Health Plans 2024 – 2025

Insurance policies: settlement practices

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This document sets out the settlement practices adopted by the insurance company for certain benefits in the Insurance Terms and Conditions (health policies), hereinafter referred to as "ITCs". The purpose is therefore to provide policyholders with clarification regarding the operation of certain policy cover items.

General themes

EMERGENCY PROCEDURE

The ITCs provide only for admissions, but as a best practice it is applied to all types of services if the medical prescription states the urgency of the service requested.

PAIN OR SYMPTOMS

For specialist examinations in connection with pain/symptoms (e.g: lumbosciatica, cervicalgia) aimed at verifying the existence of a pathology, a medical prescription including the diagnostic query and/or diagnosis is required). The company still reserves the right to request supplementary medical documentation or the file prepared by the specialist doctor.

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 (feeling of weakness and fatigue) is a symptom that can be linked to illnesses, but can also occur in healthy people for a variety of reasons, medical expenses based on the mere indication of "asthenia" are not reimbursable, as our cover always presupposes the indication of the existing pathology 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 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.

In addition to what has already been specified in the ITCs, **Replacement public medical facility** means a facility that is part of the Regional Emergency System (e.g: first aid points, and the continuity of care service).

In addition, in the event of a **road accident** - at the same time as the first claim for reimbursement for medical services rendered necessary as a result of the accident - the Insured Person must send the **CID FORM** (friendly declaration) form, if in their possession (it may be sent at a later date), or the **report** sent to their Company or that of the third party responsible for the accident.

DEDUCTIBLE/EXCESS

Unless otherwise stated in the specific cover, the deductible or excess applies per EVENT.

If the service involves a course of treatment (e.g. physiotherapy), the course of treatment is considered an event.

The course of treatment is to be understood as the total number of sessions prescribed/performed for each type of therapy per anatomical site and sent in one go.

EXAMPLE:

Prescription: 10 tecar therapy + 10 massage therapy + 10 re-educations for both wrists.
There are 6 cycles (3 types of physiotherapy x 2 wrists) and the deductible is applied to each cycle.

TELEMEDICINE (set of medical and computer techniques that enable the treatment of a patient at a distance or, more generally, the provision of healthcare services at a distance)

Specialist examinations carried out in telemedicine mode are treated as in-patient specialist examinations, with application of the relevant regulations in terms of applicable schemes (direct or indirect form), maximums, deductibles, excess.

PRE-EXISTING PATHOLOGIES

The following are covered by the policy: illnesses (including chronic and relapsing ones), malformations, pathological states, which have given rise to treatment, examinations, diagnoses before the effective date of cover.

Admissions

WHOLLY PUBLIC HEALTH SERVICE ADMISSIONS WITH HOTEL DIFFERENCE - PER DIEM

Hotel difference" refers to the additional daily expenses paid by the Insured Person in order to take advantage, during hospitalisation performed under the National Health Service, of additional services such as, for example, a reserved room, a single room with bathroom, a room equipped with a television and the possibility of an additional bed.

If the insured submits a claim for the hotel difference, the hospitalisation will be handled and settled as a private hospitalisation: Therefore, the hotel difference and any expenses incurred before and after hospitalisation will be subject to the deductibles/excesses provided for private hospitalisation (excluding, in any case, unnecessary luxury expenses such as a television set). In this case, therefore, the replacement allowance (per diem) provided for hospitalisation at the full expense of the National Health Service will not be paid.

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.

OUTPATIENT ENDOPROSTHESIS OPERATIONS

The issue mainly concerns cataract surgery, which is mainly performed on an outpatient basis, during which an artificial lens (endoprosthesis) can be inserted.

In the event of in-patient or out-patient surgery, the costs of surgical equipment, including endoprostheses, are also covered. This provision, although not present in the paragraph on outpatient operations, also applies to these operations.

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.from which the activity carried out under the COM can be deduced.

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.

DAY SERVICE

Day Service refers to an alternative mode of care to the outpatient model, carried out in care institutions, which does not involve hospitalisation, even during the day; is aimed at the management of clinical cases whose solution requires multiple and multidisciplinary clinical and instrumental investigations, including complex ones. Day service is

NOT equivalent to day hospital and is therefore not eligible for compensation. Individual services performed during the Day Service may be reimbursed if they are covered by the relevant policy cover (out-patient services).

PRE- AND POST-HOSPITALISATION BENEFITS

Pre- and post-hospitalisation benefits are subject to deductibles/ excesses, where applicable, if they have not been fully absorbed by the main event, i.e. hospitalisation, including day hospital, or out-patient surgery.

EXAMPLE:
In the case of indirect outpatient surgery with excess: 10%, minimum € 850

Surgery cost € 500
Deductible applied € 500
Residual deductible not applied € 350

Post-operative benefits € 400
Residual deductible not applied € 350
Amount paid € 50

PRE AND POST SERVICES RELATED TO CEILING OPERATIONS CARRIED OUT IN DIRECT FORM

Since there is no deductible in the case of a ceiling operations performed in direct form, the related pre- and post-operation services (both direct and indirect) are not subject to a deductible.

COMPENSATION IN THE CASE OF SEVERAL CONCURRENT PHASED OPERATIONS OR ORDINARY OPERATIONS CONCURRENT WITH PHASED OPERATIONS

In the event that the hospitalisation foresees more than one surgical operation contained in the Table "List of ceiling surgical operations" of the ITCs, the Company shall pay the indemnity at 100% up to the amount of the ceiling amount for the principal operation (as defined by the surgeon) and 70% up to the amount of the ceiling amounts relative to the secondary surgical operations, without prejudice to the application of the excess or deductible that may be foreseen.

Here are some examples.

EXAMPLES:

1. **Ceiling operation carried out under a reimbursement scheme: ceiling € 14,000**
   Cost of the operation € 10,000.00
   10% min. € 2,500 per hospitalisation
   Authorised benefit € 10,000.00 of which € 7,500.00 shall be borne by the Company and € 2,500.00 by the Insured

2. **Ceiling operation carried out under a reimbursement scheme: ceiling € 14,000**
   Cost of the operation € 17,000.00
   10% deductible min. € 2,500.00 per hospitalisation
   Indemnified benefit € 14,000.00 (as subtracting the applicable deductible would have increased the indemnity to the ceiling).

3. **First ceiling operation performed under a reimbursement scheme: ceiling € 14,000**
   Second ceiling operation carried out under the reimbursement scheme: ceiling € 14,000
   Main operation cost € 17,000.00
   Secondary operation cost € 10,000.00
   10% min. € 2,500.00 per hospitalisation (calculated on the full amount) **€ 24,300.00**
   Indemnified benefit € 14,000.00 for the first surgery, € 7,000.00 for the second

4. **First ceiling operation performed under a reimbursement scheme: ceiling € 14,000**
   Second ceiling operation carried out under the reimbursement scheme: ceiling € 14,000
   Cost of **main operation € 10,000.00**
   Cost of secondary operation € 17,000.00
   10% minimum deductible € 2,500.00 per hospitalisation (calculated on the full amount) = **€ 24,300.00**
   Indemnified benefit € 10,000.00 for the first surgery, € 11,900.00 for the second

5. **First ordinary operation carried out under the reimbursement scheme**
   Second ceiling operation carried out under the reimbursement scheme: ceiling € 14,000
   Cost of main operation € 10,000.00
   Cost of secondary operation € 17,000.00
   Indemnified benefit € 10,000.00 for ordinary operation, € 14,000.00 for ceiling operation (the 100% - 70% rule only applies in the case of 2 ceiling operations)

POST-HOSPITALISATION HOME PHYSIOTHERAPY

As a more favourable benefit for insured persons, post-hospitalisation physiotherapy at home is reimbursed (either directly or indirectly) in cases where there is a documented inability to go to a medical centre, certified by a specialist doctor's prescription.

Out-patient services

HIGHLY SPECIALISED TREATMENTS AND DIAGNOSTICS

No benefits other than those contained in the specific list in the ITCs are indemnifiable.

Endoscopic examinations not explicitly mentioned in the above list are indemnifiable under the "ordinary diagnostics" cover, even if a biopsy is performed.

Endoscopic procedures (e.g. removal of polyps) are only reimbursed within the framework of 'outpatient surgery', under the terms stipulated therein.

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.

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. Services with a generic diagnosis of "mole control" or melanocytic moles are not reimbursed

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.

INFILTRATIONS, FOCAL SHOCK WAVES AND SCLEROSANT THERAPY OR SCLEROTHERAPY

Infiltrations, focal shock waves, and sclerosant therapy or sclerotherapy are considered medical acts and are therefore paid under the "Specialist Examinations" cover; Therefore, for the purposes of compensation, the insured must indicate the doctor who performed the service.

Only the doctor's services are indemnifiable, and not any drugs used.

There is a deductible per course of treatment for these benefits.

It should be noted that:

- Shock Waves (both RADIAL and FOCAL) are indemnifiable under the PHYSIOTHERAPY cover and it is not necessary to indicate the name of the doctor performing them;

It should be noted that in the absence of any indication of the type of shock wave, it will be indemnifiable under the PHYSIOTHERAPY cover.

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 settlement terms, without prejudice to the provisions of the ITCs, for the sake of further clarification, the cover is recognised in the following cases:

- suspected malformation of the foetus;
- the insured mother has a pathology that prevents more invasive tests.

In the absence of an existing or suspected pathology, the indication "search for chromosomal alterations" is nevertheless accepted, where supported by objective evidence of potential risk: The parents' medical history must therefore be indicated, which must be consistent with the requested test.

CANCER TREATMENT AND FOLLOW-UP

CANCER TREATMENT cover is available in the event of an ACTUAL oncological disease (including relapses).

For specialist oncology follow-up examinations - provided for in the ITCs for a maximum period of 10 years from the date of onset of the pathology - a valid exemption code 048 is required or, failing this, medical documentation showing the date of first diagnosis of the oncology pathology (e.g. histological examination report).

The same documentation is also required in the case of diagnostic tests for oncological follow-up that are indemnifiable under the "Highly specialised treatment and diagnostics" and "Ordinary diagnostics" covers.

PHYSIOTHERAPY

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.

Maintenance physiotherapy services are covered, provided they are related to the pathologies covered by the cover.

In addition to the provisions of the ITCs, the following is an illustrative and non-exhaustive list of pathologies for which physiotherapy benefits are indemnifiable:

- **degenerative neurological and homeoplastic forms:** multiple sclerosis, amyotrophic lateral sclerosis (ALS) and all chronic neurological forms due to degenerative processes affecting the central nervous system (e.g. Parkinson's disease, Huntington's disease, Friedreich's ataxia);

- **neuromyopathic forms**: mixed morbidities affecting the neuromuscular system (e.g. muscular dystrophies (Duchenne Muscular Dystrophy and Becker Muscular Dystrophy), myotonic dystrophies (Steinert's disease) and spinal muscular atrophy).

LASER THERAPY

Given that laser therapy has various fields of application, including physiotherapy, dermatological treatments and some surgical procedures, where laser therapy is used to eliminate/reduce the persistence of pain following surgery in fracture outcomes, it is agreed that an "acute" pathological state is present.

LASER REHABILITATION THERAPY FOR ACUTE CONDITIONS

In order to be more favourable to insured persons, the deductible for direct benefits is applied per course of treatment. A course of treatment is to be understood as the total number of prescribed/performed sessions per anatomical site and sent in one go.

SPEECH THERAPY

In the interests of greater benefit for the insured, the following is provided for:

- speech therapy required as a result of mental illness is indemnifiable;
- Invoices issued by duly qualified speech therapists are reimbursable;
- in the case of direct benefits, the deductible is applied per course of treatment.

DSA

In the interests of greater benefit for the insured, the following is provided for:

- Invoices issued by duly qualified professionals are reimbursable;
- in the case of direct benefits, the deductible is applied per course of treatment.

ADDITIONAL SERVICES (paediatric visits)

It should be noted that all visits by a paediatrician (specialist or general practitioner) following a PATHOLOGY (not for control) are indemnifiable; therefore, a doctor's prescription with an indication of the diagnosis or the diagnostic question or, in the case of an indirect form, the examination report with an indication of the diagnosis is required

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PSYCHOTHERAPY

A prescription for PSYCHOTHERAPY can be issued by a general practitioner/paediatrician or a doctor specialising in psychiatry, neuropsychiatry, medical psychology or oncology.

The doctor issuing the prescription <u>cannot</u> be the same as performs the service.

The service may only be performed and billed by a psychotherapist/analyst or a medical doctor specialised in that branch (i.e. not by a psychologist who is not a psychotherapist or by other professionals such as, for example, a neuro- and psychomotricity therapist of the age of development). The Company, for the purposes of indemnifiability of the benefit, therefore reserves the right to verify the specialisation and professional registration of the professional, if not indicated in the documentation submitted by the insured (e.g. on the invoice).

Interviews, rounds of meetings, psychotherapy therapy, psychological interviews, anamnestic interviews, etc., are indemnifiable, provided they are carried out by the professionals indicated above.

Specialist examinations that are additional to the initial assessment of the pathology are also included in the cover and the relevant ceiling. However, the specialist examination must be performed by a medical specialist (e.g. a psychiatrist/neuropsychiatrist) and not by a psychologist who is also a psychotherapist (as such a professional is not a doctor). The invoice submitted by the insured person must be marked "specialist examination".

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.

ACUPUNCTURE

Acupuncture services, if covered, are indemnifiable if prescribed by a local primary care unit (ASL) doctor or medical specialist and practised by a doctor qualified in acupuncture. The acupuncture licence must be evidenced by the documentation submitted by the insured (e.g. invoice); otherwise, the Company reserves the right to request a diploma in acupuncture.

ARCH SUPPORTS

For members with Extra cover only, expenses incurred for custom-made insoles in specialised centres and upon presentation of a medical certificate and technical documentation are reimbursable; those for arch support footwear are not reimbursable.

Additional benefits

MEDICALLY ASSISTED PROCREATION

In addition to the ITCs, it should be noted that the following are indemnifiable:

- medical-surgical services related to medically assisted procreation techniques (e.g. egg retrieval, homologous and heterologous, level I - simple insemination - and level II and III - IVF, GIFT, ICSI. In general, all medical and surgical services related to the operational phase of the medically assisted procreation procedure are considered indemnifiable);

POST-PARTUM ASSISTANCE

A check-up of the lower limbs (angiology/vascular surgery examination) to establish the presence of pathological changes in the superficial and deep venous circulation of the lower limbs can be carried out within 6 months of delivery during the period of cover. Diagnostic examinations are not eligible for compensation.

Prevention

NUTRITIONAL CHECK-UP + DIET

In the event that the service is provided partly in the direct form (e.g. nutritional consultation) and partly in the indirect form (e.g. diet), the conditions set out in the ITCs for the type of scheme used apply.