatments, nursing care Accompanying person (see "Accompanying person" section)
PRE-TREATMENT BENEFITS	Diagnostic assessments and specialist consultations in the 100 day period.				
POST-TREATMENT BENEFITS	Diagnostic assessments, medication, medical, surgical and nursing services, treatments (including hydrotherapeutic, excluding hotel costs) in the 100 day period. physiotherapy and rehabilitation treatments(1) within a 120 day period.				
LIMIT	€ 100,000 per household/year	€ 150,000 per household/year	€ 150,000 per household/year	€ 150,000 per household/year	€ 500,000 per household/year
EXCESS DEDUCTIBLE	In-Network: € 350 Out-of-network: 25% min.€ 750		In-Network: € 350 Out-of-network: 20% min € 750		
NOTES	*For outpatient surgery in the context of specialist visits, consult the "Insurance Policies: Interpretations" section.* PRE services that have already been liquidated relative to the "Specialist Treatments" coverage cannot be reassessed for liquidation relative to the "Admissions" coverage *Physiotherapy and rehabilitation treatments (1): reimbursable only if received exclusively at medical centres equipped with Health Departments - cf. Policy Glossary* *For surgeries with a ceiling, see list on pages 70/71*				

Admission (continued)

CAESAREAN BIRTH	BASIC p	BASIC+ p	STANDARD p	PLUS p	EXTRA p
BENEFITS DURING TREATMENT	Doctors' fees, delivery room fees, materials, medical and nursing care, medicines, diagnostic assessments and treatments Accompanying person (see "Accompanying person" section)				
PRE-TREATMENT BENEFITS	Diagnostic assessments and specialist visits in the 100 day period.				
POST-TREATMENT BENEFITS	Diagnostic assessments, medications, medical, surgical and nursing services, and treatments, in 100 day period.	Diagnostic assessments, medications, medical, surgical and nursing services, and treatments, in 100 day period.	Diagnostic assessments, medication, medical, surgical and nursing services, physiotherapy and treatments in the 100 day period. Physiotherapy and rehabilitation treatments[1] within a 120 day period	Diagnostic assessments, medication, medical, surgical and nursing services, physiotherapy and treatments in the 100 day period. Physiotherapy and rehabilitation treatments[1] within a 120 day period	Diagnostic assessments, medication, medical, surgical and nursing services, physiotherapy and treatments in the 100 day period. Physiotherapy and rehabilitation treatments[1] within a 120 day period
NEONATAL EXPENSES	-	-	Charge per inpatient day (neonatal ward), diagnostic assessments, medical and nursing care up to a maximum limit of € 1,000.00 household/year.	Charge per inpatient day (neonatal ward), diagnostic assessments, medical and nursing care up to a maximum limit of € 1,000.00 household/year.	Charge per inpatient day (neonatal ward), diagnostic assessments, medical and nursing care up to a maximum limit of € 1,000.00 household/year.
CHARGES PER INPATIENT DAY (admissions outside the national health service)	No daily limits (does not include expenditure on unnecessary luxuries)				
LIMIT	€ 3,500 per household/year (applies to admission only, including hospital fees)	€ 4,000 per household/year (applies to admission only, including hospital fees)	€ 6,000 per household/year (applies to admission only, including hospital fees. The limit includes neonatal expenses)	€ 6,000 per household/year (applies to admission only, including hospital fees. The limit includes neonatal expenses)	€ 9,000 per household/year (applies to admission only, including hospital fees. The limit includes neonatal expenses)
EXCESS DEDUCTIBLE	-				
NOTES	Obstetrical care (during admission and PRE and POST treatment) is reimbursable up to a sublimit of € 1,500 per household per year. The conditions are also applicable in the case of therapeutic abortion *For elective caesarean births, consult the "Insurance Policies: Interpretations" section.* PRE services that have already been liquidated relative to the "Specialist Treatments" coverage cannot reassessed for liquidation relative to the "Admissions" coverage *Physiotherapy and rehabilitation treatments [1]: reimbursable only if received exclusively at medical centres equipped with Health Departments - cf. Policy Glossary*				

Admission (continued)

NATURAL BIRTH	BASIC p	BASIC+ p	STANDARD p	PLUS p	EXTRA p
BENEFITS DURING TREATMENT	Doctors' fees Delivery room fees Medicines, diagnostic assessments and treatments Accompanying person (see "Accompanying person" section)				
PRE-TREATMENT BENEFITS	Diagnostic assessments and specialist consultations in the 100 day period				
POST-TREATMENT BENEFITS	Diagnostic assessments, medications, medical surgical and nursing services, and treatments, in 100 day period.				
NEONATAL EXPENSES	-	-	Charge per inpatient day (neonatal ward), diagnostic assessments, medical and nursing care up to a maximum limit of € 1,000.00 household/year.	Charge per inpatient day (neonatal ward), diagnostic assessments, medical and nursing care up to a maximum limit of € 1,000.00 household/year.	Charge per inpatient day (neonatal ward), diagnostic assessments, medical and nursing care up to a maximum limit of € 1,000.00 household/year.
CHARGES PER INPATIENT DAY (admissions outside the national health service)	No daily limits (does not include expenditure on unnecessary luxuries)				
LIMIT	€ 2,500 per household/year (applies to admission only, including hospital fees)	€ 3,000 per household/year (applies to admission only, including hospital fees)	€ 3,000 per household/year (applies to admission only, including hospital fees)	€ 3,000 per household/year (applies to admission only, including hospital fees)	€ 6,000 per household/year (applies to admission only, including hospital fees. The limit includes neonatal expenses)
EXCESS DEDUCTIBLE	-				
NOTES	Obstetrical care (during admission and PRE and POST treatment) is reimbursable PRE services that have already been liquidated relative to the "Specialist Treatments" coverage cannot be reassessed for liquidation relative to the "Admissions" coverage				

Admission (continued)

DENTAL SURGERY	BASIC p	BASIC+ p	STANDARD p	PLUS p	EXTRA p
BENEFITS DURING TREATMENT	Specialist fees Dental implants Medicines, diagnostic assessments and treatments				
PRE-TREATMENT BENEFITS	Diagnostic assessments and specialist consultations in the 100 day period.				
POST-TREATMENT BENEFITS	Diagnostic assessments, medications, medical, surgical and nursing services, and treatments, in 100 day period.				
HOSPITAL FEES	Admissions: - In-Network: no daily limit - Out-of-Network: up to €200.00/day Does not include expenditure on unnecessary luxuries	Admissions: - In-Network: no daily limit - Out-of-Network: up to €200.00/day Does not include expenditure on unnecessary luxuries	Admissions: - In-Network: no daily limit - Out-of-Network: up to € 300.00/day (reduced to € 250.00 for Day Hospital) Does not include expenditure on unnecessary luxuries	Admissions: - In-Network: no daily limit - Out-of-Network: up to € 300.00/day (reduced to € 250.00 for Day Hospital) Does not include expenditure on unnecessary luxuries	Admissions: - In-Network: no daily limit - Out-of-Network: up to € 300.00/day (reduced to € 250.00 for Day Hospital) Does not include expenditure on unnecessary luxuries
LIMIT	10,000 household/year (Including all the above costs)	15,000 household/year (Including all the above costs)	10,000 household/year (Including all the above costs)	10,000 household/year (Including all the above costs)	10,000 household/year (Including all the above costs)
EXCESS DEDUCTIBLE	In-Network: € 350 Out-of-network: 10%, minimum € 1,500	In-Network: € 350 Out-of-network: 10% min. € 1200	In-Network: € 200 Out-of-network: 20% minimum € 1,000	In-Network: € 200 Out-of-network: 20% minimum € 1,000	In-Network: € 0 Out-of-network: 20% minimum € 1000
NOTES	Cover applies to: maxillary osteitis, bone neoplasms of the upper or lower jaw, follicular or radicular cysts, adamantinoma, odontoma. Particular documentation needs to be presented (see policy summary). PRE services that have already been liquidated relative to the "Specialist Treatments" coverage cannot be reassessed for liquidation relative to the "Admissions" coverage				

Admission (continued)

MYOPIA	BASIC p	BASIC+ p	STANDARD p	PLUS p	EXTRA p
BENEFITS DURING TREATMENT	-	Reimbursement of surgery expenses for refraction and laser excitation treatments, team fees, operating theatre fees, surgical materials			
PRE-TREATMENT BENEFITS	-	Diagnostic assessments and specialist consultations in the 100 day period.			
POST-TREATMENT BENEFITS	-	Diagnostic assessments, medications, medical, surgical and nursing services in the 100 day period.			
HOSPITAL FEES (admissions outside the national health service)	-	In-Network: no daily limits. Out-of-network: € 250 per day (including the case of admission to a Day Hospital) (does not include expenditure on unnecessary luxuries)	In-Network: no daily limits. Out-of-network: € 300 per day (€ 250 per day in case of admission to a Day Hospital) (does not include expenditure on unnecessary luxuries)	In-Network: no daily limits. Out-of-network: € 300 per day (€ 250 per day in case of admission to a Day Hospital) (does not include expenditure on unnecessary luxuries)	In-Network: no daily limits. Out-of-network: € 300 per day (€ 250 per day in case of admission to a Day Hospital) (does not include expenditure on unnecessary luxuries)
CONDITIONS	-	Differential between eyes of over 4 dioptres or a visual defect in an eye of at least 8 dioptres			
LIMIT	-	€ 150,000 per household/year	€ 150,000 per household/year	€ 150,000 per household/year	€ 500,000 per household/year
EXCESS DEDUCTIBLE	-	In-Network: € 350 Out-of-network: 10% min. € 500/1,200/1,500 (based on type of surgery: outpatient, day hospital or with admission)	In-Network: € 200 Out-of-network: 10% min. € 1000	In-Network: € 200 Out-of-network: 10% min. € 1000	In-Network: € 0 Out-of-network: 10% min. € 1000
NOTES	-	PRE services that have already been liquidated relative to the "Specialist Treatments" coverage cannot be reassessed for liquidation relative to the "Admissions" coverage			

Admission (continued)

WHOLLY PUBLIC HEALTH SERVICE ADMISSIONS (*)	BASIC p	BASIC+ p	STANDARD p	PLUS p	EXTRA p
REPLACEMENT DAILY ALLOWANCE (for every day admitted into hospital, meaning those including an overnight stay)	€ 55 per day 50% of € 55 per day for Day Hospital (with no overnight stay)	€ 55 per day € 30 per day for Day Hospital (with no overnight stay) € 75 per day for major surgery	€ 80 per day with surgery € 60 per day without surgery € 40/day Day Hospital (completed with no overnight stay) with procedure € 30/day Day Hospital (completed with no overnight stay) with no procedure € 100 per day major surgery	€ 80 per day with surgery € 60 per day without surgery € 40/day Day Hospital (completed with no overnight stay) with procedure € 30/day Day Hospital (completed with no overnight stay) with no procedure € 100 per day major surgery	€ 100 per day € 50/day Day Hospital (with no overnight stay) € 120/day major surgery
DAILY LIMITS	90 days per person/year	120 days per person/year	180 days per person/year	180 days per person/year	300 days per person/year
PRE-TREATMENT BENEFITS	Diagnostic assessments and specialist consultations in the 100 day period.				
POST-TREATMENT BENEFITS	Diagnostic assessments, medication, medical, surgical and nursing services, treatments (including hydrotherapeutic, excluding hotel costs), physiotherapy and rehabilitation treatments[(1)] in the 100 day period.				
NOTES	Post-treatment benefits: Only in the case of surgery the limit of 100 days will be increased to 120 days for physiotherapy and rehabilitation treatments *Physiotherapy and rehabilitation treatments [(1)]: reimbursable only if received exclusively at medical centres equipped with Health Departments - cf. Policy Glossary* PRE services that have already been liquidated relative to the "Specialist Treatments" coverage cannot be reassessed for liquidation relative to the "Admissions" coverage				

(*) for services governed under ADMISSIONS, see admissions area policy letter C

Admission (continued)

ACCOMPANYING PERSON	BASIC p	BASIC+ p	STANDARD p	PLUS p	EXTRA p
BENEFITS	Reimbursement of expenses for room/board and transport for an accompanying person				
CONDITIONS	Services pursuant to letter A, points 1), 2), 6), 7), 9), 10), 11)	Services pursuant to letter A, points 1), 2), 6), 7), 10), 11), 12)	Services pursuant to letter A, points 1), 2), 3), 4), 5), 6), 7), 10), 11), 12)	Services pursuant to letter A, points 1), 2), 3), 4), 5), 6), 7), 10), 11), 12)	Services pursuant to letter A, points 1), 2), 3), 4), 5), 6), 7), 10), 11), 12)
LIMIT	€ 60 per day up to a maximum of 30 days per household/year	€ 60 per day up to a maximum of 30 days per household/year	€ 60 per day up to a maximum of 30 days per household/year	€ 60 per day up to a maximum of 30 days per household/year	€ 80 per day up to a maximum of 90 days per household/year Major surgery: € 180 per day up to a maximum of 90 days per household/year

HEALTH TRANSPORT	BASIC p	BASIC+ p	STANDARD p	PLUS p	EXTRA p
BENEFITS	Ambulance within Italy All transport abroad				
CONDITIONS	Services pursuant to letters A (exclusive of points 5), 8) and C	Services pursuant to letters A (exclusive of points 5), 8), 9) and C	Services pursuant to letters A (exclusive of points 5), 8), 9) and C	Services pursuant to letters A (exclusive of points 5), 8), 9) and C	Services pursuant to letters A (exclusive of points 5), 8), 9) and C
LIMIT	€ 2,000 per household/year	€ 2,000 per household/year	€ 2,000 per household/year	€ 2,000 per household/year	€ 3,000 per household/year

Specialist Treatment

Consultations, diagnostic assessments and other specialist services

Specialist Treatments

HIGHLY SPECIALISED (TREATMENTS AND MAJOR DIAGNOSTICS)	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	Reimbursement for: high performance diagnostic as per attached list				
CONDITIONS	Prescription from a doctor from the local primary care unit (ASL) or a specialist (*)				
LIMIT	€ 4,500 per household/year	€ 5,000 per household/year	€ 5,000 per household/year	€ 5,000 per household/year	€ 7,500 per household/year
EXCESS DEDUCTIBLE	In-Network: fixed cost € 60 per service/ cycle of therapy Out-of-network: 30% min. € 75 per invoice Cost 45% min. € 112.50 per invoice for services in affiliated healthcare facilities without activating the direct form Cost 60% min. € 150 per invoice for services in affiliated healthcare facilities on the TOP Clinic List without activating the direct form	In-Network: fixed cost € 60 per invoice Out-of-network: 30% min. € 75 per invoice Cost 45% min. € 112.50 per invoice for services in affiliated healthcare facilities without activating the direct form Cost 60% min. € 150 per invoice for services in affiliated healthcare facilities on the TOP Clinic List without activating the direct form			In-Network: fixed cost € 35 per invoice Out-of-network: 30% min. € 75 per invoice Cost 45% min. € 112.50 per invoice for services in affiliated healthcare facilities without activating the direct form Cost 60% min. € 150 per invoice for services in affiliated healthcare facilities on the TOP Clinic List without activating the direct form

(*) see "Policyholder's Guide"

List of treatments and diagnostics

HIGHLY SPECIALISED DIAGNOSTICS

- Digital angiography
- Arthrography
- Bronchography
- Cisternography
- Cystography
- Cholangiography
- Percutaneous cholangiography
- Cholecystography
- Dacryocystography
- Fistulography
- Phlebography
- Fluorescein angiography
- Galactography
- Hysterosalpingography
- Lymphography
- Myelography
- Pneumoencephalography
- Retinography
- Sialography
- Splenoportography
- Pyelography
- Vasoseminal vesiculography
- Coronarography
- Scintigraphy
- Amniocentesis for women over 35 or if prescribed as a result of suspected foetal malformation
- Nmr with or without contrast
- Cat with or without contrast

ENDOSCOPY (ALSO WITH BIOPSY SAMPLING)

- Bronchoscopy
- Proctoscopy
- Colonoscopy
- Duodenoscopy
- Esophagoscopy
- Gastroscopy

The removal of polyps, cysts are considered as endoscopic surgery

TREATMENTS

- Dialysis
- Alcoholisation
- Laser therapy
  (Excluded for rehabilitation purposes, with the exception of those done for acute pathologies, reimbursable up to a maximum of 18 sessions)
  Please note that the service shown on the list is not the one used for surgical purposes (e.G. Excision of wart or mole).
  Consult the “insurance policies: interpretations relative to laser therapy

THERAPIES RELEVANT TO ONCOLOGICAL DISEASES

- Chemotherapy
- Radiotherapy
- Cobalt therapy

Specialist Treatments (continued)

HIGH LEVEL DIAGNOSTICS (PRENATAL GENETIC TESTING OF FOETAL DNA)	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	Non-invasive prenatal genetic tests which, through analysis of freely circulating foetal DNA, isolated from a sample of maternal blood, determines the presence of foetal aneuploidies common during pregnancy, specifically those relative to chromosomes 21, 18, and 13 and the sex chromosomes E and Y (e.g. Harmony test, Prenatal Safe.				
CONDITIONS	For women from 30 or if prescribed as a result of suspected foetal malformation Prescription from a doctor from the local primary care unit (ASL) or a specialist (*)				
LIMIT	€ 4,500 per household/year	€ 5,000 per household/year	€ 5,000 per household/year	€ 5,000 per household/year	€ 7,500 per household/year
EXCESS DEDUCTIBLE	In-Network: fixed cost € 60 per service/ cycle of therapy Out-of-network: 30% min. € 75 per invoice Cost 45% min. € 112.50 per invoice for services in affiliated healthcare facilities without activating the direct form Cost 60% min. € 150 per invoice for services in affiliated healthcare facilities on the TOP Clinic List without activating the direct form	In-Network: fixed cost € 60 per invoice Out-of-network: 30% min. € 75 per invoice Cost 45% min. € 112.50 per invoice for services in affiliated healthcare facilities without activating the direct form Cost 60% min. € 150 per invoice for services in affiliated healthcare facilities on the TOP Clinic List without activating the direct form			In-Network: fixed cost € 35 per invoice Out-of-network: 30% min. € 75 per invoice Cost 45% min. € 112.50 per invoice for services in affiliated healthcare facilities without activating the direct form Cost 60% min. € 150 per invoice for services in affiliated healthcare facilities on the TOP Clinic List without activating the direct form

(*) see "Policyholder's Guide"

Specialist Treatments (continued)

DIAGNOSTIC ASSESSMENTS (ORDINARY DIAGNOSTICS)	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	-	Reimbursement of costs (excluding dental and orthodontic assessments, except in the event of accident)			
CONDITIONS	-	Prescription from a doctor from the local primary care unit (ASL) or a specialist (*)			
LIMIT	-	Included in € 3,000 household/year for SPECIALIST CONSULTATIONS	Included in € 3,000 household/year for SPECIALIST CONSULTATIONS	Included in € 3,000 household/year for SPECIALIST CONSULTATIONS	Included in € 5,500 household/year for SPECIALIST CONSULTATIONS
EXCESS DEDUCTIBLE	-	In-Network: fixed cost € 60 per invoice Out-of-network: 30% min. € 75 per invoice Cost 45% min. € 112.50 per invoice for services in affiliated healthcare facilities without activating the direct form Cost 60% min. € 150 per invoice for services in affiliated healthcare facilities on the TOP Clinic List without activating the direct form			In-Network: fixed cost € 35 per invoice Out-of-network: 30% min. € 75 per invoice Cost 45% min. € 112.50 per invoice for services in affiliated healthcare facilities without activating the direct form Cost 60% min. € 150 per invoice for services in affiliated healthcare facilities on the TOP Clinic List without activating the direct form
NOTES	-	Ordinary diagnostic assessments which do not count as major diagnostics Consult the “Insurance Policies: Interpretations” section for cases relative to: - mental health diseases / pain or symptoms / asthenia			-

(*) see "Policyholder's Guide

Specialist Treatments (continued)

SPECIALIST CONSULTATIONS	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	Reimbursement of consultation fees: - Cardiology - Oncology	Reimbursement of consultation fees, excluding: - Paediatric monitoring - dental and orthodontic (except in case of accident)	Reimbursement of consultation fees, excluding: - Paediatric monitoring - dental and orthodontic (except in case of accident)	Reimbursement of consultation fees, excluding: - Paediatric monitoring - dental and orthodontic (except in case of accident)	Reimbursement of consultation fees, excluding: - Paediatric monitoring - dental and orthodontic (except in case of accident)
CONDITIONS	Prescription from a doctor from the local primary care unit (ASL) or a specialist (*)				
LIMIT	€ 2,500 per year/household	€ 3,000 per household/year	€ 3,000 per household/year	€ 3,000 per household/year	€ 5,500 per household/year
EXCESS DEDUCTIBLE	Network: excess € 60 per service Out-of-network: 30% min. € 75 per invoice Cost 45% min. € 112.50 per invoice for services in affiliated healthcare facilities without activating the direct form Cost 60% min. € 150 per invoice for services in affiliated healthcare facilities on the TOP Clinic List without activating the direct form	In-Network: fixed cost € 60 per invoice Out-of-network: 30% min. € 75 per invoice Cost 45% min. € 112.50 per invoice for services in affiliated healthcare facilities without activating the direct form Cost 60% min. € 150 per invoice for services in affiliated healthcare facilities on the TOP Clinic List without activating the direct form			In-Network: fixed cost € 35 per invoice Out-of-network: 30% min. € 75 per invoice Cost 45% min. € 112.50 per invoice for services in affiliated healthcare facilities without activating the direct form Cost 60% min. € 150 per invoice for services in affiliated healthcare facilities on the TOP Clinic List without activating the direct form
NOTES	Dental and orthodontic consultations are refundable if necessitated by an accident Medical acts (e.g. infiltrations) are paid for as part of said guarantee and provide for the reimbursement of the doctor's service only, not the medicine, which remains the responsibility of the Insured. *Consult the "Insurance Policies: Interpretations" section for cases relative to:* *outpatient surgery in the context of specialist visits / mental health diseases / pain or symptoms / asthenia / home visits*				

Specialist Treatments (continued)

PHYSIOTHERAPY	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	-	Reimbursement of the cost of the therapy			
CONDITIONS	-	Treatment following: - Accident, documented by PS certificate issued within 48 hours of the event[1] and occurring 24 months prior to the physiotherapy service - Stroke, neoplasms, degenerative neurological, neuromyopathic and homeoplastic forms - Heart and thoracic surgery; amputation of limbs Services made by medical prescription *Reimbursable only if received exclusively at medical centres equipped with Health Departments*			
LIMIT	-	€. 500 household/year	€. 1,400 household/year	€. 1,400 household/year	Up to € 5,500 per household/year for SPECIALIST CONSULTATIONS
EXCESS DEDUCTIBLE	-	20% min. € 60 per treatment cycle	In-Network: fixed cost of € 40 per treatment cycle Out-of-Network: cost 20% min. € 60 per treatment cycle	In-Network: fixed cost of € 40 per treatment cycle Out-of-Network: cost 20% min. € 60 per treatment cycle	In-Network: fixed cost of € 40 per treatment cycle Out-of-Network: cost 20% min. € 60 per treatment cycle
	-	Cost 30% min. € 90 per treatment cycle, if done in affiliated healthcare facilities, without activating the direct form Cost 40% min. € 120 per treatment cycle, if done in affiliated healthcare facilities on the List of TOP Clinics, without activating the direct form.			
NOTES	-	If there are no Accident & Emergency Departments in the location where the accident has occurred, the Insured may present a certificate issued by a replacement public medical facility issued within 48 hours from the event. Reimbursement of expenses incurred for the rental of equipment used for rehabilitation is NOT provided For information on "Reimbursement of physiotherapy expenses" consult the "Insurance Policies: Interpretations" section.			

Specialist Treatments (continued)

HOME PHYSIOTHERAPY	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	-	The Policyholder may request access to rehabilitation services provided directly in their **own home** through the Operation Centre.			
CONDITIONS	-	Treatment following: - Accident, documented by PS certificate issued within 48 hours of the event(1) and occurring 24 months prior to the physiotherapy service - Stroke, neoplasms, degenerative neurological, neuromyopathic and homeoplastic forms - Heart and thoracic surgery; amputation of limbs Services made by medical prescription			
LIMIT	-	Cf. Physiotherapy maximum limit	Cf. Physiotherapy maximum limit	Cf. Physiotherapy maximum limit	Cf. Physiotherapy maximum limit
EXCESS DEDUCTIBLE	-	For access to this scheme there is a single call/activation cost of € 20.00.			
NOTES	-	(1) If there are no Accident & Emergency Departments in the location where the accident has occurred, the Insured may present a certificate issued by a replacement public medical facility issued within 48 hours from the event. Service only provided in in-Network/Direct form (not in Indirect/refundable form) As well as access to therapists, all electromedical equipment required for the safe and complete provision of the required treatment shall be made available on site. This service is available throughout Italy.			

Specialist Treatments (continued)

ACUPUNCTURE	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	-				Reimbursement of the cost of the therapy
CONDITIONS	-				Prescription from a doctor from the local primary care unit (ASL) or a specialist Services provided by a doctor
LIMIT	-				Up to € 5,500 per household/year for SPECIALIST CONSULTATIONS
EXCESS DEDUCTIBLE	-				20% min. € 40 per invoice

Specialist Treatments (continued)

CANCER TREATMENTS	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	- Home nursing care - Chemotherapy - Radiotherapy - Other therapies for cancer treatments - Specialist consultations				
CONDITIONS	Prescription from a doctor from the local primary care unit (ASL) or a specialist (*)				
LIMIT	€ 2,000 per household/year. If fully used, the same limit envisaged for highly specialised treatments and consultations is applied	€ 2,000 per household/year. If fully used, the same limit envisaged for highly specialised treatments and consultations is applied	€ 10,000 household/year. If fully used, the same limit envisaged for highly specialised treatments and consultations is applied	€ 10,000 household/year. If fully used, the same limit envisaged for highly specialised treatments and consultations is applied	€ 12,000 per household/year. If fully used, the same limit envisaged for highly specialised treatments and consultations is applied
EXCESS DEDUCTIBLE	-				
NOTES	Specialist consultations for oncology follow-ups are paid for as part of said guarantee for a maximum period of 10 years from the date of onset of the pathology				

(*) see "Policyholder's Guide"

Specialist Treatment (continued)

SPEECH THERAPY	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	-		Speech therapy following illness or accident, provided by qualified personnel		
CONDITIONS	-		Casualty Certificate where arising from an accident Prescription from a doctor from the local primary care unit (ASL) or a specialist		
LIMIT	-		€ 1,000 per household/year		
EXCESS DEDUCTIBLE	-		In-Network: fixed cost € 40 per invoice Out-of-Network: cost 20% min. € 60 per invoice		
	-		Cost 30% min. € 90 per invoice for services in affiliated healthcare facilities without activating the direct form Cost 40% min. € 120 per invoice for services in affiliated healthcare facilities on the “List of TOP Clinics” without activating the direct form.		

Specialist Treatment (continued)

PSYCHOTHERAPY	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	-			Psychotherapy	
CONDITIONS	-			Prescription from a doctor from the local primary care unit (ASL) or a specialist	
LIMIT	-			€ 1,000 per household/year	€ 1,500 per household/year
EXCESS DEDUCTIBLE	-			In-network and out-of-network: 50% of the documented costs incurred	

MATERNITY PACKAGE	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	Consultation and assessments in the first 6 months of pregnancy				
CONDITIONS	Prescription from a doctor from the local primary care unit (ASL) or a specialist				
LIMIT	€ 500 per household/year				
EXCESS DEDUCTIBLE	None				
NOTES	In the case of spontaneous/natural abortion, within 3 months of the event, full reimbursement for 1 gynaecology examination and a maximum of 3 psychological support consultations, both in and out of network.				

Specialist Treatments (continued)

DSA (Specific Learning Disabilities) for minors	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	Expenses sustained for the treatment and cure of specific learning disabilities (DSA)				
CONDITIONS	According to the provisions of DSM-5, the *Specific Learning Disabilities* diagnosis must be certified by a doctor specialising in child neuropsychiatry within the National Health Service. Medical (ASL) or specialist prescription with related diagnostic query is required in order to access the services				
LIMIT	€ 1,500 per household/year for moderate to severe cases, according to DSM-5 € 500 per household/year for mild cases, according to DSM-5				
EXCESS DEDUCTIBLE	In-Network: fixed cost € 40 per invoice Out-of-Network: cost 20% min. € 60 per invoice				
	Cost 30% min. € 90 per invoice for services in affiliated healthcare facilities without activating the direct form Cost 40% min. € 120 per invoice for services in affiliated healthcare facilities on the TOP Clinic List without activating the direct form				
NOTES	Guarantee in addition to that relative to speech therapy				

Specialist Treatments (continued)

ORTHOPEDIC PROSTHESES AND HEARING AIDS	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	Purchase, repair and replacement costs				
CONDITIONS	-				
LIMIT	€ 3,000 per household/year				
EXCESS DEDUCTIBLE	-	-	-	-	For the extensions indicated in the NOTES: 30% min. € 50 per invoice
NOTES	-	-	-	-	The cover extends to: - Orthopaedic devices - hernia trusses - curative orthopaedic braces - ocular prostheses - mobility aids - hearing aids - speech aids. The following are excluded: - arch support footwear - aesthetic/shaping corsetry and bodices

Consult the “Insurance Policies: Interpretations" relative to arch support and orthopaedic devices

Specialist Treatments (continued)

ACCIDENT-RELATED DENTAL TREATMENT	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	Reimbursement of expenses resulting from an accident				
CONDITIONS	Hospital Casualty Certificate Injury occurred within the 24 months prior to the execution of treatment				
LIMIT	€ 3,000 per household/year	€ 4,000 per household/year	€ 4,000 per household/year	€ 4,000 per household/year	€ 7,000 per household/year

REIMBURSEMENT OF PUBLIC HEALTH AUTHORITY PRESCRIPTION CHARGES	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	Refund of national health service prescription charges for benefits included in the plan.				
CONDITIONS	Prescription from a doctor from the local primary care unit (ASL) or a specialist (*)				
LIMIT	The costs are within the limit envisaged for the individual type of benefit				
NOTES	Some health structures may offer services both under the National Health Service and privately: in order to consider services as under the National Health Service prescriptions, with application of the relative liquidation conditions, the expense document must clearly indicate the method used for disbursement (prescription quota for co-payment of National Health Service charges).				

(*) see "Policyholder's Guide"

Specialist Treatments (continued)

ADDITIONAL BENEFITS	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	-	-	-	-	Paediatric medical expenses (up to 14 years of age)
LIMIT	-	-	-	-	€ 1,500.00 per household/year € 500.00 per year/per head
EXCESS DEDUCTIBLE	-	-	-	-	30%

LENSES	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	-	-	-	Reimbursement for corrective glasses and contact lenses (exclusive of disposable)	
CONDITIONS	-	-	-	Prescription by an ophthalmologist, optometrist or orthoptist with certificate of compliance First prescription or change in visual acuity	
LIMIT	-	-	-	€ 300 per household/year € 120 per person/year	€ 400 per household/year € 150 per person/year
NOTES	-	-	-	Inclusive of spectacle fitting	

Specialist Treatments (continued)

DENTAL TREATMENT	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	-	-	-	-	Dental treatment, extractions and prostheses with exclusion of orthodontics
LIMIT	-	-	-	-	€ 250.00 per year/household (within a limit of € 1,500.00 of the additional benefits/ paediatric consultations)
EXCESS DEDUCTIBLE	-	-	-	-	35%

Specialist Treatments (continued)

COMPARATIVE DIAGNOSIS (SECOND OPINION)	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	-	-	-	Diagnostic assessment for the most serious diseases, by world-leading specialists, plus the most useful therapeutic indications for treating the diagnosed disease	
CONDITIONS	-	-	-	The service is available for the following diseases: - Alzheimer's disease - AIDS - Blindness - Malignant tumours - Cardiovascular problemsDeafness - Kidney failure - Loss of speech - Transplants of vital organs - Neuromotor diseases - Multiple Sclerosis - Paralysis - Parkinson's disease - Stroke - Coma	
NOTES	-	-	-	If they wish, policyholders may seek a consultation with the specialist who assessed their case. Only the expenses incurred by the Policyholder in relation to the medical consultation will be reimbursed	

Additional Services

Various other healthcare services

Additional Services

CASUALTY SERVICES	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	Clinic services following an accident, without admission to hospital (plaster casts, medicines, diagnostic assessments, medical care and transport)				
LIMIT	€ 1,000 per event				

TREATMENT FOR SUBSTANCE ABUSE	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	Contribution to the costs incurred for rehabilitation				
CONDITIONS	Rehabilitation at treatment centres affiliated with the local primary health care unit (ASL)				
LIMIT	€ 3,000 per person (to be applied to the number of requests/year for all persons registered on the plan, up to a maximum limit of € 30,000)				

ADVANCE PAYMENT OF HEALTH EXPENSES	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	Max. 50% of expenses				
CONDITIONS	For major surgery				

Additional Service (continued)

NURSING CARE	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	-	-	Medical and home nursing care for terminal illnesses that are adequately attested to by certificate from a doctor and/or hospital	Medical and home nursing care for terminal illnesses that are adequately attested to by certificate from a doctor and/or hospital	Medical and home nursing care for terminal illnesses that are adequately attested to by certificate from a doctor and/or hospital
LIMIT	-	-	€ 50/day, max 90 days per household/year	€ 50/day, max 90 days per household/year	€ 50/day, max 90 days per household/year

REPATRIATION OF DECEASED	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	Reimbursement of repatriation expenses for death abroad				
CONDITIONS	For hospitalisation for illness or accident, with or without surgery				
LIMIT	€ 1,500 per event	€ 2,000 per event	€ 2,000 per event	€ 2,000 per event	€ 2,000 per event

Additional Service (continued)

HOME HOSPITALISATION FOLLOWING MAJOR SURGERY	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	-	-	-	-	Home hospitalisation Integrated health care at home
CONDITIONS	-	-	-	-	Prescription from a doctor from the local primary care unit (ASL) or a specialist
LIMIT	-	-	-	-	€ 15,000 per household/year
EXCESS DEDUCTIBLE	-	-	-	-	In-Network: 0 Out-of-network: 10% min. € 1200
NOTES	-	-	-	-	Max. 50 days per hospitalisation

MEDICALLY ASSISTED PROCREATION (all methods)	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	- medical and surgical benefits for MAP - pharmacological treatments linked to the fertilisation method used				
LIMIT	€ 700 per household/year				
EXCESS DEDUCTIBLE	In-network: no cost not covered by insurance Out-of-network: no cost not covered by insurance				
NOTES	Expenses relative to the travel/transfer of the Policyholder are excluded from reimbursement, as are costs for any accompanying person.				

Additional Service (continued)

POST-PARTUM ASSISTANCE	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	Services aimed at full recovery after giving birth. **A) Post-partum psychological support** Within 3 months of birth (occurring during the coverage year), a maximum of 3 psychological visits are covered **B) Lower Limb Check** Within 6 months of birth (occurring during the coverage year), it is possible to have a lower limb check to determine the presence of pathological changes in the superficial and deep venous system of the lower limbs **C) Well-being weekend** Within 1 year of birth (occurring during the coverage year), provision of the following package of services is foreseen: - dietary visit - meeting with nutritionist - meeting with personal trainer - basic physical exercise lesson - hydrotherapy treatment				
EXCESS DEDUCTIBLE	No cost not covered by insurance				
NOTES	This guarantee is provided exclusively through in-network structures which adhere to the Previmedical Network under the Direct regime, subject to booking				

Additional Service (continued)

HYDROTHERAPEUTIC TREATMENTS for MINORS	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	Expenses for hydrotherapeutic treatments, inhalation treatments and Politzer treatments for minors. A visit before and after the treatment is also foreseen.				
CONDITIONS	Disease or accident of the minor				
LIMIT	Maximum 1 (one) cycle per year (maximum of 12 consecutive sessions with a break mid-cycle), carried out in an affiliated health structure indicated by the Previmedical Operation Centre, subject to booking. Expenses for services provided to the Policyholder are paid directly to the structures by the Company for a maximum amount of € 35 per session.				
EXCESS DEDUCTIBLE	Visits before and after treatment are paid without the application of any percentage or fixed costs				
NOTES	Hotel costs for the minor and any accompanying person are excluded				

Additional Service (continued)

DOWN SYNDROME	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	In the case of diagnosis of Trisomy 21 (Down Syndrome), the guarantee foresees the payment of an indemnity				
CONDITIONS	Certified diagnosis within the first 3 years of life				
LIMIT	€ 1,000 year/newborn for a maximum period of 5 years				
EXCESS DEDUCTIBLE	No cost not covered by insurance				

NEWBORNS	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	Treatment and procedures subsequent to malformations or congenital physical defects in newborns, provided they are carried out during the first year of life. In the case that said malformations and/or physical defects are evident as of the first year of birth of the newborn in question and the medical/clinical impossibility of performing a surgical operation during the first year of life can be ascertained and documented, the period during which the operation can be reimbursed is extended to the first 10 years of life.				

Additional Service (continued)

HEALTH ACCOUNT	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS/CONDITIONS	The Health Account is a cumulative account for healthcare purposes aimed at enabling the household to accumulate, for the years following the first insurance year, the financial benefits not used in the insurance year. **A) Good Health Bonus:** If, over the course of the two-year period, the Policyholder demonstrates an average Claims to Contributions ratio for the household that is equal to or less than 75% and the annual prevention protocols have been followed continuously t hroughout the insurance period (sufficient when carried out by only the policyholder), a bonus of 20% of the contribution paid in the previous year will be automatically credited to the Health Account. This amount can be used to increase, in any case up to the limit of the expense, the amount of reimbursements requested by the household and / or to reduce the incidence of any fees to be borne by the insured party (percentage and fixed costs) in the following years. **B) Health Savings:** If, over the course of the year, the household has not submitted a reimbursement claim for any health benefit (with the exception of the annual prevention service provided for by the policy, which does not fall within the scope of this calculation) the policyholder has the right to request a credit to its Health Account of the annual savings up to the amount of 10% of the annual contribution. This amount can be used to increase, in any case up to the limit of the expense, the amount of reimbursements requested by the household and / or to reduce the incidence of any fees to be borne by the insured party (percentage and fixed costs) in the following years.				

Additional Service (continued)

FOR PARENTS HOSPITALISED IN RSA (RESIDENTIAL CARE HOMES)	BASIC p	BASIC + p	STANDARD p	PLUS p	EXTRA p
BENEFITS	The insurance provides for the payment of compensation, payable as a lump sum, for medical, health and care expenses incurred by the Policyholder for parents admitted to a public or private Residential Care Home (RSA) due to their being non-self-sufficient or no longer able to remain at home without very serious compromises to their health and independence.				
CONDITIONS	Benefit accessible for family members who in the course of the year have not submitted claims for any health benefits. The compensation shall be paid at such time that the admission to a Residential Care Home (RSA) has endured for at least 12 consecutive months.				
LIMIT	In-Network: Scheme not applicable. Out-of-Network: € 350.00 per person per year.				
EXCESS DEDUCTIBLE	No cost not covered by insurance				

Preventive Services

Services related to control health

Preventive Service

PREVENTION	BASEp	BASE+ p	STANDARD p	PLUS p	EXTRA p
BENEFITS	Preventive services are offered directly by Uni.C.A. in the context of periodic Prevention Campaigns (normally every two years). Additionally, under the responsibility of the insurer, the following services are foreseen, which can be used either through the Affiliated Network or the Previmedical Authorised Centres.				

CHECK-UPS	BASEp	BASE+ p	STANDARD p	PLUS p	EXTRA p
BENEFITS	Possibility to have a visit to a specialist, of any specialisation, once per month, any day of the week				
CONDITIONS	The service is guaranteed also in the case of consultation/check-up, and therefore no medical or specialist prescription is requested during authorisation				
EXCESS DEDUCTIBLE	No cost not covered by insurance				
NOTES	The benefits are provided through the Direct regime at affiliated healthcare structures which are part of the Previmedical Network, subject to booking. Only specialist consultations available through the affiliated structure are possible				

Preventive Service (continued)

INFLUENZA VACCINE	BASEp	BASE+ p	STANDARD p	PLUS p	EXTRA p
BENEFITS	Annual provision of the influenza vaccine				
CONDITIONS	As this is a preventive treatment, no medical or specialist prescription is required				
EXCESS DEDUCTIBLE	No cost not covered by insurance				
NOTES	The benefit is provided exclusively under the indirect scheme following the presentation of a copy of the invoice or receipt. WARNING: Before obtaining these provided services, please consult your local primary care unit (ASL) or doctor relative to any possible contraindications or significant collateral effects, based on the age or health of the Policyholder/Insured				

Preventive Service (continued)

PREVENTION HERPES ZOSTER	BASEp	BASE+ p	STANDARD p	PLUS p	EXTRA p
BENEFITS	Prevention of Herpes Zoster and complications for all Policyholders aged 55 or older				
CONDITIONS	These services are liquidated as preventive treatments, therefore no medical or specialist prescription is requested during authorisation.				
EXCESS DEDUCTIBLE	€ 36.15 per service				
NOTES	The benefits are provided through the Direct regime at affiliated healthcare structures which are part of the Previmedical Network, subject to booking of admission or through the indirect regime WARNING: Before obtaining these services, please consult your local primary care unit (ASL) or doctor relative to any possible contraindications or significant collateral effects, based on the age or health of the Policyholder/Insured				

Preventive Service (continued)

PAEDIATRIC CHECK-UP	BASEp	BASE+ p	STANDARD p	PLUS p	EXTRA p
BENEFITS	Paediatric specialist check-up visit for minors between 6 months and 6 years of age, under the following conditions: - 1 visit between 6 months and 12 months - 1 visit at 4 years - 1 visit at 6 years				
CONDITIONS	These services are liquidated as preventive treatments, therefore no medical or specialist prescription is requested during authorisation.				
EXCESS DEDUCTIBLE	Expenses for services provided to the Policyholder are liquidated directly to the healthcare structures by the Company, with the application of a fixed cost of € 36.15 per service.				
NOTES	This guarantee is provided exclusively through in-network structures which adhere to the Previmedical Network under the Direct regime, subject to booking For EXTRA policyholders: additional guarantee for paediatric medical expenses (up to 14 years of age)				

Preventive Service (continued)

NUTRITIONAL CONSULTATION AND PERSONALISED DIETARY REGIME	BASEp	BASE+ p	STANDARD p	PLUS p	EXTRA p
BENEFITS	One nutritional consultation, including a personalised dietary plan, is provided per two-year period per person.				
LIMIT	In-Network: unlimited Out-of-Network: € 80.00 (€ 50.00 for the consultation + € 30.00 for the diet)				
EXCESS DEDUCTIBLE	No cost not covered by insurance				

STEM CELL STORAGE	BASEp	BASE+ p	STANDARD p	PLUS p	EXTRA p
BENEFITS	Expenses incurred for the storage and autologus donation of cord stem cells, both in and out of network.				
LIMIT	€ 500 per household/year				
EXCESS DEDUCTIBLE	None				

Insurance policies: Interpretations

Following reports of problems interpreting the policy, received from Members regarding a number of pathologies, enquiries were made with the Insurance Company and the Service Provider Previmedical aimed at clarifying the policy provisions and arriving at agreed interpretations of said provisions.

We are therefore informing the Policyholders of the specifications that derived from this, in the spirit of comparing and sharing the results, which were published with News items in the Info (Informativa) section of the Uni.C.A. website.

PAIN OR SYMPTOMS

For **specialist consultations** in view of pain/symptoms (for example lumbosciatic pain, cervical pain) aimed at verifying the **existence of a pathology** a medical prescription containing the diagnostic query and/or the diagnosis is required (prescriptions indicating vague and/or generic symptoms are not authorised). The company still reserves the right to request supplementary medical documentation or the file prepared by the specialist doctor. The "state of the pathology" found makes no difference in deciding whether the service is reimbursable.
Instrumental tests (radiological or ultrasonographic) aimed at **ascertaining the origin of the symptom** (e.g. RMN for lumbosciatic pain) are authorised/reimbursed.
You are reminded that, in all cases, the **prescription must have been prepared by a doctor other than the specialist who performed the service (directly or indirectly)**, or, if the prescribing doctor also carried out the service provided, the same must be certified by transmission of the related file or report containing the diagnosis.

ASTHENIA

Given that asthenia (sense of weakness and tiredness) is a symptomatology, which can be associated with illnesses, but also exist in healthy people, for the most varied reasons, **medical expenses based only on the indication of "asthenia" are not reimbursable,** because our coverage always presupposes indication of the existing or suspected pathology.

INJURY

The insurance policy (ref. "glossary") defines injury as "*an event due to an unforeseen, violent and external cause, that produces objectively ascertainable bodily harm*".
Therefore, for the event to be classifiable as injury under the terms of the policy **3 simultaneous causes** must occur:

- by "**unforeseen**" is meant: "a result of chance", "accidental, not voluntary", "unpredictable or unavoidable";
- "**violent**" is meant: "intense and capable of damaging" (all slow degenerations, such as certain inflammations and fraying are therefore excluded);
- by "**external**" is meant: an "external cause not inside the body (pre-existing pathological state), or an event caused by an external force"

The injury must be documented by a hospital **Accident & Emergency Department Certificate** issued within 48 hours from the event[1] which is a public deed that provides full proof of the circumstances reported in it.
However, the circumstance that the A&E report contains the term " injury" does not determine in and of itself whether the event is reimbursable under the policy terms; to understand whether or not an injury has occurred under the terms of the policy it is necessary to examine what is written on the A&E certificate and in any supplementary medical documentation.
Situations in which pathologies coexist with unforeseen, violent and external events must be assessed case by case, in light of the medical documentation presented.

You are reminded, finally, that the policy provides expressly for cases of exclusion of the insurance cover, in the case of injury, when the circumstances specified in the relevant section (**Services excluded**) occur.

Some examples of events that can be **defined as injuries** under the terms of the policy are listed below:

- The A&E certificate reports: "Skiing accident with dislocation of the left shoulder and contusions"
- On a bicycle, crossing a junction with a green traffic light; from the orthogonal (perpendicular) road a car arrives which does not stop at the red light and hits me, injuring me
- An object falls on me accidentally (without having caused it to fall) and injures me

Some examples of events that **CANNOT** be defined as injuries under the terms of the policy are listed below:

- Domestic accident, but the A&E certificate also specifies: "in summer episode of lumbar pain treated with deltacortene, last week following exertion, reappearance of lumbar pain treated with bentelan. Today reappearance of pain while reducing assumption of bentelan"
- Injury incurred by road accident caused by drink driving
- The A&E certificate states "Lumbar pain caused by lifting a bag"
- The A&E certificate states "non-traumatic shoulder pain"
- The A&E certificate notes that "the lumbar pain was accentuated while getting out of the car" and that the patient is "already affected by slipped disc L4-L5 left (diagnosed by magnetic resonance)"; the diagnosis is lumbar pain.

OPERATIONS IN OUTPATIENT SURGERIES

When a surgical operation in an outpatient surgery (surgical operation without hospitalisation) is **immediately preceded by a consultation** provided by the same professional who performs the operation, aimed at checking the patient's conditions and the existence of the conditions of admissibility for the operation, this is **part of the said outpatient operation** and cannot be paid separately.

[1] If there are no Accident & Emergency Departments in the location where the accident has occurred, the Insured may present a certificate issued by a replacement public medical facility issued within 48 hours from the event

LASER THERAPY

Given that laser therapy has several fields of application, including physiotherapy, dermatological treatments and a number of surgical operations, when laser therapy is used to **eliminate/reduce the persistence of pain following a surgical operation after a broken bone**, it has been agreed that this constitutes a pathological state "in an acute form", and the coverage described on page 24 of the "health plan comparison" is therefore valid.

COM

Complex Outpatient Macro-activity, the activities of which are an organisational method for complex therapeutic and diagnostic services, where several specialists must interact in a coordinated manner. This organisational model regards activities until recently carried out in Day Hospitals and/or in ordinary hospital stays but does not replace the classic outpatient system where single services are provided in a non-complex context. COM activities are not of a surgical kind; they can be prescribed only by specialists of the structure in which they are carried out.

COM therefore enables the provision of services of a diagnostic, therapeutic and rehabilitative nature which do not entail the need for ordinary hospitalisation. However, due to their nature or the complexity required to carry them out, a continual system of medical and nursing assistance must be guaranteed, and this cannot be implemented in an outpatient clinic.

The various COM pathways, in the context of the medical department , can be summarised and grouped together according to the following indications:

- oncological patients in chemotherapy treatment
- patients who need complex diagnostic manoeuvres
- patients who need support therapies
- treatment of patients with acute and chronic/newly-acute pathologies

In payment terms, COM is equivalent to a DH (Day Hospital) when the following are presented: the medical record or hospital discharge form or an equivalent document.

MENTAL ILLNESSES

Specialist consultations (including more than one) and **diagnostic tests** carried out to ascertain the **pathological state of the Policyholder** (mental/psychiatric illness) and backed by a medical prescription containing the diagnostic query and/or the diagnosis are reimbursable. The company still reserves the right to request supplementary medical documentation or the file prepared by the specialist doctor.

When psychiatric illness has **already been ascertained**, its nature/features are not being reconsidered, and there are merely "check-ups" (e.g.: check on medicine dosage),

nothing should as a rule be reimbursed. However, if there is a specific "psychotherapy" guarantee (literally therapy for the treatment of psychiatric illnesses), in the context of the specific guarantee for **psychotherapy** further **specialist consultations** are **reimbursed** with respect to the initial ascertainment of the pathology, providing greater benefit.

Situations in which the psychiatric specialist consultation is not a mere check-up, but serves to understand whether the illness has undergone an change/transformation which entails a different treatment must be assessed case by case: these situations, by definition "border line", are the most difficult to interpret, and from this perspective producing the specialist report is indispensable for the purpose of assessing whether or not the expense is reimbursable. These situations include consultations aimed at identifying the most appropriate pharmacological treatment in view of an confirmed pathology.

MOLES AND SKIN GROWTHS

Dermatological and diagnostic tests must be backed by a medical prescription containing the diagnostic query and/or the diagnosis of suspected mole.

The request for **removal of an unusual or suspicious mole** must be backed by a clinical report containing:

- the site and description of the lesion;
- why it is suspicious (e.g.: asymmetry, irregular edges, varied and uneven colour, dimensions of more than 6 mm and development or growth);
- the methods of the removal procedure (aesthetic procedures such as: diathermocoagulation, laser treatments or other **aesthetic procedures are not reimbursable**);
- the indication of the histological examination.

CAESAREAN BIRTH AT THE MOTHER'S REQUEST

In terms of payment, a caesarean birth at the mother's request, not resulting from pathologies of the mother or child that would make it necessary, **is reimbursed, applying the less favourable conditions of a physiological birth.**

ARCH SUPPORTS

Only for **Policyholders with EXTRA coverage**: expenses incurred for **arch supports made to measure in specialised centres are reimbursable on presentation of a medical certificate and technical documentation**; those for arch support footwear are not reimbursable.

ORTHOPAEDIC DEVICES

Given that a inconsistency has been found between the indications provided, on the question of orthopaedic and acoustic prosthetics, in the Health Plan Comparison

Prospectus and in the policy texts (EXTRA3 Policy): in the Comparison orthopaedic devices are indicated as reimbursable, in the policy text only orthopaedic devices for hernias, **the interpretation most favourable for Policyholders with the EXTRA coverage has been agreed**: all orthopaedic devices will therefore be reimbursed.

PHYSIOTHERAPY EXPENSES

Regulatory reference (for the sake of simplicity, referred to the New Plus Plan)

1) Glossary: physiotherapy and rehabilitation treatments: **physical and rehabilitative medical services provided by a doctor or medical professional with a degree in physiotherapy or an equivalent qualification recognised in Italy, exclusively provided at medical centres**, aimed at enabling recovery of one or more organs or an apparatus affected by disease or injury indemnifiable under the terms of the policy. In any case, all services aimed at treating problems of an aesthetic nature must be excluded from the present coverage, as well as services carried out with instruments that are mainly used in the context of aesthetic medicine.

2) Policy text: specialist, out-of-hospital and/or outpatient services section point D: physiotherapy:

PHYSIOTHERAPY

The Company reimburses, up to the amount of € 1,400.00 per household and per year, **expenses incurred for physiotherapy, exclusively at Medical Centres, provided by a specialist doctor with a degree in physiotherapy or an equivalent qualification recognised in Italy,** accompanied by a prescription from a specialist doctor indicating the rehabilitation treatment plan, following:

- Injury, documented by hospital accident and emergency certificate issued within 48 hours from the event, which occurred within 24 months prior to performance of the physiotherapy;
- stroke;
- neoplasms;
- degenerative neurological and homeoplastic forms; by way of example: multiple sclerosis, amyotrophic lateral sclerosis (ALS) and all chronic neurological forms due to degenerative processes affecting the central nervous system.
- neuromyopathic forms: mixed pathological forms affecting the neuromuscular system;
- heart surgery, thoracic surgery and amputation of limbs.

Only in cases in which there is a documented impossibility of accessing a Medical Centre, invoices issued by the professional who provided the services can be accepted (in any case, the professional must have a degree in physiotherapy or an equivalent qualification recognised in Italy), accompanied by a prescription from a specialist doctor indicating the rehabilitation treatment plan.

The services listed above are reimbursed against a medical or specialist prescription and with the application of:

- an excess of € 40.00 per treatment cycle if received in affiliated healthcare structures;
- an uninsured percentage of 20%, with a minimum of € 60.00 per treatment cycle if not received in affiliated healthcare structures;

- an uninsured percentage of 30%, with a minimum of € 90.00 per treatment cycle, if received in affiliated healthcare structures without activating the direct form (as of 01 May 2018);
- an uninsured percentage of 40%, with a minimum of € 120.00 per treatment cycle, if received in affiliated healthcare structures on the "TOP Clinic List" without activating the direct form (as of 01 May 2018).

For the purposes of the application of a single uninsured percentage or excess, the request for reimbursement must be presented by the Insured party at the end of the treatment cycle.
In any case, coverage of therapies received in fitness or beauty centres is excluded.

Physiotherapy and rehabilitation treatments are also reimbursable in the context of post-hospitalisation expenses, in accordance with the provisions of the relevant policy section (Admissions, letter A).

3) Healthcare plan summary prospectus – physiotherapy

4) SINGLE_Previmedical_Direct and Indirect Policyholder's Guide: "*to be able to carry out physiotherapy and rehabilitation treatments, intending the physical and rehabilitative medicine services aimed at enabling*
the recovery of one or more organs or an apparatus affected by disease or injury indemnifiable under the terms of the policy, it is necessary to make use of doctors or medical professionals with a degree in physiotherapy or an equivalent qualification recognised in Italy. The said services must be provided exclusively at Medical Centres, with a Medical Administration Office".

From the set of rules presented above, the following application follows, in keeping with the indication contained in the "glossary", also aimed at clarifying the impact of the provisions included in the policy texts and in the Previmedical Policyholder's Guide:

- **physical and rehabilitative medicine services provided by a doctor specialised in the field in question, or by a doctor who also has a degree in physiotherapy or an equivalent qualification recognised in Italy, or by a professional who has a degree in physiotherapy or an equivalent qualification recognised in Italy, provided that the services are, in this latter case, carried out at medical centres are reimbursable.**

In other words:

- physiotherapy services provided by a specialised doctor are reimbursable even if they are not carried out at medical centres
- physiotherapy services provided by a physiotherapist are reimbursable only if carried out at medical centres, with a medical administration office (controlled therefore by a doctor).

The case of a service at home constitutes an exception to this last principle, in accordance with the following rule: *"Only in cases in which there is a documented impossibility of accessing a Medical Centre, invoices issued by the professional who provided the services can be accepted (in any case, the professional must have a degree in physiotherapy or an equivalent qualification recognised in Italy), accompanied by a prescription from a specialist doctor indicating the rehabilitation treatment plan*."

In other words, if there is documentation that accessing a medical centre is impossible (on the basis of a prior medical declaration issued by a doctor other than the one that performs the service) , reimbursement of the service carried out by
a physiotherapist will be authorised.

PRENATAL GENETIC TESTING OF FOETAL DNA PRENATAL SAFE

This consists of taking a blood sample from the mother in which the circulating foetal DNA will be sought and analysed directly. With this test, which is 99% accurate, it is possible to identify the main chromosomal anomalies: down syndrome (chromosome 21), Edwards syndrome (chromosome 18), Patau syndrome (chromosome 13), and the anomalies related to chromosomes X and Y. In addition it is possible to identify the foetal gender.

It is a very convincing alternative for pregnancies in which an invasive diagnosis is not recommended owing to the risk of spontaneous abortion; on the contrary, in specific cases where it is necessary to look for the presence of hereditary genetic illnesses, it is still necessary to resort to invasive examinations such as amniocentesis and villocentesis, which are still recommended when the pregnant woman is more than 35 years old.

In payment terms, the following must be respected:

- the service is included among high-level diagnostic services: to be reimbursed, there must be an indication of an "**existing or suspected pathology**", or for the woman involved to be older than 35 (in line with the rule related to amniocentesis, to which the Prenatal Safe is an alternative).
- In the absence of an existing or suspected pathology, the indication "**search for chromosomal alterations", will be accepted if backed by objective evidence of potential risk.**

CHECK ON TOLERABILITY OF TREATMENT

Consultations/tests which a Policyholder has done to check the tolerability of specific treatments or medicines **are reimbursable if backed by an indication of the existing or presumed pathology** that is meant to be treated and for which the said prior tolerability check is necessary.

HOME VISITS

Apart from the cases expressly provided for (e.g. after major surgery), these are paid for in all **cases in which the person involved cannot leave their home** (an aspect that must be certified by the attending doctor or by the medical structure where the patient was treated) and in the case of **specialist consultations at paediatric age** (children up to 14 years old). While obvious, please note that, as is customary, the specialisation of the doctor who provides the consultation must be related to the existing or suspected pathology.

List of Top Clinics

ROME

- Casa di Cura Paideia S.p.A.
- Casa di Cura Mater Dei S.p.A.
- Ars Medica
- Villa Benedetta
- Casa di Cura Villa Flaminia
- Casa di Cura Villa Margherita

MILAN

- Istituto Nazionale Tumori
- European Institute of Oncology/Monzino
- Casa di cura Columbus
- 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.

List of in-network and out-of-network surgeries for which there is a limit of indemnity (ceiling)

TYPE OF SURGERY	LIMIT
Ligation and stripping of veins (varicocele included)	€ 3,500
Functional septoplasty, including necessary turbinate procedures	€ 3,500
Reduction and setting procedures of fractures to large bones (femur, humerus, tibia)	€ 9,000
Reduction and setting procedures of fractures to medium bones (clavicle, sternum, patella, radius, ulna, fibula)	€ 6,000
Reduction and setting procedures of fractures to small bones (all other bones)	€ 3,000
Removal of fixation devices (e.g. nails, plates, screws)	€ 3,000
Tonsillectomy/adenotonsillectomy	€ 3,000
Hernias and/or incisional hernia of the abdominal wall	€ 5,000
Haemorrhoidectomy and/or removal of rhagades and/or fistulas and/or rectal prolapse	€ 4,500
Hallux valgus surgery with or without metatarsal-phalangeal realignment, hammer toe, hallux rigidus	€ 4,000
Knee surgery (other than ligaments)	€ 7,000
Operative hysteroscopy	€ 4,000
Ligament reconstruction	€ 8,500
Rotator cuff surgery	€ 7,500
Removal of ovarian cysts	€ 8,500
Thyroidectomy (excluding radical for malignant neoplasm)	€ 10,000
Cholecystectomy	€ 8,500
Surgery for herniated disc and/or vertebral stabilization	€ 11,000
Arthrodesis and/or vertebral stabilisation (any method), including removal of herniated intervertebral disc (any method, including robotic)	€ 14,000
Transurethral resection of the prostate (TURP)	€ 9,000
Radical prostatectomy to treat malignant	€ 18,000

TYPE OF SURGERY	LIMIT
Hysterectomy	€ 10,000
Hysterectomy to treat malignant neoplasm (including ovariosalpingectomy and lymphadenectomy)	€ 15,000
Hip arthroplasty	€ 20,000
Removal of skin growths (cysts in general, lymphomas and moles) (1)	€ 1,000
Knee arthroplasty	€ 15,000
Dupuytren's Disease, Guyon Syndrome	€ 2,000
Carpal tunnel surgery	€ 1,500
Trigger finger and ulnar nerve entrapment at elbow procedure	€ 2,500
Cataract (with or without IOL) - per eye	€ 2,000
Removal of cysts and benign lesions of the breast (nodulectomy)	€ 3,500
Appendectomy	€ 4,000
Surgery to paranasal, frontal, maxillary sinuses and/or FESS	€ 3,500

The LIMIT applies to the admission only and does not apply to pre- and post-admission expenses.

Where two or more of the operations on this list are carried out during the same admission, 100% of the limit is applicable for the main operation (as defined by the surgeon) and 70% for the secondary procedures; any excess is applied once only, on the total overall cost.

In the case of operations with limits with direct access, the excess envisaged for admissions with surgery does not apply.

If the estimate of the facility chosen by the Insured is higher than the compensation limit envisaged by this insurance cover, at least 2 alternative affiliated facilities that are able to guarantee the service with lower costs than the compensation limit are identified, if locally available.

(1) Consult the “Insurance Policies: Interpretations” section for cases relative to moles and skin growths