2025 Report and Financial Statements
General Meeting Draft

Investing in health, supporting the future

Uni.C.A.
PER IL PERSONALE E LE AZIENDE DEL GRUPPO
UniCredit

Table of contents

Corporate bodies 03

Board of Directors' Report 04

Focus on the national health situation 06

Evolution of the Italian healthcare system: from structural limits, to changing demand and supplementary healthcare (by the OCPS of CeRGAS-SDA Bocconi) 06

The Uni.CA model 23

01 The UniCredit Group's health benefits fund: about us 24

02 Organisational model 25
2.1 Uni.C.A.'s staff 25
2.2 Supervisory Board pursuant to Legislative Decree 231/01 26

03 Service model 27
3.1 Insurance and service partnership 27
3.2 The agreement between Uni.C.A. and UniCredit 28
3.3 The benefits provided by Uni.C.A. and its beneficiaries 29

Report on operations 30

04 Members as of 12/31/2025 and trends 31

05 Coverage offered to members 39
5.1 Health plans 2026-2027 39
5.2 Prevention: 2024-2025 campaign results 40
5.3 Other directly financed initiatives 45
5.4 Complaints reporting and management procedures 46
5.5 Audit of membership database. 49

06 Loss Ratios 50
6.1 Basic health cover (insurance policies) 50
6.2 Dental coverage 53

07 Key operational and management data. Summary 54

08 Benefits provided: analysis and comparison with previous years 55
8.1 Performance of basic cover 55
8.2 Trends in dental coverage 67

09 Exercise of Director's powers. Legal disputes 73

10 Application of the Sacconi Decree 74

11 Association activities 75

12 2026: activities related to the 1st quarter 76

Financial statements as at and for the year ended 31 December 2025 77

13 Statement of financial position as at 31 December 2025 78

14 Income statement for the year ended 31 December 2025 79
14.1 Employee section 80
14.2 Retiree section 81

15 Notes 82
15.1 Accounting policies 83
15.2 Notes to the Statement of Financial Position and the Income Statement 85

Board of Auditors' report 92

Corporate bodies as at 31.12.2025

Board of Directors
Chairman Antonio Argento[1]
Deputy Chairman Igor Do'
Directors Renato Carlo Bianchi, Francesco Bruno, Emilio Campagna, Patrizia Cantarini, Cinzia Caracciolo, Adriano Ceriani, Gianluca D'Auria, Ignazio Stefano Farina, Luigi Luca Ghislotti, Maria Cristina Gobbi, Federico Granito, Massimo Gregorio, Ruggero Louvier, Giuseppe Matta, Giovanna Statti, Guglielmo Valenti

Executive Committee
Chairman Antonio Argento
Deputy Chairman Igor Do'
Directors Emilio Campagna, Ignazio Stefano Farina, Massimo Gregorio, Renato Carlo Bianchi, Giuseppe Matta, Giovanna Statti

Board of Auditors
Chairman David Davite
Standing Auditors Cristina Costigliolo, Fiorenza Sibille, Vincenzo Ferraro
Alternate Auditors Riccardo Achenbach, Gianna Maria Roggero

Director Miriam Travaglia
Deputy Director Renato De Mattia

[1] Following the renewal of the Corporate Bodies which took effect on 1 January 2026, the new Chairman is the signatory of these financial statements.

"2025 was a challenging year marked by significant innovations, during which we continued to pursue our goal with determination: to ensure high-quality healthcare services and to put the health of our members at the heart of every decision.

The Chairman
Gianfranco Cascino

Dear Members,

In 2025, the Association continued to consolidate its position, marking its nineteenth year of operation. The year was marked by significant challenges, including the renewal of the Health Plans and the introduction of innovative services, such as the new digital primary care service.

The renewal work has required a significant commitment, against the backdrop of a complex national healthcare landscape, characterised by the challenges facing the public health system and the resulting increase in the use of private healthcare services. This trend has led insurance companies to adopt a more cautious approach focused on cost containment.

In this context, our objective has remained unchanged: to ensure the continuity, stability and quality of the healthcare services provided to our members.

The negotiations, which confirmed Generali S.p.A. as the insurance partner and Welion as the service provider for non-dental cover, have yielded significant results:

> the maintenance and strengthening of healthcare cover, with improvements in the areas of mental health, maternity and cancer care;

> greater financial sustainability of the healthcare plans, achieved in part through targeted rationalisation measures;

> the renewal of the health check-up campaign for the 2026–2027 period, recognising the social and health benefits of prevention.

The new prevention campaign, which will be launched in 2026, has therefore been confirmed. The campaign that concluded in 2025 was well received by members, with a participation rate of over 56% (62% among employees and 34% among retirees).

Regarding dental coverage, the existing system has been confirmed, alongside the introduction of a new plan designed to meet the needs of families with children under 18 for preventive services. However, a slight adjustment to the contributions, which had remained unchanged for over ten years, was necessary to ensure their long-term sustainability. Aon has been confirmed as the service provider.

Then, thanks to the contribution of the company's social partners through the union agreement signed in February 2025, the Fund took a major step towards innovation by launching MediPhonica, a new digital primary care service available 24/7 and accessible from abroad in English, in October 2025.

The free service is provided by a team of doctors specialising in remote care and is accessible via a dedicated app. It is available to all UniCredit Group employees.

The audit activities, which began in 2023 and are scheduled to continue for several years, have confirmed the soundness of Fund's management procedures.

On the institutional level, Uni.CA continued its discussions with the Ministry of Health as part of the Healthcare Services Dashboard project, aimed at strengthening the public information base on healthcare funds and insurance plans.

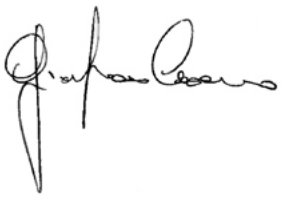
Full compliance with the provisions of the so-called Sacconi Ministerial Decree has also been ensured for 2025, guaranteeing the tax deductibility of contributions paid by members.

The 2025 Financial Statements close with an accounting surplus of €76,906, which will be allocated to the Fund's capital reserves.

In conclusion, 2025 was a challenging year marked by significant innovations, during which we continued to pursue our goal with determination: to ensure high-quality healthcare services and to put the health of our members at the heart of every decision.

We would like to thank you sincerely for your feedback, comments and suggestions. They are invaluable to us and help us to continuously improve our services and develop a support model that is ever more tailored to your needs.

The Chairman
Gianfranco Cascino



FOCUS ON THE NATIONAL HEALTH SITUATION

Evolution of the Italian healthcare system: from structural limits, to changing demand and supplementary healthcare

Contribution from the Observatory on Private Healthcare Expenditure (OCPS) at CeRGAS – SDA Bocconi (Centre for Research on Healthcare and Social Care Management at the SDA Bocconi School of Management)

Introduction

Drawing on the most recent evidence gathered in the OASI 2025 Report, edited by CeRGAS - SDA Bocconi and other institutional sources, we aim to provide a systematic analysis of the emerging issues facing the National Health Service (NHS) and the trends in private spending and supplementary healthcare in meeting the health needs of Italians.

Starting from the evidence regarding unjustified variations in healthcare expenditure, the system's productivity constraints and staff shortages – particularly among nursing staff – this analysis examines how these dynamics, which are often overlooked, are intertwined with changes in the way citizens choose between public and private healthcare. In particular, the aim is to highlight the fact that the main causes of the NHS's shortcomings identified in the national debate do not always provide a complete picture; we therefore seek to offer new food for thought on how to better manage demand and ensure a more efficient and effective use of the resources available to both the public and private healthcare sectors.

The big picture

Following the period of increased funding for the NHS linked to the pandemic emergency, the proportion of Gross Domestic Product (GDP) invested in healthcare has returned to levels similar to those seen at the end of 2010. Although the level of funding has increased in absolute terms, the proportion of GDP allocated to healthcare provides a clear picture of a country's willingness or ability to fund its own healthcare system. The Italian government is caught between the constraints of maintaining pension expenditure and managing a public debt that remains a critical issue, and this situation is reflected in the proportion of GDP allocated to healthcare, which is lower than in several countries within and outside the eurozone.

Table 1 - **Per capita health expenditure (in euros) by financing regime and selected OECD countries, 2024**

Expenditure	Public or private mandatory expenditure[1]		Voluntary private expenditure		Total health expenditure	
Country	€ per capita	GDP %	€ per capita	GDP %	€ per capita	GDP %
Germany	€5,459	10.6%	€869	1.7%	€6,328	12.3%
Austria	€4,749	9.0%	€1,477	2.8%	€6,226	11.8%
France	€4,149	9.7%	€764	1.8%	€4,913	11.5%
Portugal	€1,707	6.4%	€1,037	3.9%	€2,745	10.2%
The Netherlands	€5,260	8.3%	€1,064	1.7%	€6,324	10.0%
Spain	€2,187	6.7%	€816	2.5%	€3,003	9.2%
Italy	€2,331	6.3%	€808	2.2%	€3,139	8.4%
Greece	€1,106	4.8%	€747	3.3%	€1,853	8.1%

NON-EURO COUNTRIES

Expenditure	Public or private mandatory expenditure[1]		Voluntary private expenditure		Total health expenditure	
Switzerland	€7,728	8.0%	€3,476	3.6%	€11,371	11.8%
United Kingdom	€4,385	9.1%	€1,008	2.1%	€5,393	11.1%
Sweden	€5,134	9.7%	€860	1.6%	€5,994	11.3%
Poland	€1,453	6.3%	€409	1.8%	€1,862	8.1%

[1] By 'mandatory private expenditure', the OECD refers to health expenditure relating to health insurance policies that some countries require their citizens to purchase.

Source: Adaptation of Table 6.4, page 11, online, M. Cavazza, M. Del Vecchio, L. Fenech, L. Preti, V. Rappini, Private Consumption in Healthcare, in Cergas Bocconi, OASI Report 2025, EGEA, Milan, 2025. https://forms.sdabocconi.it/brochure/2026/oasi/

Thus, Italian private healthcare spending, at 2.2% of GDP, is in line with other countries, with the exception of Portugal and Greece (and Switzerland, where the context has different definitions and mechanisms), bringing the total share of GDP allocated to public and private healthcare spending to 8.4%, the lowest in the European rankings. It is noteworthy that Spain and Portugal, with a public health expenditure/GDP ratio similar to Italy, achieve a GDP/total health expenditure ratio 1-2 percentage points higher than Italy through higher private spending.

This table helps us understand how necessary it is to reflect on the effective and efficient use of resources available to both public and private healthcare.

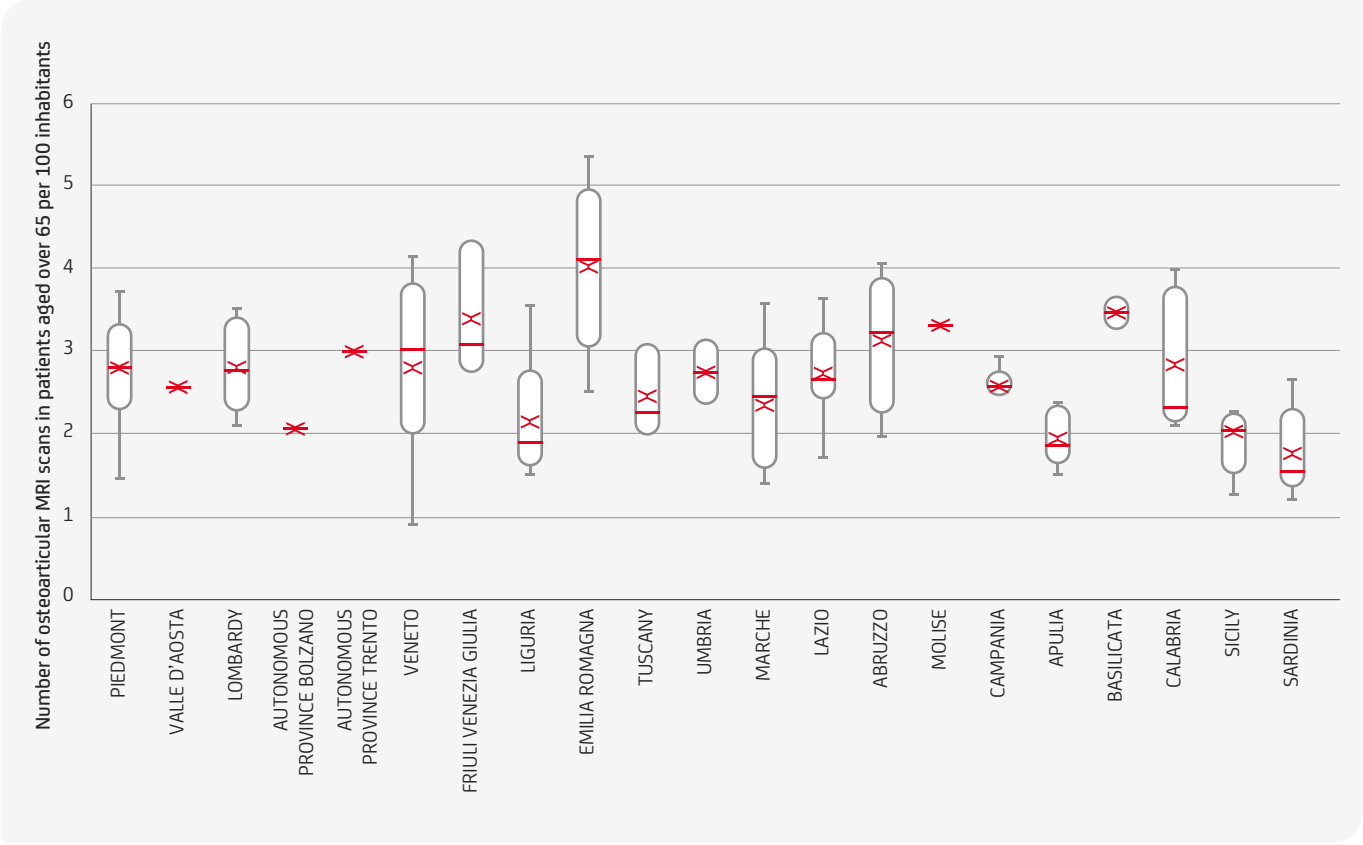
Emerging critical issues in Italian public healthcare

From the perspective described above, there is therefore a need to fully understand the critical issues actually present in the National Health Service in terms of resource use and organisation.

Emerging critical issues in the NHS: unjustified variability of consumption

A significant but underestimated indicator of a failure to manage demand for services within the NHS is the unjustified variability of consumption. The data highlights significant regional differences in healthcare consumption. For example, the uptake of osteoarticular magnetic resonance imaging (MRI) scans among patients aged over 65 varies considerably across Italian regions, with disparities ranging from around 1.5 to 5.5 scans per 100 inhabitants (Emilia-Romagna vs Sardinia, 2023 data). This type of representation of the phenomenon (see the box plot in Figure 1) highlights the fact that there is also considerable variation within a single region. For example, in the Veneto region, there are healthcare trusts where the figure ranges from a maximum of just over 4 MRIs per 100 inhabitants to a minimum of 1 per 100 inhabitants. The Emilia-Romagna region, which borders the Veneto region and is likely to have very similar epidemiological conditions, has an average of 4 MRIs per 100 inhabitants (indicated by the x in Figure 1), compared with just under 3 in Veneto, with a range of 2.5 to 5.5 MRIs per 100 inhabitants.

Figure 1 - **Use of osteoarticular magnetic resonance imaging (MRI) services among patients aged over 65 per 100 inhabitants, regional box plots, 2024**



Note: The '–' line in the box represents the median, while the 'x' represents the mean. The so-called 'whiskers' above and below the box represent the maximum and minimum value respectively.

Source: Figure 9.1., page 12 online in Broccolo G., Furnari A., Longo F., Puritani G., Ricci A. The variability of consumption and prescriptions in the NHS: an inter- and infra-regional comparison, in Cergas Bocconi (ed.), OASI Report 2025, EGEA, Milan 2025. https://forms.sdabocconi.it/brochure/2026/oasi/

Figure 2 also shows how the level of population density has a significant impact on the provision of services, classifying the providers of the Lombardy Regional Health Service based on the density of their catchment area, between low density areas (less than 297 inhabitants/km²), medium density (between 297 and 841 inhabitants/km²) and high density (greater than 841 inhabitants/km²). In particular, there are significant variations between the various Regional Health and Social Care Authorities (ASSTs): high-density areas tend to consume more (with an average of 75.9 and 214 appointments per 1,000 inhabitants, respectively in the general population and among the over-65s), while medium-density areas consume less overall (61.3 and 164 appointments respectively).

Figure 2 - **Consumption of MRI services per 1,000 inhabitants and per 1,000 inhabitants over 65 by ASST (Lombardy), 2024**

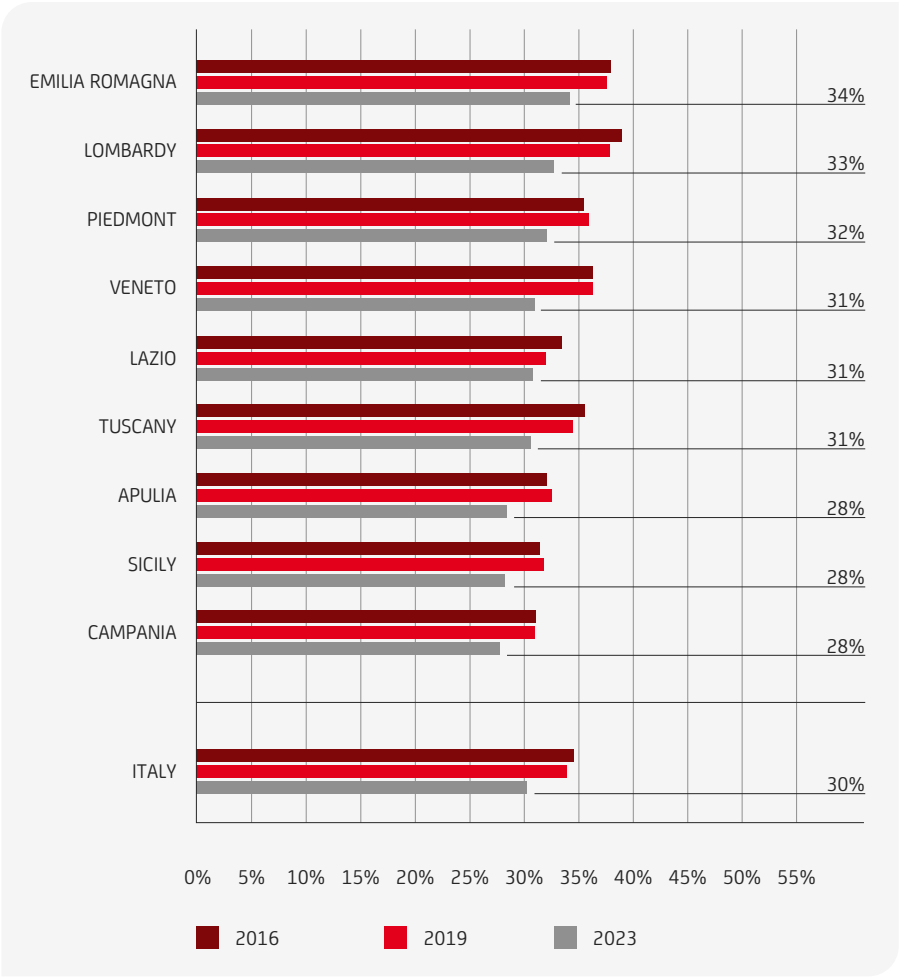
Note: the capital letters on the x-axis represent the Lombardy Local Health Authorities (ASST) that provide hospital and local health services as well as social health services.

Source: Fig. 9.17, p. 28 online Broccolo G., Furnari A., Longo F., Puritani G., Ricci A., The variability of consumption and prescriptions in the NHS: an inter- and infra-regional comparison, in Cergas Bocconi (ed.), OASI Report 2025, EGEA, Milan 2025. https://forms.sdabocconi.it/brochure/2026/oasi/

System efficiency: financial balance vs. productivity growth

The value of healthcare production (hospitalisations and outpatient specialist care) in relation to regional public healthcare spending provides a possible relationship between system inputs and outputs in individual regional contexts, revealing a worrying trend. After reaching 34% in 2016, it dropped to 28-30% in 2023 in several regions. This figure raises questions about the system's ability to increase productivity rather than simply maintaining financial stability. In recent years, efforts have rightly focused on achieving the latter. However, this has not led to the organisational changes that could have increased the productivity of the Regional Health Service's (SSR) physical and human capital.

Figure 3 - **Production value (hospitalisations + outpatient specialist care) in relation to regional public health expenditure**



Source: adapted from F. Longo, Narration and Emerging Criticisms: a double agenda for the Directors General of the National Health Service, Presentation of the OASI 2025 Report, 3 December 2025, Milan, by Furnari A., Notarnicola E., Giordana Puritani, Alberto Ricci and Silvia Rota, Health expenditure and the costs of services: composition and evolution from a national, regional and corporate perspective, Cergas Bocconi (ed.) OASI 2025 Report, Egea, Milan. Fig 3.11, p. 28 online.

Consider, for example, the closure or conversion of small hospitals into community hospitals, or the establishment of disease-specific networks based on a hub-and-spoke model, as has been done for breast cancer. This involves identifying regional reference centres (hubs) connected to structures spread throughout the territory (spokes). For example, breast pathology hubs perform surgical procedures, ensuring quality thanks to their high activity levels. The spokes, on the other hand, support patients during chemotherapy close to their homes. Although these are organisational solutions that have been proven to be effective and efficient, they often clash with different perceptions. On the one hand, there are doctors who prefer to work in hub centres. On the other hand, there is the local population and politicians who fear that activities will be 'delocalised' from their small hospitals, which are destined to become spokes, towards the hubs, even when the latter guarantee greater quality and safety. Another emblematic example of these dynamics is the reopening of maternity wards with fewer than 400 births per year, despite international and national guidelines indicating 400 births as the threshold value. Below this level, a reduction in activity volumes is actually associated with an increased risk of adverse events during childbirth.

Absence of explicit priority criteria

The NHS, inspired by the Beveridge model [2], was born from the idea that collective choice allocates limited resources better than potentially infinite needs. Its universal system is considered to be more rational than insurance systems and the Bismarck model of social insurance, which is present in countries such as France and Germany. According to this logic, waiting lists are seen as a natural and even beneficial tool because they make priorities clear. In theory, the NHS is therefore designed to manage 'scarcity' by defining and enforcing collective priorities to maximise social benefit. However, despite this system, the NHS currently does not express clear priority criteria for access to services, with obvious consequences. As already noted in previous years, the payment methods for healthcare services show that between 2019 and 2023 the share of out-of-pocket spending (private healthcare spending) increased significantly from 33% to 37% for specialist appointments, and from 23% to 30% for diagnostic tests.

The lack of prioritisation also manifests itself in more clinically complex pathways, even when remaining within the deadlines established by the protocols. For example, this is the case for the waiting period between biopsy and breast surgery in the Milan Health Authority (ATS) catchment area. The data shows that patients who undergo all tests through the public system wait an average of 51.66 days, whereas those who use the private system wait an average of 32.49 days.

[2] model characterised by public financing of health care, where the state plays a central role in the provision of services.

Table 2 - **Number of days waiting between biopsy and breast surgery in the Milan Health Authority (ATS), 2024.**

Population stratification by assessment method	No. of patients	Average days for tests
Patients who undergo all tests in the public sector	1,207	51.66
Patients with paid or private benefits, but with a prevalence of public benefits	2,732	54.22
Patients undergoing the same number of tests in the regional health services and in the private-payment regime	258	53.19
Patients with services under the regional health services regime, but prevalence of private-payment regime	519	48.99
Patients who undergo all tests under a private-payment regime	147	32.90

Source: adapted from F. Longo, Narration and Emerging Criticisms: a dual agenda for the Directors General of the NHS, Presentation of the OASI 2025 Report, 3 December 2025, Milan.

Finally, an indicator of a frequent lack of governance and effective care emerges from the large number of prescriptions that are not followed by the provision of the service. This phenomenon emerges, for example, in regions such as Lombardy, where there are health authorities where the specialist appointments prescribed and actually provided are limited to 48%. This phenomenon occurs to a slightly lesser extent for diagnostics, reaching 54%.

37%

Private healthcare spending on specialist appointments

+4% between 2019 and 2023

51.66 days

Average waiting time for public health tests

48%

Specialist appointments prescribed and actually provided

Currently the NHS does not express clear priority criteria in accessing services, with obvious consequences

Figure 4 - **Prescribing differences in appointments: Prescriptions and consumption of appointments per 1,000 inhabitants by Territorial Socio-Healthcare Company (ASST), Milan, 2024**

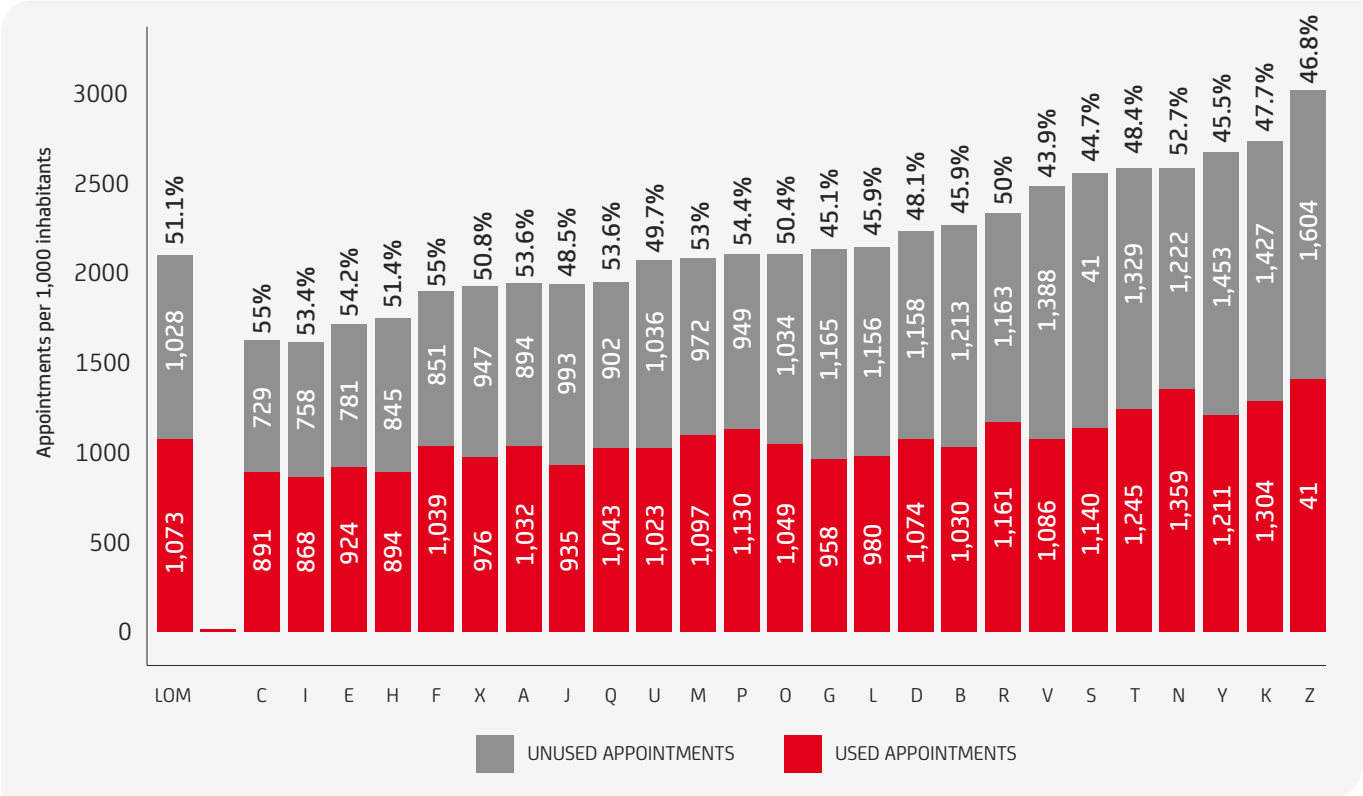
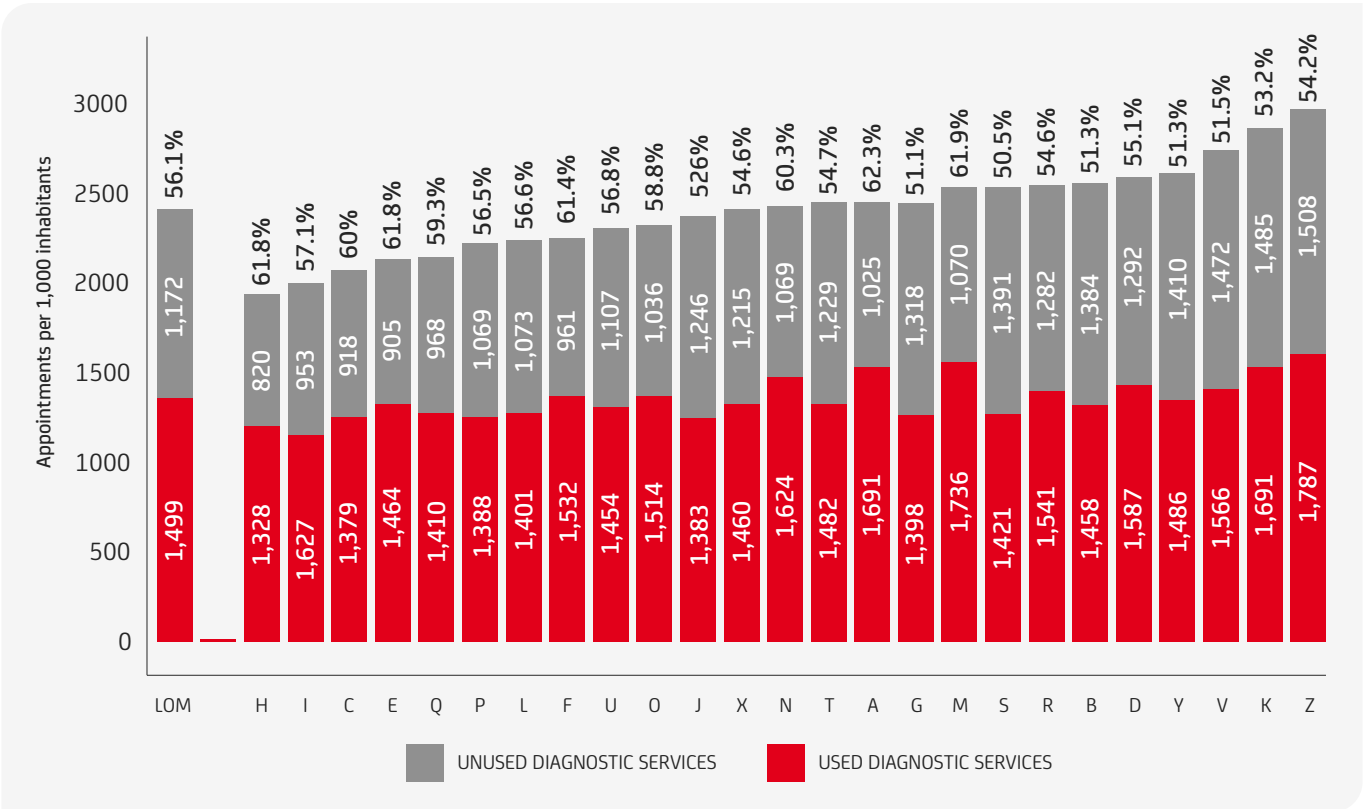


Figure 5 - **Prescriptive differentials in diagnostic performance: Diagnostic prescriptions and consumption per 1,000 inhabitants by Territorial Health Authority (ASST), 2024**



Note: on the x-axis, the capital letters represent the ASSTs, while the abbreviation 'LOM.' indicates the average value for the entire Lombardy Region.

Source: Figures 9.18 and 9.19, p. 30 online in Broccolo G., Furnari A., Longo F., Puritani G., Ricci A., The variability of consumption and prescriptions in the NHS: an inter- and infra-regional comparison, in Cergas Bocconi (ed.), OASI Report 2025, EGEA, Milan 2025. https://forms.sdabocconi.it/brochure/2026/oasi/

The reasons for the trend shown in Figure 4 and Figure 5 could, of course, be multiple, ranging from access to services from private providers in payment or through supplementary healthcare, following waiting lists or complexity in booking. The possibility of the need disappearing must also be considered, but also, as a last resort, the decision to forgo treatment. Finally, in areas with high population density, the percentage of prescriptions converted into consumption drops by up to 10 percentage points, likely due to a broader supply network.

Growing shortage of nursing staff

Despite the widespread media attention surrounding the shortage of doctors, the critical situation of nursing staff receives far less attention, although it is much more difficult to address. In fact, OECD data indicates that, while in 2018 only 1% of Italian fifteen-year-olds aspired to become nurses, in 2022 the percentage remained unchanged, compared to 12% who aspire to the medical profession.

The outlook remains bleak, as for the 2025-26 academic year, out of 20,409 nursing positions available in Italy, there have been only 17,215 applications (or 'filter' semester positions), highlighting a structural gap in the profession's attractiveness.

This situation is present in all European countries, but in Italy it reaches a highly critical level (4.1 nurses vs. 6.2 doctors per 1,000 inhabitants), jeopardising all the initiatives to redesign health services and the interventions for territorial assistance envisaged by the NRRP.

New care settings and resource reallocation

Although the NRRP and the Ministerial Decree 77/2022 [3] foresee significant investments in new territorial care settings:

> 2,400 Community Houses (of which 1,847 still to be built)

> 1,200 Community Hospitals (of which 1,023 still to be built)

> 602 Territorial Operations Centres (of which 542 still to be built)

The estimated need for nursing staff for these new services, which amounts to over 101,000 units, requires a significant reallocation of human resources between hospital and community settings. Hospitals complain about nurses being transferred to the community without integrating their human resources, and on the other hand, demand for, for example, community nurses (key figures in the new Community Homes) is not being met. A possible contribution to overcoming this condition could come from the digital ecosystem provided by the NRRP.

Digital ecosystem: poorly defined strategic goals

Despite the acceleration of digitalisation thanks to the NRRP and Ministerial Decree 77/2022 (Electronic Health Record - FSE, telemedicine, Single Booking Centre - CUP, Electronic Medical Record - CCE), the system's strategic objectives and the guidelines for transforming services are not yet clearly defined. Furthermore, there is a lack of defined indicators and targets to evaluate the actual impact of these innovations.

In other words, effective use of these tools made available by the NRRP would, on the one hand, allow for an increase in the system's productivity by supporting a better use of available human resources as well as greater opportunities for effective patient care. On the other hand, there seems to be a lack of a strategy across the various care areas that would lead to a redesign of services by reassigning roles and functions—a necessary condition for this to happen. Without a significant medium-term institutional and organisational support effort and change management at the hospital and regional levels, it is difficult to envision effective changes in the daily operations of the NHS.

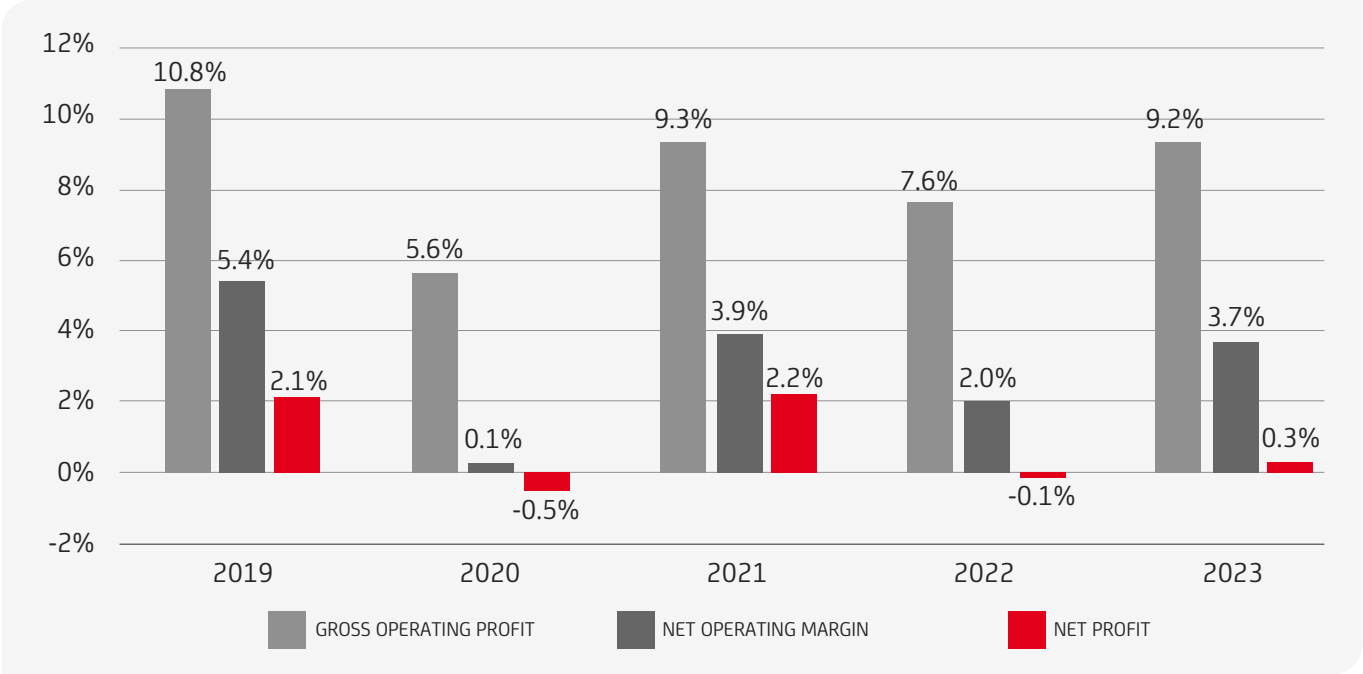
Cost-effectiveness of healthcare companies

Large public hospitals show significant variability in the incidence of personnel costs on production value (from 35% to 45%) and in the value of services provided (from 40% to 75%). Care work is carried out by human capital. However, within the NHS, the productivity of this resource appears to vary considerably. This raises the issues regarding the relationship between inputs and outputs in the NHS that have already been discussed above.

Regarding accredited private facilities, the 34 main national healthcare groups (with revenues exceeding €100 million) recorded a gross operating margin of 9.2% in 2023, with significant differences between those operating predominantly under the NHS and those operating under the private sector. In light of the latest available data (2023), it appears that at that time the accredited private facilities had not yet consolidated their pre-Covid net income.

[3] Ministerial Decree 77/2022 is the decree of the Ministry of Health that defines the models and standards for the development of territorial assistance in the Italian National Health Service (NHS), aiming for a more integrated and citizen-friendly healthcare system. By 2026, it aims to reorganise community medicine through Community Homes, Community Hospitals, Local Operations Centres (COTs), and telemedicine.

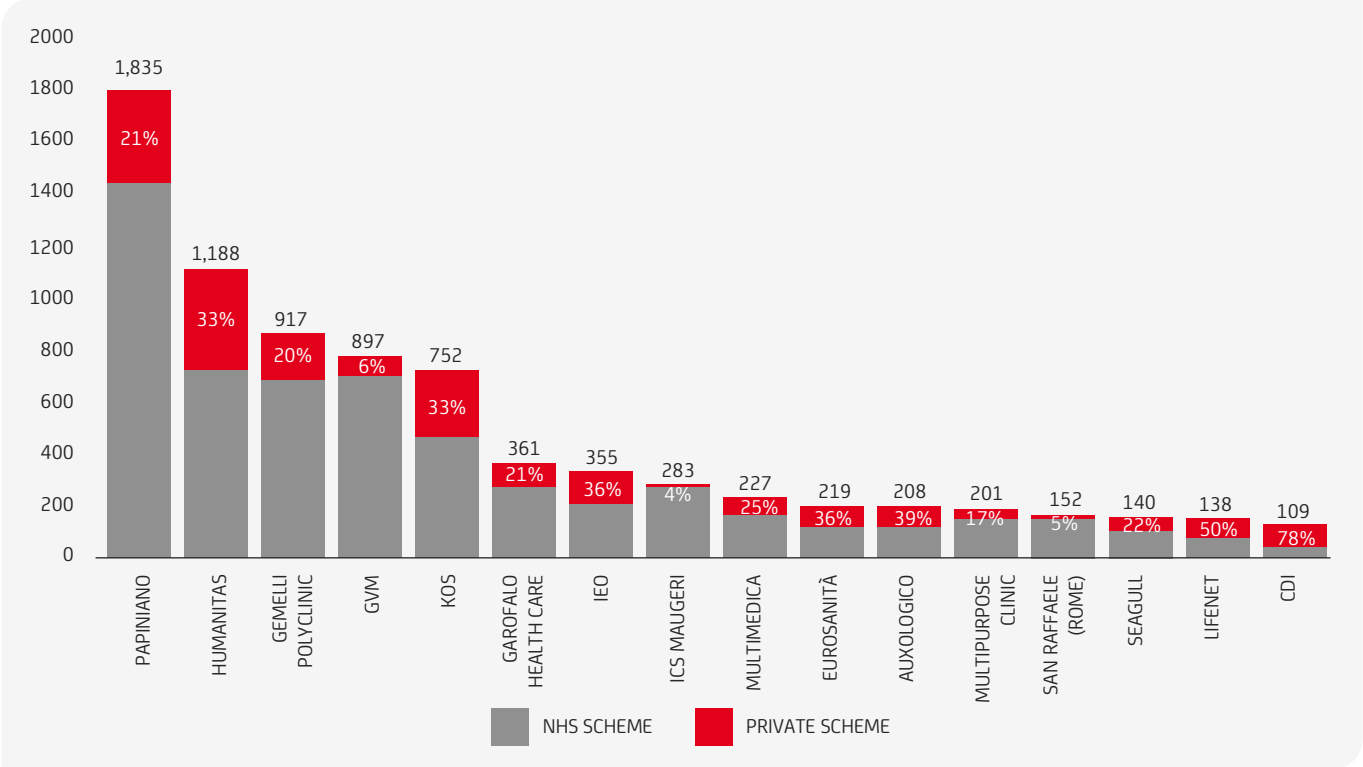
Figure 6 - **Trend in Gross and Net Operating Margin and Net Income as a percentage of revenues, aggregate of the main healthcare groups (>€100 million), 2019-2023**



Source: Fig. 4.8, p. 30 online, OASI processing on Mediobanca Research Area data in Giudice L., Preti L., Ricci A. Accredited private providers: framework in the NHS offer and evolution of economic results, Cergas Bocconi (ed.) OASI Report 2025 https://forms.sdabocconi.it/brochure/2026/oasi/ (2025).

Differentiating between care areas, it emerges that the actors involved in the outpatient and laboratory care area, being less dependent on the NHS, have greater flexibility and opportunities for manoeuvre in terms of margins, as confirmed by the following figure on the sources of revenue of some operators based on the analysis by Mediobanca (2025).

Figure 7 - **Main private healthcare groups: healthcare revenue (€ million) and percentage breakdown by regime, 2023**



Source: Fig. 4.9, p. 32 online, OASI processing on Mediobanca Research Area data in Giudice L., Preti L., Ricci A. Accredited private providers: framework in the NHS offering and evolution of economic results, Cergas Bocconi (ed.) OASI 2025 Report https://forms.sdabocconi.it/brochure/2026/oasi/

What strategies?

Given the challenges outlined above, one gets the impression that the debate is centred on what the OASI 2025 Report has termed 'consolatory narratives', which do not appear to offer a way forward to address these challenges.

In particular, reference is often made to the fact that NHS expenditure is 'easily increased', when in reality – setting politics aside – demographics (14.4 million over-65s versus 7.2 million under-15s), social security expenditure (INPS receives 100 billion from general taxation) and the scale of unmet needs (51% of consultations, 35% of outpatient diagnostics, 93% of non-self-sufficient elderly people) make a significant increase difficult.

A second strand of the debate identifies the solution in greater efficiency within the NHS, but it should be noted that 'sustainable' efficiency improvements have already been achieved, leaving room only for 'painful' measures (merging of clinical units, reduction of outpatient facilities, conversion of small hospitals).

Finally, another strand focuses exclusively on the problem of waiting lists, which account for 50–60% of appointments booked within the NHS; clearing these lists risks fuelling further inappropriate use of services, as it does not distinguish between citizens who over-use or under-use services, and is particularly fragmented in the case of chronic patients.

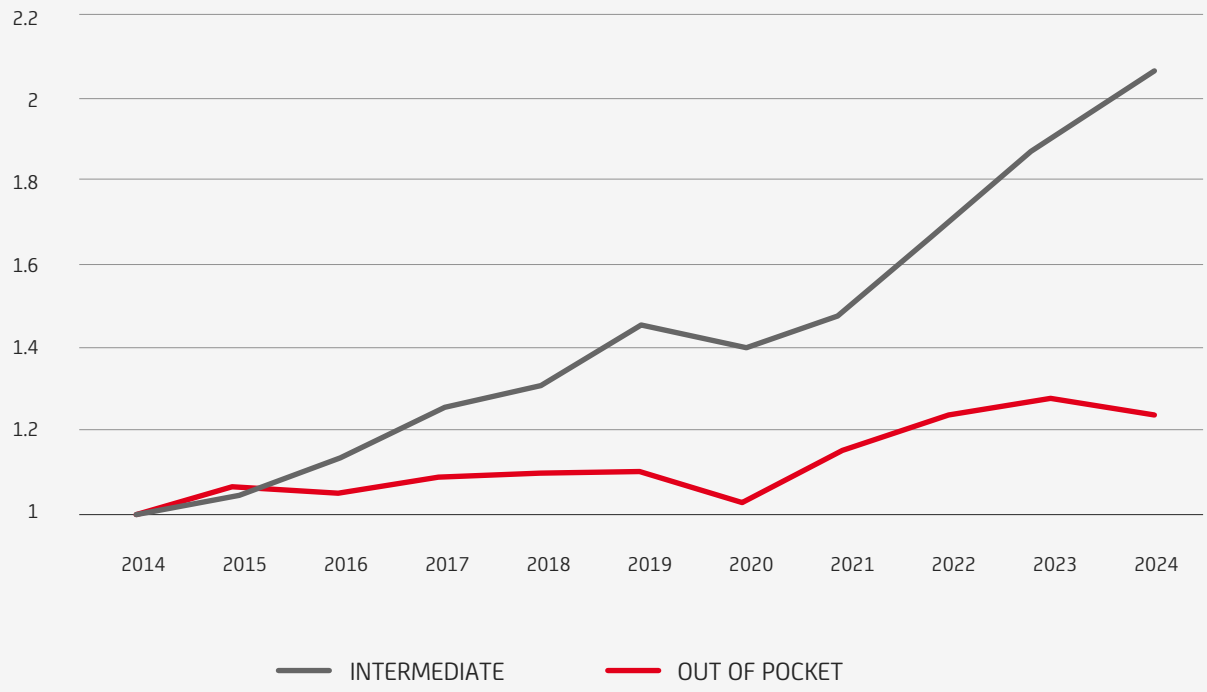
In attempting, however, to identify possible solutions consistent with the context in which Italy currently finds itself, the issue of the role of General Practitioners (GPs) in local healthcare has been raised, for example. The current debate focuses on the solution of employing GPs in community centres in order to create a link between these contracted doctors and NHS staff. However, certain contextual factors must be taken into account: 'forced' physical proximity does not necessarily represent the most coherent solution in the context of the digital transition currently underway in our country as well. Today in Italy (from Lecco to Naples), 70% of contacts between patients and GPs already take place remotely (via telephone, email, WhatsApp, and general practice platforms). Thus, GPs' need to liaise with NHS colleagues increasingly relies on digital tools such as peer teleconsultation and telereporting following an initial phase of getting to know one another, in addition to tele-visits and tele-assistance for monitoring chronic patients. Therefore, from this perspective, even the proposal for 'greater physical coverage' must take into account the digital transition that the NHS is expected to undergo at a time when platforms in other sectors have already completely transformed working methods and business models. Early practical experience suggests that these tools can be used by carefully identifying the characteristics of the target group and planning an initial face-to-face consultation followed by remote ones. It should be emphasised that this applies both to doctor/healthcare staff and patient relationships, and to interactions between professionals.

Finally, options based on purchasing additional services from accredited private providers and providing incentives for unattractive jobs, such as nursing, are responses capable of addressing emergency situations such as waiting lists and staff shortages, but which merely impact the system's productive capacity, i.e. the supply side. The demand side, however, remains unaddressed, as does the urgent – albeit politically more complex – need to establish effective demand management and carry out a thorough reorganisation of services.

Consumption and private healthcare expenditure between 2014 and 2024

From 2014 to 2024, private healthcare expenditure in Italy increased in nominal terms (from €36.3 billion to €47.7 billion). However, the trend was not linear. Following fluctuations linked to the pandemic, a slight reduction compared to 2023 was recorded for the first time in 2024. This reduction was entirely due to out-of-pocket expenditure. (direct expenditure by individual citizens), falling by 1.1 billion (-2.6%), while the component of voluntary funding schemes (intermediated expenditure) rose steadily, driven by insurance expenditure, which increased from 4.3 billion to 4.7 billion (+9.3%).

Figure 8 - **Out-of-pocket and intermediated expenditure trends, 2014 - 2024**



Source: V. Rappini, Private Consumption in Healthcare, Presentation of the OASI 2025 Report, Milan, 3 December 2025. https://cergas.unibocconi.eu/sites/default/files/media/attach/5_Rappini_OASI25.pdf?_gl=1*37tjbo*_up*MQ..*_ga*MTU1ODA1NzcxMC4xNzcxNjkxNjA2*_ga_SH2F98CFTM*czE3NzE2OTE2MDUkbzEkZzAkdDE3NzE2OTE2MDUkajYwJGwwJGw

Table 3 - **Private healthcare expenditure by type of financing, 2014-2024**

Direct household expenditure and voluntary schemes (insurance companies, businesses, non-profit organisations)	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**
Billions of euros	36.3	38.2	38.7	40.4	41.0	41.6	38.6	43.6	46.5	**48.2**	**47.7**
- of which Out of Pocket	33.3	35.0	35.2	36.6	36.9	37.1	34.3	39.0	41.2	**42.4**	**41.3**
- of which Intermediate	3.1	3.2	3.5	3.9	4.1	4.5	4.3	4.6	5.3	**5.9**	**6.4**
As a % of total expenditure	25.1%	26.0%	26.1%	26.7%	26.6%	26.8%	24.2%	25.5%	26.3%	**26.9%**	**25.7%**
In % of GDP	2.2%	2.3%	2.3%	2.3%	2.3%	2.3%	2.3%	2.4%	2.3%	**2.3%**	**2.2%**

Source: V. Rappini, Private Consumption in Healthcare, Presentation of the OASI 2025 Report, Milan, 3 December 2025. https://cergas.unibocconi.eu/sites/default/files/media/attach/5_Rappini_OASI25.pdf?_gl=1*37tjbo*_up*MQ..*_ga*MTU1ODA1NzcxMC4xNzcxNjkxNjA2*_ga_SH2F98CFTM*czE3NzE2OTE2MDUkbzEkZzAkdDE3NzE2OTE2MDUkajYwJGwwJGw

The reduction in private healthcare expenditure appears to have been concentrated in hospital spending, where it fell from €6.9 billion to €6.2 billion, thus reducing its share of overall expenditure by approximately 2%.

Looking more closely at the three components of brokered insurance, it is worth noting that individual insurance, after growing steadily in recent years, appears to have stabilised in 2024, accounting for 33% of the total, whilst the loss ratio (claims-to-premiums ratio) for the health sector, following the increase that followed the pandemic emergency, appears to have stabilised at 71%. It should be noted that this is an aggregate representation that does not allow for a distinction between group and individual policies. Data on group policies for 2024 are not yet available.

€6.2 bn

Hospital health expenditure

-2% compared to 2014

71%

Loss-ratio of the health sector

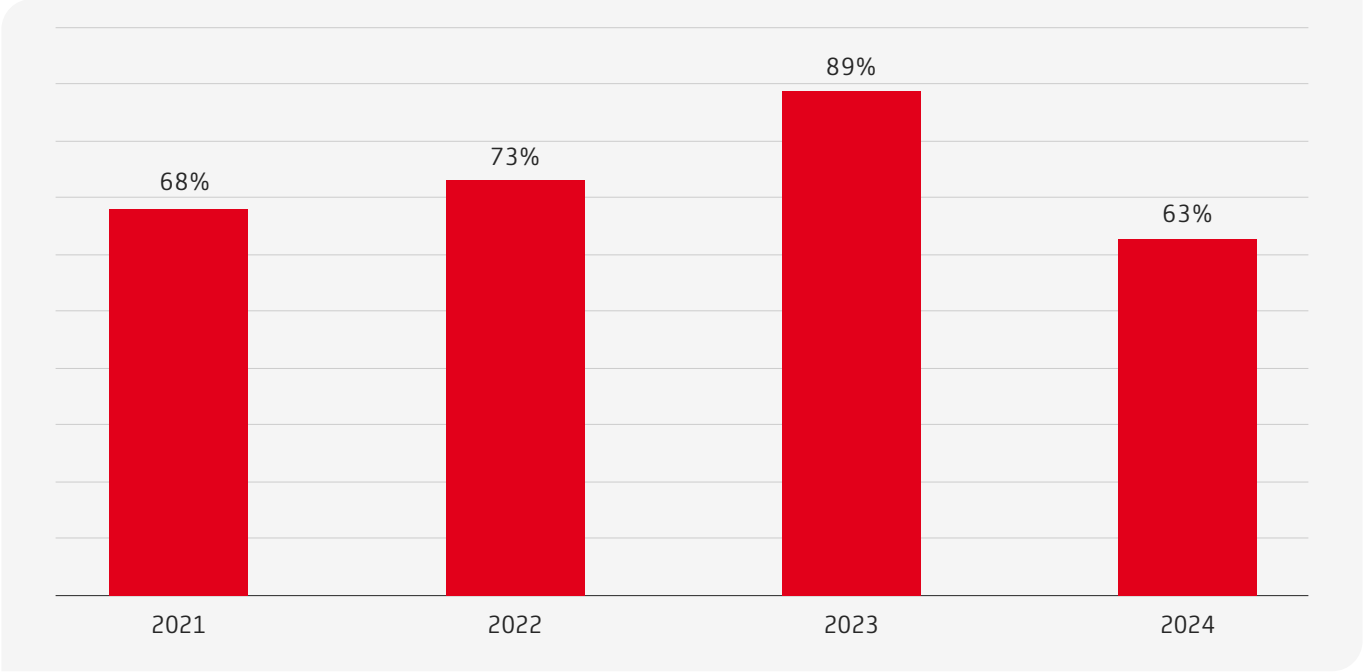
Table 4 - **Data relating to health insurance policies, 2019-2024**

Policy data	2019	2020	2021	2022	2023	2024
Plans collected within the branch (€ million)	3,210	3,105	3,277	3,702	**4,180**	**4,403**
% policies related to individual policies	32%	31%	32%	34%	**34%**	**33%**
% policies relating to health funds and other similar entities	56%	59%	56%	53%	**54%**	**67%**
% policies related to other group policies	12%	10%	12%	13%	**12%**	**n.a.**
Loss-ratio for health insurance	67%	70%	84%	70%	**71%**	**71%**
Loss-ratios for policies relating to health funds and other similar bodies	83%	84%	110%	86%	**87%**	**87%**

Source: Table 6.9, p. M. Cavazza, M. Del Vecchio, L. Fenech, L. Preti, V. Rappini, Private Consumption in Healthcare, in Cergas Bocconi, OASI Report 2025, EGEA, Milan, 2025. https://forms.sdabocconi.it/brochure/2026/oasi/

While the loss-ratio appears to have stabilised at around 86-87% after the 2021 peak, thus gaining around 4-5% compared to the pre-Covid phase, claims frequency appears to be following a different trend (Figure 9). This is the ratio between the number of claims with follow-up (i.e. claims reported/initiated, not just paid in the health branch, attributable to supplementary healthcare funds or similar) recorded in the reference year for that portfolio and the number of risk units (e.g. insured/covered by the collective agreement, or equivalent persons) exposed to the risk in the same period. After peaking at 90% in 2023, the figure appears to have returned to levels similar to those seen in 2021, a year still considered to have been marked by the pandemic. It will be important to check next year whether this stabilisation also applies to 2025.

Figure 9 - **Claim frequency for group policies linked to supplementary health funds and similar schemes**



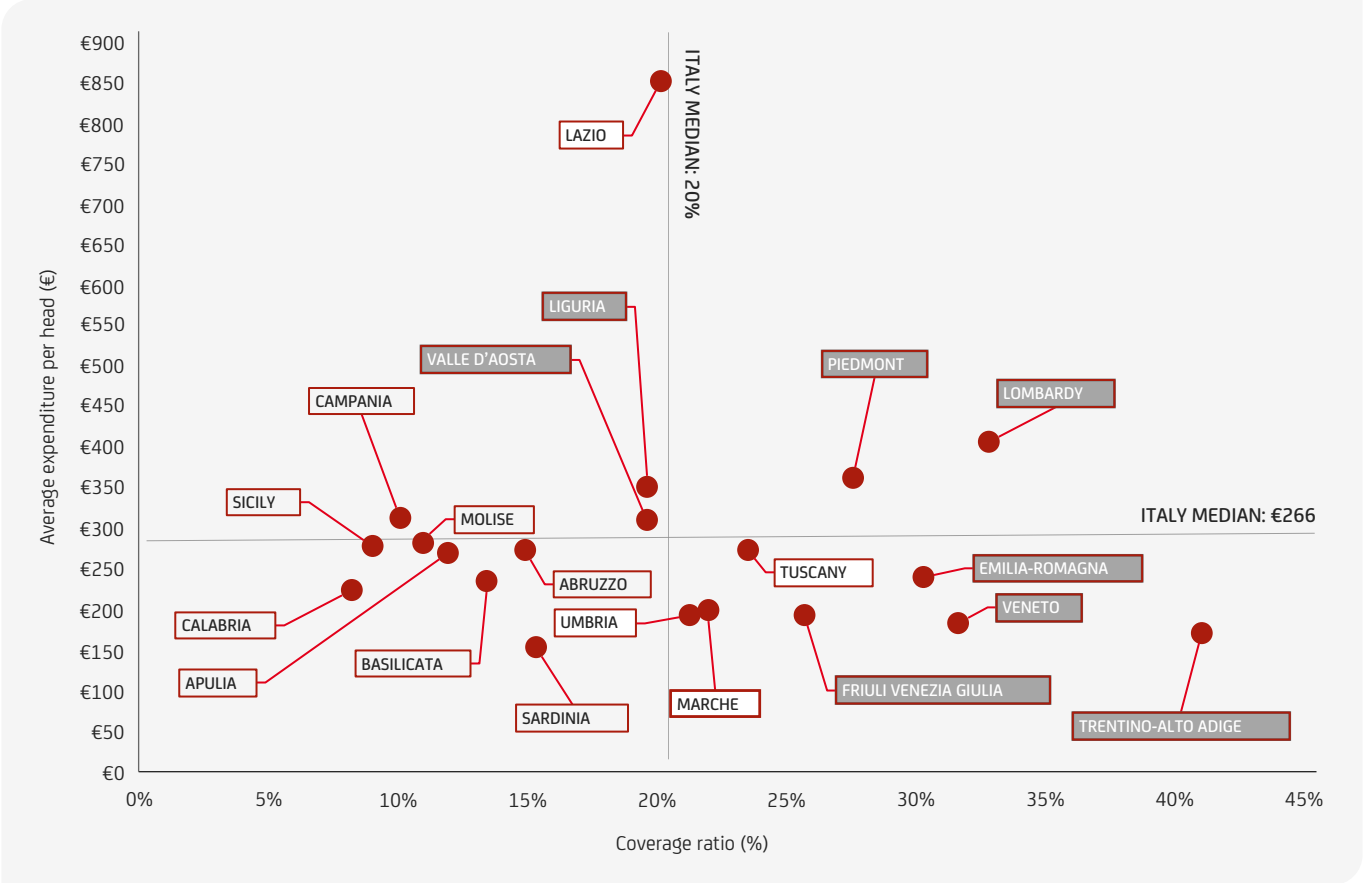
Source: Ania, Data collection on collective agreements signed in the Health branch 2023 and 2024. https://www.ania.it/documents/35135/1013476/Esercizio+2024_polizze+collettive+malattia.xls/529e3e0a-cafe-4f67-0cbd-a275bdd25a98?version=1.0&t=1765468892927; https://www.ania.it/documents/35135/852104/Esercizio+2023_polizze+collettive+malattia.xls/edbb2e13-0421-4337-0b15-8a99a5a569c8?version=1.0&t=1728037243303

Further information at the national and regional level is available using data from the Agenzia delle Entrate (Italian Tax Revenue Agency) regarding tax deductions and allowances granted to members of supplementary healthcare funds and mutual aid societies (therefore, individual policies and coverage provided by corporate welfare platforms are not included). Figure 10 shows, in particular, at the regional level the relationship in 2021 between population coverage (on the x-axis, the percentage of the contributing population who requested deductions for their contributions to supplementary coverage) and per capita expenditure (on the y-axis, the average per capita expenditure per region estimated on the basis of the funds' declarations on the benefits covered by their insured persons to prevent the application of the 19% deduction on the benefit already reimbursed). It emerges that 20% (median) of the taxpaying population has group supplementary health cover, with figures exceeding 30% in the northern regions, with the exception of Liguria and Val d'Aosta, whilst the median per capita expenditure reimbursed at national level is €266.

A key point to note is that this figure includes funds with very different contribution structures and coverage provisions, ranging from supplementary health funds established under national collective labour agreements to supplementary health funds set up by companies or linked to contractual status (for example, senior managers and middle managers). The second point concerns the distribution of reimbursed expenditure across the regions. On the one hand, contributors in the Lazio region are an outlier, with a figure approaching €850, followed by Lombardy at €450. On the other hand, there is a group of regions, ranging from Calabria to Veneto, which have a similar median per capita expenditure, regardless of the proportion of the population with supplementary health insurance. One possible explanation could be the large number of providers available between Rome and Milan, which is reflected in data from Lazio and Lombardy. This is also reflected in the lower capacity for use in Calabria and Sardinia, and the increased use of specialist outpatient services, rather than hospitalisations, in Veneto and Emilia-Romagna.

The median 20% of the contributing population has collective supplementary health coverage, with rates above 30% in the northern regions, with the exception of Liguria and the Aosta Valley

Figure 10 - **Coverage rate by supplementary health funds and average per capita expenditure intermediated by supplementary health funds, declared by Italian citizens to the Agenzia delle Entrate (Italian Tax Revenue Agency), 2021**



Source: Fig. 6.7, p. 32 in M. Del Vecchio, L. Fenech, L. Preti and V. Rappini, Private Consumption in Healthcare in Cergas Bocconi, OASI Report 2023, EGEA, Milan 2023.

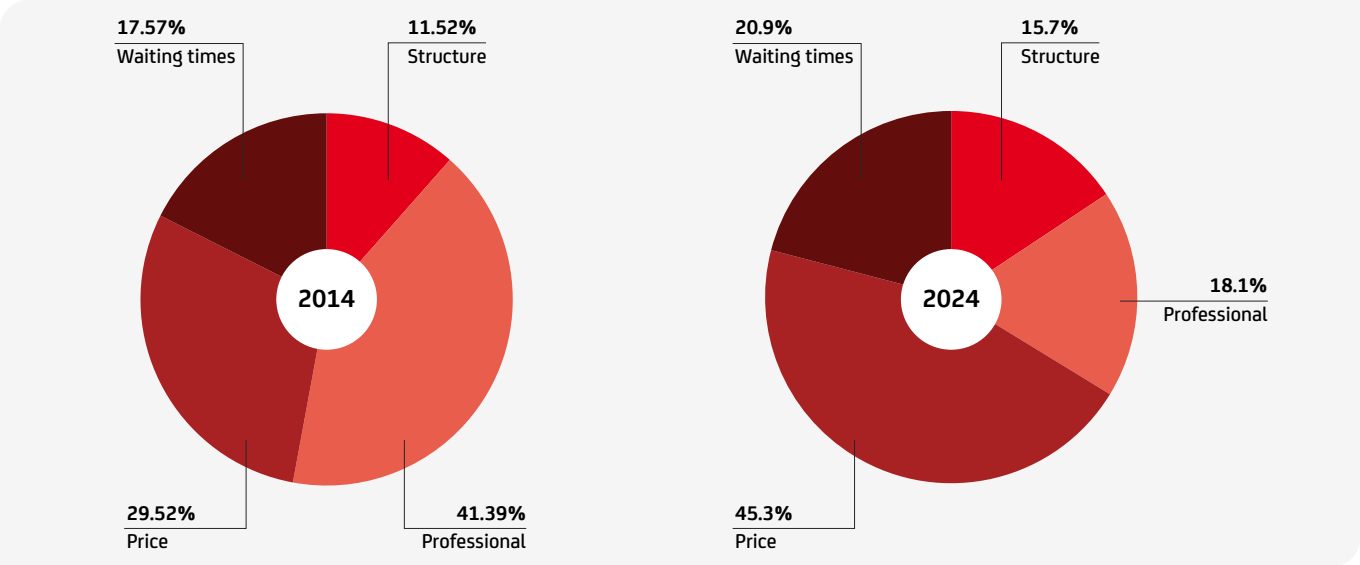
It is worth noting that a recent update to 2023 of the data on the population with supplementary health cover, from the same source, shows a 2% increase across all Italian regions.

A shift in reasons for choosing: from trust to accessibility

In addition to the figures on expenditure, it is essential to understand how and why Italians' behaviour has changed when it comes to healthcare choices. In 2024, the OCPS Observatory conducted an in-depth survey into the factors influencing the choice of private healthcare provider, whether accessed at the patient's own expense or through supplementary health insurance, replicating a similar study carried out in 2014. The aim is to assess how the factors influencing choice have evolved across three types of service: specialist appointments, advanced imaging (CT scans, MRI scans) and physical rehabilitation. The methodology used – *conjoint analysis* – makes it possible to quantify how respondents rate the various characteristics of a healthcare service: the facility or healthcare professional (known, recommended, unknown), distance, waiting times and price.

The results of this analysis reveal profound changes in the determinants of healthcare choices, changes that are also confirmed by data from ISTAT surveys on health conditions and access to healthcare services.

Figure 11 - **The change in the drivers of expenditure between 2014 and 2024**



Source: V. Rappini, Private Consumption in Healthcare, Presentation of the OASI 2025 Report, Milan, 3 December 2025. https://cergas.unibocconi.eu/sites/default/files/media/attach/5_Rappini_OASI25.pdf?_gl=1*37tjbo*_up*MQ..*_ga*MTU1ODA1NzcxMC4xNzcxNjkxNjA2*_ga_SH2F98CFTM*czE3NzE2OTE2MDUkbzEkZzAkdDE3NzE2OTE2MDUkajYwJGwwJGgw

The decline of the trust component

The most obvious and significant change concerns the drastic reduction in the weight of trust in the healthcare facility or professional as a selection criterion. In 2014, for specialist appointments, the trust component had a relative weight of 57.4% in the overall decision; in 2024 this weight was reduced to 36.3%. In practical terms, this means that whereas ten years ago the decision on where and by whom to seek treatment depended for more than half on personal knowledge or having been recommended by someone, today this factor accounts for just over a third.

The decline is even more pronounced in the field of heavy diagnostics, where the weight of the structure (known versus unknown) has fallen from 40.7% in 2014 to 20.3% in 2024, halving over the course of a decade. Similarly, for physical rehabilitation, the weight of the structure has reduced from 57.4% to 36.3%.

This phenomenon can be observed in both public and private consumption, albeit to varying degrees. In the private sector, where trust has historically been a key factor, the percentage of people citing trust in the institution or professional as their primary motivation for choosing a business has dropped from 70% in 2013 to 40% in 2019 (ISTAT data). In the public circuit, in the same period, the reduction was from 48% to approximately 30%.

This evolution reflects a profound cultural change. Whereas, up until a decade ago, the choice of a healthcare service was based almost exclusively on personal trust in the practitioner or the facility – a sort of 'word of mouth' that made healthcare a sector with a strong interpersonal dimension – this aspect has gradually faded to the point where it is no longer necessarily a significant factor in the decision-making process. Today's citizen-patient is better informed, more independent in their decision-making, and takes into account a range of factors that go far beyond the traditional concept of trust.

The rise of waiting times as a decisive factor

In parallel with the decline in trust, the weight of waiting times as a crucial determinant of choice emerges with increasing force. For specialist appointments, the weight of this factor increases from 18% in 2014 to 21% in 2024. The trend is far more pronounced for complex diagnostic procedures: the weighting of waiting times rises from 24.3% in 2014 to 48.1% in 2024, doubling and becoming by far the most important factor in the decision.

ISTAT data confirm this trend from another perspective as well. In 2019, 23% of people who chose a private facility indicated that 'they would have to wait too long for the NHS' as the main reason; This percentage rises to 34% when considering only private consumption. Even more telling is the trend regarding the phenomenon of 'forgoing treatment': among those who say they have foregone treatment despite needing it, the proportion citing waiting times as the main reason has risen from 48% in 2019 to 60% in 2023, whilst over the same period the proportion citing financial reasons has fallen from 39% to 26%.

This data is particularly significant because it overturns a consolidated narrative. For years, public debate assumed that the main obstacle to access to care was economic, namely the excessive cost of private services. The data show, however, that while the economic factor remains relevant, it is also accompanied by problems of temporal accessibility. In other words, more and more Italians are giving up on healthcare not so much because they can't afford it, but because they can't access it within a reasonable timeframe through the public health system, and in the meantime, their health condition worsens, the service becomes less useful, or other obstacles arise.

This shift in priorities has profound implications for health policy. Traditional strategies for containing out-of-pocket spending through discounted tickets or exemptions risk proving ineffective if not accompanied by structural interventions on waiting times. On the other hand, policies aimed at reducing waiting lists must also be carefully designed: for example, expanding the geographical areas in which services can be provided in order to reduce waiting times may conflict with other factors such as proximity and convenience.

The emergence of the economic dimension as a driver of choice

The third major change that emerged from the analysis concerns the growing weight of the economic factor – understood as the price of the service – in healthcare choices. This element represents perhaps the most surprising innovation of the 2024 research, because it introduces a typically 'market' dynamic into a field traditionally governed by professional and relational logic.

For specialist appointments, the weight of price in the overall decision increases from 26.6% in 2014 to 43.2% in 2024, becoming the most important factor after the facility/professional. For heavy diagnostics, while remaining an important factor in the choice, the weight of price goes from 20.7% to 19.7% - substantially stable -. Finally, for physical rehabilitation, the weight of the price increases from approximately 30% to 43.2%.

Of particular interest is the analysis of the 'utility coefficients' associated with the different price levels. The survey shows that the increase in the overall weight of the economic factor is mainly due to the amplification of the value attributed to the lowest price level. In other words, Italians today are not simply more price-sensitive in an abstract sense, but they place much greater value on the ability to access affordable services. This suggests that the growth in economic sensitivity is linked to an actual tightening of household budget constraints, rather than to a generic 'commoditisation' of healthcare.

This phenomenon can also be interpreted through data on the composition of consumption by payment method. In 2023, 51% of specialist appointments made by Italians were paid for using private resources (45% out-of-pocket and 6% intermediated), with a significant reduction in public services requiring ticket payments (from 32% in 2019 to 29% in 2023). For diagnostic tests, over 35% of services are financed through private resources (30% out-of-pocket and 6% intermediated), compared to 33% in the two-year period 2021-2022.

The fact that 51% of specialist appointments are now provided privately—symbolically exceeding the 50% threshold—is a significant figure that calls for a reflection on the very model for responding to healthcare needs in our country. This doesn't necessarily mean that the public system is failing, but it certainly indicates that a growing share of citizens find it more convenient—in terms of time, accessibility, and value for money—to turn to private providers for certain services.

60%

People who forgo treatment due to waiting times

+12% between 2019 and 2023

48.1%

Weight of waiting times for heavy diagnostics

+23.8% between 2014 and 2024

34%

People who choose private facilities due to waiting times for the NHS

+11% between 2019 and 2023

Conclusions

The analyses presented show how the NHS is currently facing a double challenge: on the one hand, ensuring sustainability and equity in a context of limited resources, a rapidly aging population, and a shortage of professionals; on the other hand, managing a demand whose dynamics and methods are changing very quickly compared to the past. In this context, neither an indiscriminate increase in public spending nor simply resorting to accredited private providers appear to be sufficient solutions. Instead, it becomes a priority to develop explicit tools for prioritising and managing demand and to use the digital ecosystem to rethink care processes, roles, and settings, rather than replicating traditional organisational models on new platforms. Only an integrated approach that combines priority setting, personnel policies, and service reorganisation can transform the highlighted critical issues into levers of change that promote quality, accessibility, and fairness in healthcare. In such a highly complex scenario, it is crucial to quickly understand the positioning and role of supplementary healthcare and its sustainability.

It is becoming a priority to develop explicit tools for prioritising and managing demand and to use the digital ecosystem to rethink care processes, roles, and settings, rather than replicating traditional organisational models on new platforms.

Bibliographic references

ANIA, Data collection on collective agreements relating to the Health branch, distinguishing those subscribed by health funds or similar entities*Year – 2023. October 4, 2024. https://www.ania.it/documents/35135/0/Esercizio+2023_polizze+collettive+malattia.pdf/7e115de3-8341-8b99-e6a3-263b34a52d91?version=1.0&t=1728037484948 (last accessed February 20, 2025).

Del Vecchio M., Fenech L., Rappini V., Preti L. Private consumption in healthcare, in OASI Report 2024, EGEA Milan 2024.

Longo F., Ricci A. The National Health Service's main diagnosis: four critical issues and four 'unpopular' perspectives for change, in the OASI Report 2024, EGEA Milan 2024.

Preti L., Private consumption in healthcare in Presentation of the OASI 2024 Report, Milan, 3 December 2024.

Ricci, A. Evolution of the healthcare offer, main critical issues and prospects for a sustainable NHS. Presentation of the OASI 2024 Report, Milan, 3 December 2024.

Ricci A., Merlino L. G. (2025), Waiting lists, productivity levels and trends in outpatient specialisation in the post-Covid NHS. Are we looking at the finger or the moon?, Mecosan, forthcoming

THE UNI.CA MODEL

1 The UniCredit Group's health benefits fund: about us

Our history

Organisational model 2

Our organisation

3 Service model

Our service model

1 The UniCredit Group's health benefits fund: about us

Uni. C.A. is a non-profit association, established on 15 November 2006 pursuant to Article 36 of the Italian Civil Code, with the aim of providing and managing, exclusively for welfare purposes and in accordance with the principles of solidarity and mutual aid, healthcare services – including those supplementing those guaranteed by the National Health Service – for the benefit of its members – natural persons – and their family members.

The Association was established following an agreement signed on 15 December 2005 between UniCredit (formerly UniCredito Italiano) and the Group's trade unions.

Uni.CA officially began operations on January 1, 2007, and over the years has established itself as a significant player in the Italian healthcare landscape.

Over the course of its **nineteen years** of operation, the Association has undergone significant evolution, progressively refining its service model and strengthening its control and governance structures.

Since 2018, Uni.C.A.'s registered office has been located in Milan, at Piazza Gae Aulenti 3, at UniCredit's Head Office, which also houses the Group's Head Office.

19 years of operation

15 November 2006

Founded as a non-profit organisation

1 January 2007

Uni.CA enters the Italian healthcare landscape

2 Organisational model

Uni.C.A.'s staff

In compliance with art. 16 of Uni.C.A.'s Articles of Association, UniCredit provides the personnel to staff the Association, including the Director.

During 2025, in addition to normal routine activities and the ongoing support provided to institutional bodies, the Supervisory Body pursuant to Legislative Decree 231/01, and the external auditor, the staff's work focused, for much of the year, on the renewal process of the health plans valid for the two-year period 2026-2027. This included activities, concentrated in the last quarter of 2025, related to the launch of mass enrolments in the renewed plans, with the aim of ensuring continuity of health coverage for members.

UniCredit provides the staff dedicated to the operation of the Fund, including the Director

Supervisory Board pursuant to Legislative Decree 231/01

The Supervisory Body carried out its audit activities in accordance with the provisions of the annual plan for 2025, undertaking the following:

To identify and evaluate the controls implemented by the Fund with reference to the sensitive area of activity 'Management of member records and financial and accounting aspects of premiums paid by members'

To maintain monitoring of training initiatives aimed at promoting increasingly adequate knowledge of the Organisational model by all recipients

To intervene on any reports or critical issues of an extemporaneous nature

During the 2025 financial year, the Supervisory Body found no violations of the Organisational Model.

3 Service model

Insurance and service partnership

Uni.CA is committed to providing its patients with quality healthcare, using policies with leading insurance companies and the support of companies specialising in managing services for access to services within its approved network and for the payment of reimbursements.

In addition to health coverage, the Fund has promoted initiatives to benefit its members, at no additional cost to them. These include prevention programmes and extraordinary interventions related to serious health conditions not covered by insurance contracts, evaluated and approved by the Board of Directors.

Since 2014, Uni.CA has adopted a 'single provider' model for non-dental services, stipulating insurance and service contracts with partners belonging to the same corporate group.

Thanks to the synergies generated by this model, the Association has managed to ensure high levels of coverage over time, despite the challenging context of its context, characterised by the economic crisis, reduction of public services, increased reliance on the private healthcare sector, an aging population, and rising healthcare inflation.

Since 2016, Uni.CA has self-insured all dental insurance risks, entrusting operational management to Aon (Aon Advisory and Solutions srl), a specialist provider with proven experience and reliability.

Model

SINGLE PROVIDER

since 2014

The Agreement between Uni.C.A. and UniCredit

The Operating Agreement signed in 2013 between Uni.CA and UniCredit clearly defines roles, responsibilities, and areas of collaboration, ensuring effective management of the activities necessary for the functioning of the Fund and the achievement of its social objectives.

Under the agreement, Uni.CA can count on the support of some UniCredit Group structures for information technology (IT) services and administrative activities, ensuring operational continuity and high standards of efficiency.

The Association employs a dedicated corporate team responsible for administrative and member support activities.

Thanks to the consolidated collaboration with the team, the Association has been able to optimise numerous internal processes, improve the quality of services, and respond increasingly promptly to the needs of its members.

Over the years, the Convention has been updated to respond to regulatory and organisational changes; in particular, it was integrated for the appointment of the DPO – in compliance with the GDPR Regulation – and for the formalisation of changes in the management of some operational processes.

Support for IT services and administrative activities

to ensure operational continuity and high standards of efficiency

Collaboration with the dedicated administrative team

to optimise processes and improve the quality of services

Periodic integration

to adapt to regulatory and corporate organisational changes.

The benefits provided by Uni.C.A. and its beneficiaries

In accordance with Article 7 of the Articles of Association, the Association offers its members and their families a wide range of health services, provided on a mutual basis. The coverage includes both direct and indirect benefits, i.e., reimbursement of expenses incurred by the insured.

Services are provided through agreements with insurance companies, institutions, or specialised service providers, or directly by the Fund, as in the case of self-insured dental services.

In addition to insurance and dental services, the Association has provided additional initiatives aimed at the well-being of its members, such as prevention programmes and extraordinary interventions to support particularly serious situations. These measures, approved by the Board of Directors, are a concrete expression of Uni.C.A.'s mutualist and solidarity-based nature; subject to available resources, the organisation is able to assist its members at times of greatest need arising from difficult health conditions.

Uni.CA benefits are available to UniCredit Group employees, retirees, personnel who have left the service as part of early retirement incentive initiatives (so-called 'early retirees'), as well as the survivors of employees and retirees. Furthermore, former employees who have transferred to other companies outside the UniCredit Group following the transfer of a business unit, as provided for by specific union agreements, also retain the right to membership.

Members can extend coverage to their family members by paying a dedicated contribution based on their relationship and tax status.

The Association has guaranteed additional initiatives aimed at the well-being of its members, such as prevention programmes

REPORT ON OPERATIONS

Our members

4 Members as of 12/31/2025 and trends

Coverage

The coverage offered to members 5

Loss ratios

6 Loss Ratios

4 Members as of 31/12/2025 and trends

As at 31.12.2025, there were **103,457** Uni.C.A. members. Of these, **49,852** are policyholders (48.2%) and **53,605 are family members** (51.8%).

The number of active and retired members, i.e., those who left service to access benefits from the Credit Sector Solidarity Fund, amounted to **39,491** (79.2% of total beneficiaries), a decrease of approximately 3% compared to the previous year.

The component represented by retired members amounted to **10,361 policyholders** (20.8% of the total policyholders).

Of the family members included in assistance, **40,215** were declared as dependents for tax purposes, equal to 75% of the total family members, and **13,390** were declared as not dependents for tax purposes, equal to the remaining 25% of the total family members.

Of the dependent family members, 37,478 were included among active and retired personnel, and 2,737 among retired personnel, while paid family members were, for the two categories, 8,765 and 4,625 respectively. The highlighted numbers are consistent with the composition of the family units of the two categories, smaller and of higher age for retired personnel.

Overall, compared to 2024, there has been a **1.2%** decrease in the number of policyholders: in particular, for the Group's employees, a 3.4% reduction was recorded - linked to physiological staff turnover and company agreements regarding staffing - and a 7.3% increase for retired employees.

Overall, including registered family members, there was a **1.3%** reduction in membership in 2025.

The average age of policyholders recorded at the end of 2025 is 53.92 years, an increase compared to 2024. The trend is likely due to the increase in membership among retirees, i.e. older members.

The following tables (from 1 to 11) show figures relating to membership at 31 December 2025 and policyholder trends over the years.

Tables 1 - **Membership figures at 31 December 2025**

Table 1.a - **Members by membership category**

Members [1]	2025	Percentage of total members 2025	2024	Percentage of total members 2024	Difference % 2025 vs 2024	Male members	Female members
TOTAL EMPLOYEES/EARLY RETIREES	**39,491**	**38.2%**	**40,798**	**38.9%**	**-3.2%**	**17,149**	**16,563**
GROUP EMPLOYEES[2]	**32,900**	-	**34,075**	-	**-3.4%**	**16,701**	**16,199**
Non-Senior Management	32,300	-	33,423	-	-3.4%	16,227	16,073
Senior Management	600	-	652	-	-8.0%	474	126
EXTERNAL COMPANY STAFF[3]	**812**	-	**856**	-	**-5.1%**	**448**	**364**
Non-Senior Management	789	-	834	-	-5.4%	430	359
Senior Management	23	-	22	-	4.5%	18	5
EARLY-RETIREE STAFF[2]	**5,779**	-	**5,867**	-	**-1.5%**	**3,601**	**2,178**
Non-Senior Management	5,606	-	5,699	-	-1.6%	3,448	2,158
Senior Management	173	-	168	-	3.0%	153	20
RETIRED STAFF	**10,361**	**10.0%**	**9,655**	**9.3%**	**7.3%**	**6,312**	**4,049**
TOTAL POLICYHOLDERS	**49,852**	**48.2%**	**50,453**	**48.1%**	**-1.2%**	**27,062**	**22,790**
TOTAL FAMILY MEMBERS	**53,605**	**51.8%**	**54,372**	**51.9%**	**-1.4%**	**24,011**	**29,594**
GRAND TOTAL	**103,457**	-	**104,825**	-	**-1.3%**	**51,073**	**52,384**

[1] The number of members does not include 86 managers exclusively signed up for dental coverage

[2] Belonging to the UniCredit group

[3] The number of members of external companies also includes 35 early retirees.

Table 1.b - **Family members included in basic coverage**

Policy description	Dependent family	% Difference vs 2024	Paying family members	% Difference vs 2024	Total	% Difference vs 2024
PLUS employees	36,376	-2.0%	8,386	-5.4%	44,762	-2.7%
NON employees	1,102	-5.0%	379	-8.5%	1,481	-5.9%
TOTAL EMPLOYEES[1]	**37,478**	**-2.1%**	**8,765**	**-5.6%**	**46,243**	**-2.8%**
BASE retirees	807	21.9%	1,494	10.9%	2,301	14.5%
BASE + retirees	1,530	8.7%	2,599	5.4%	4,129	6.6%
STANDARD retirees	324	4.2%	435	1.2%	759	2.4%
OVER 85 retirees	76	-5.0%	97	-9.3%	173	-7.5%
TOTAL RETIREES	**2,737**	**11.3%**	**4,625**	**6.3%**	**7,362**	**8.1%**
GRAND TOTAL	**40,215**	**-1.3%**	**13,390**	**-1.8%**	**53,605**	**-1.4%**

[1], of whom 5,510 are family members of early retirees from the UniCredit Group and 1,066 are family members of early retirees from companies outside the Group.

Table 1.c - **Membership for basic coverage, with breakdown by type of family member included**

Policy description	No. Policyholders	% of total	Dependent family members Spouses	Dependent family members Children	Dependent family members Total	% of total	Paying family members Spouses	Paying family members Children	Paying family members Other	Paying family members Total	% of total
PLUS employees	38,695	98.0%	2,479	33,897	36,376	97.1%	6,012	1,545	829	8,386	95.7%
NON employees	796	2.0%	137	965	1,102	2.9%	282	64	33	379	4.3%
TOTAL EMPLOYEES[1]	**39,491**	**79.2%**	**2,616**	**34,862**	**37,478**	**93.2%**	**6,294**	**1,609**	**862**	**8,765**	**65.5%**
BASE retirees	3,215	31.0%	399	408	807	29.5%	1,219	260	15	1,494	32.3%
BASE + retirees	5,767	55.7%	828	702	1,530	55.9%	2,228	339	32	2,599	56.2%
STANDARD retirees	1,056	10.2%	215	109	324	11.8%	347	83	5	435	9.4%
OVER 85 retirees	323	3.1%	76	-	76	2.8%	97	-	-	97	2.1%
TOTAL RETIREES	**10,361**	**20.8%**	**1,518**	**1,219**	**2,737**	**6.8%**	**3,891**	**682**	**52**	**4,625**	**34.5%**
GRAND TOTAL	**49,852**	-	**4,134**	**36,081**	**40,215**	-	**10,185**	**2,291**	**914**	**13,390**	-
% of total by category	-	-	10.3%	89.7%	-	-	76.1%	17.1%	6.8%	-	-

[1]of which 5,779 retiree policyholders belonging to the UniCredit Group and 812 policyholders belonging to companies outside the Group, including 35 early retirees

Table 2 - **Membership by age group**

Policy description	Up to 30	31 to 40	41 to 50	51 to 60	Over 60	Total
PLUS employees	3,331	4,004	10,580	15,754	5,026	38,695
NON employees	-	34	212	383	167	796
TOTAL EMPLOYEES	**3,331**	**4,038**	**10,792**	**16,137**	**5,193**	**39,491**
BASE retirees	3	-	2	26	3,184	3,215
BASE + retirees	-	-	1	31	5,735	5,767
STANDARD retirees	-	-	-	5	1,051	1,056
OVER 85 retirees	-	-	-	-	323	323
TOTAL RETIREES[1]	**3**	**-**	**3**	**62**	**10,293**	**10,361**
GRAND TOTAL	**3,334**	**4,038**	**10,795**	**16,199**	**15,486**	**49,852**
% of total	6.7%	8.1%	21.7%	32.5%	31.1%	-

[1] Members under the age of 60 are survivors entitled to continued membership

Note: all policies are restricted to members aged no older than 85, with the exception of the specific Over 85 policy for retirees. The policies restricted to retirees may include the recipients of survivor pensions regardless of age (not over the age of 85).

Table 3 - **Membership of dependent family members by age group**

Policy description	Spouses				Children				Total
	Up to 40	41 to 50	Over 50	Total	Up to 20	21 to 30	Over 30	Total	
PLUS employees	184	584	1,711	2,479	25,233	8,224	440	33,897	36,376
NON employees	18	40	79	137	738	220	7	965	1,102
TOTAL EMPLOYEES	**202**	**624**	**1,790**	**2,616**	**25,971**	**8,444**	**447**	**34,862**	**37,478**
BASE retirees	-	7	392	399	76	234	98	408	807
BASE + retirees	-	4	824	828	97	394	211	702	1,530
STANDARD retirees	1	2	212	215	15	53	41	109	324
OVER 85 retirees	-	-	76	76	-	-	-	-	76
TOTAL RETIREES	**1**	**13**	**1,504**	**1,518**	**188**	**681**	**350**	**1,219**	**2,737**
GRAND TOTAL	**203**	**637**	**3,294**	**4,134**	**26,159**	**9,125**	**797**	**36,081**	**40,215**
% of total	4.9%	15.4%	79.7%	-	72.5%	25.3%	2.2%	-	-

Table 4 - **Paying family members' membership by age group**

Policy description	Spouses				Children				Other				Total
	Up to 40	41 to 50	Over 50	Total	Up to 20	21 to 30	Over 30	Total	Up to 40	41 to 50	Over 50	Total	
PLUS employees	419	1,523	4,070	6,012	64	1,217	264	1,545	109	191	529	829	8,386
NON employees	9	66	207	282	-	55	9	64	5	5	23	33	379
TOTAL EMPLOYEES	**428**	**1,589**	**4,277**	**6,294**	**64**	**1,272**	**273**	**1,609**	**114**	**196**	**552**	**862**	**8,765**
BASE retirees	-	2	1,217	1,219	-	76	184	260	-	-	15	15	1,494
BASE + retirees	-	1	2,227	2,228	1	109	229	339	-	-	32	32	2,599
STANDARD retirees	-	1	346	347	3	16	64	83	-	-	5	5	435
OVER 85 retirees	-	-	97	97	-	-	-	-	-	-	-	-	97
TOTAL RETIREES	**-**	**4**	**3,887**	**3,891**	**4**	**201**	**477**	**682**	**-**	**-**	**52**	**52**	**4,625**
GRAND TOTAL	**428**	**1,593**	**8,164**	**10,185**	**68**	**1,473**	**750**	**2,291**	**114**	**196**	**604**	**914**	**13,390**
% of total	4.2%	15.6%	80.2%	-	3.0%	64.3%	32.7%	-	12.5%	21.4%	66.1%	-	-

Table 5.a - **Basic coverage membership by geographical area**

Policy description	North	Centre	South and Islands	Abroad [1]	Total
PLUS employees	48,848	18,496	16,076	37	83,457
NON employees	1,902	275	95	5	2,277
TOTAL EMPLOYEES	**50,750**	**18,771**	**16,171**	**42**	**85,734**
BASE retirees	2,738	1,770	1,008	-	5,516
BASE + retirees	5,287	3,571	1,038	-	9,896
STANDARD retirees	883	805	127	-	1,815
OVER 85 retirees	206	272	18	-	496
TOTAL RETIREES	**9,114**	**6,418**	**2,191**	-	**17,723**
GRAND TOTAL	**59,864**	**25,189**	**18,362**	**42**	**103,457**
% of total	57.9%	24.3%	17.7%	0.0%	-

[1] Expatriate employees with family in Italy

Table 5.b - **Patients by region**

Region	Employees - Early retirees		Retirees		Grand total	
	No.	%	No.	%	No.	%
Abruzzo	646	0.6%	67	0.1%	713	0.7%
Basilicata	219	0.2%	23	-	242	0.2%
Calabria	629	0.6%	90	0.1%	719	0.7%
Campania	4,060	3.9%	421	0.4%	4,481	4.3%
Emilia Romagna	8,188	7.9%	2,271	2.2%	10,459	10.1%
Friuli Venezia Giulia	1,821	1.8%	188	0.2%	2,009	1.9%
Lazio	13,300	12.9%	5,558	5.4%	18,858	18.2%
Liguria	1,147	1.1%	486	0.5%	1,633	1.6%
Lombardy	21,225	20.5%	3,575	3.5%	24,800	24.0%
Marche	1,242	1.2%	103	0.1%	1,345	1.3%
Molise	381	0.4%	50	-	431	0.4%
Piedmont	7,858	7.6%	1,963	1.9%	9,821	9.5%
Apulia	2,507	2.4%	408	0.4%	2,915	2.8%
Sardinia	719	0.7%	108	0.1%	827	0.8%
Sicily	7,656	7.4%	1,091	1.1%	8,747	8.5%
Tuscany	2,289	2.2%	534	0.5%	2,823	2.7%
Trentino Alto Adige	813	0.8%	36	-	849	0.8%
Umbria	1,294	1.3%	156	0.2%	1,450	1.4%
Valle d'Aosta	218	0.2%	23	-	241	0.2%
Veneto	9,480	9.2%	572	0.6%	10,052	9.7%
Overseas	42	-	-	-	42	-
Grand total	**85,734**	**82.9%**	**17,723**	**17.1%**	**103,457**	**100.0%**

Table 5.c - **Distribution of % of patients by geographical area (excluding abroad)**

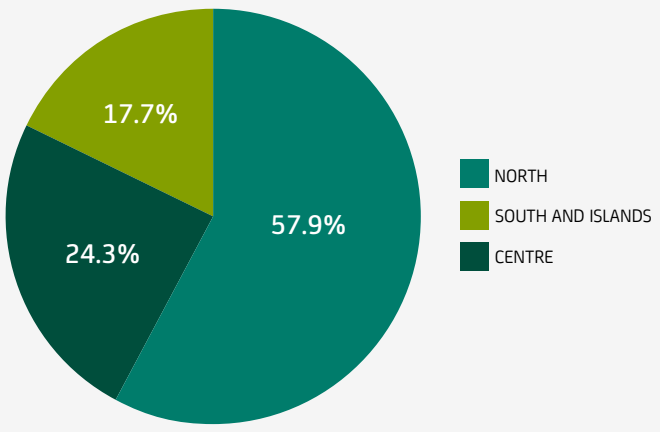


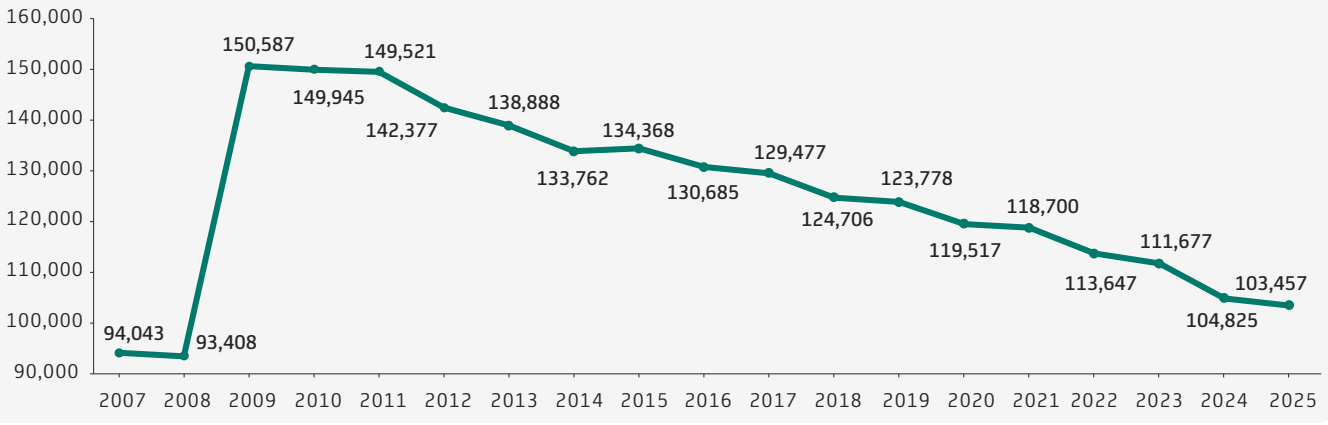
Table 6 - **Dental coverage memberships**

Description of dental cover[1]	No. Policyholders	No. Family members included
Collective dental[2]	**32,489**	-
Extended collective dental cover	4,603	10,600
Comprehensive for senior management	724	1,281
Comprehensive extended for senior management	55	145
Total	**37,871**	**12,026**
Dental policy Treviso	86	-

[1] For early retirees, dental coverage is optional.

[2] The data refers to non-executive employees (including those from external companies), employees who have left the company early, and senior managers.

Table 7 - **Changes in membership numbers from 2007 to 2025**



Note: the peak in membership in 2009 is linked to the merger between the former Unicredito and Capitalia banking groups and the consequent enrolment of the latter's employees and retirees in Uni.C.A.

In the following tables 8 and 9, the trends relating to the percentage ratio between the number of retiree policyholders and the number of employed policyholders as well as the average age of registered policyholders appear to be increasing: This is due to the increase in memberships from retired staff recorded in 2025.

Table 8 - **Ratio of retirees to employees from 2007 to 2025**

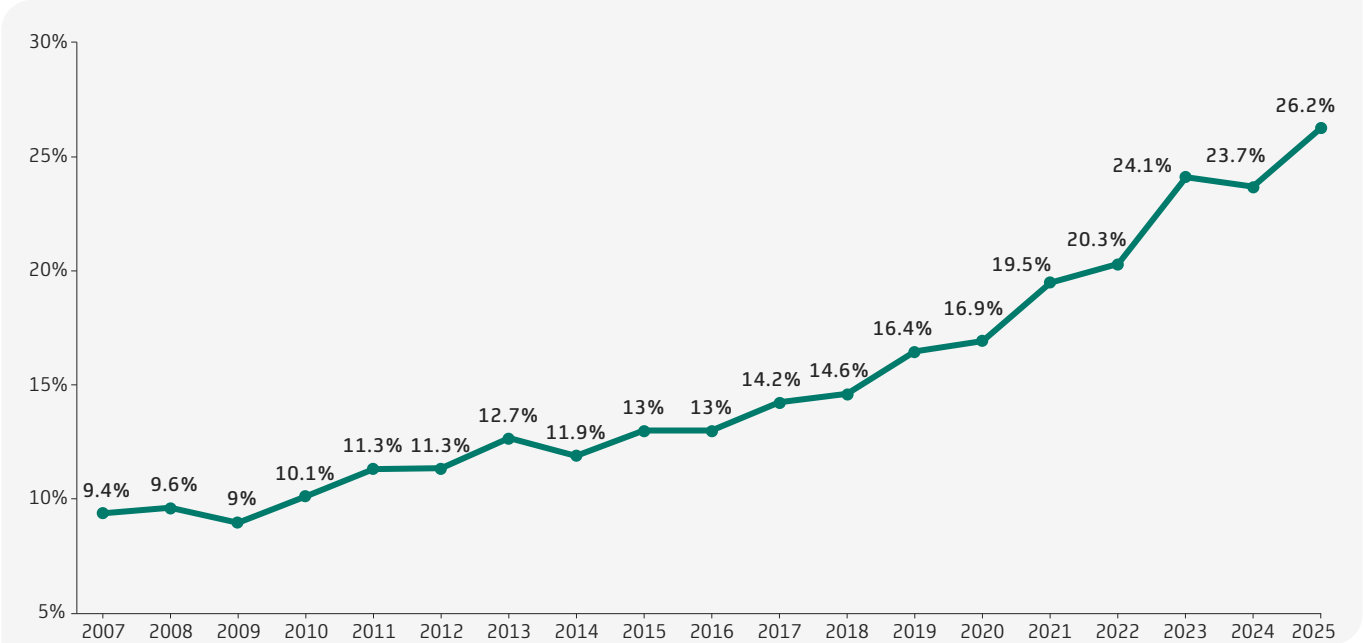


Table 9 - **Trend for the average age of policyholders**

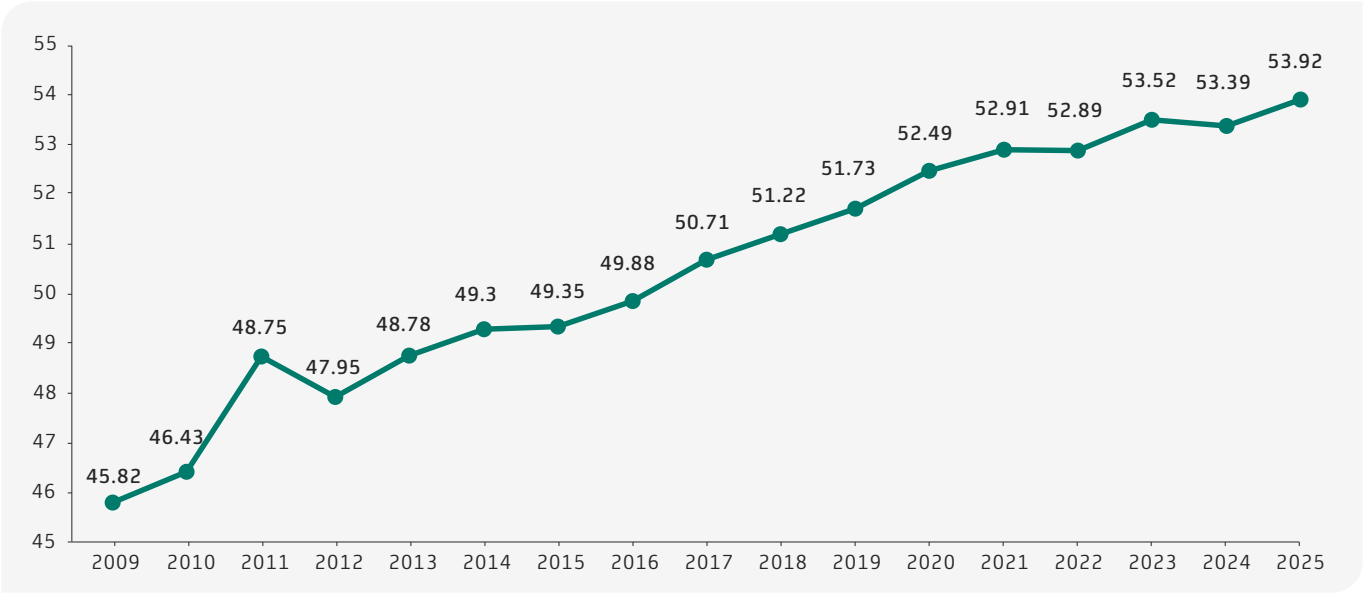


Table 10 - **Percentage changes by macro-category of members from 2007 to now**

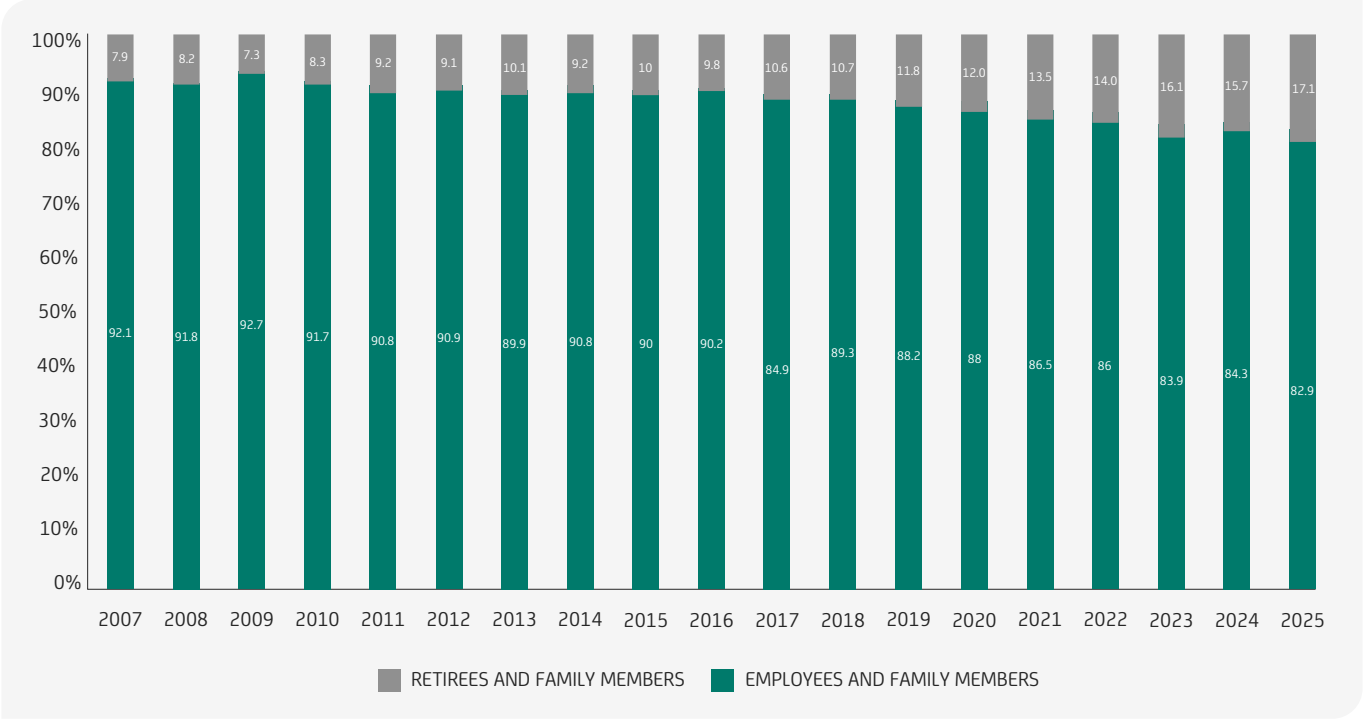
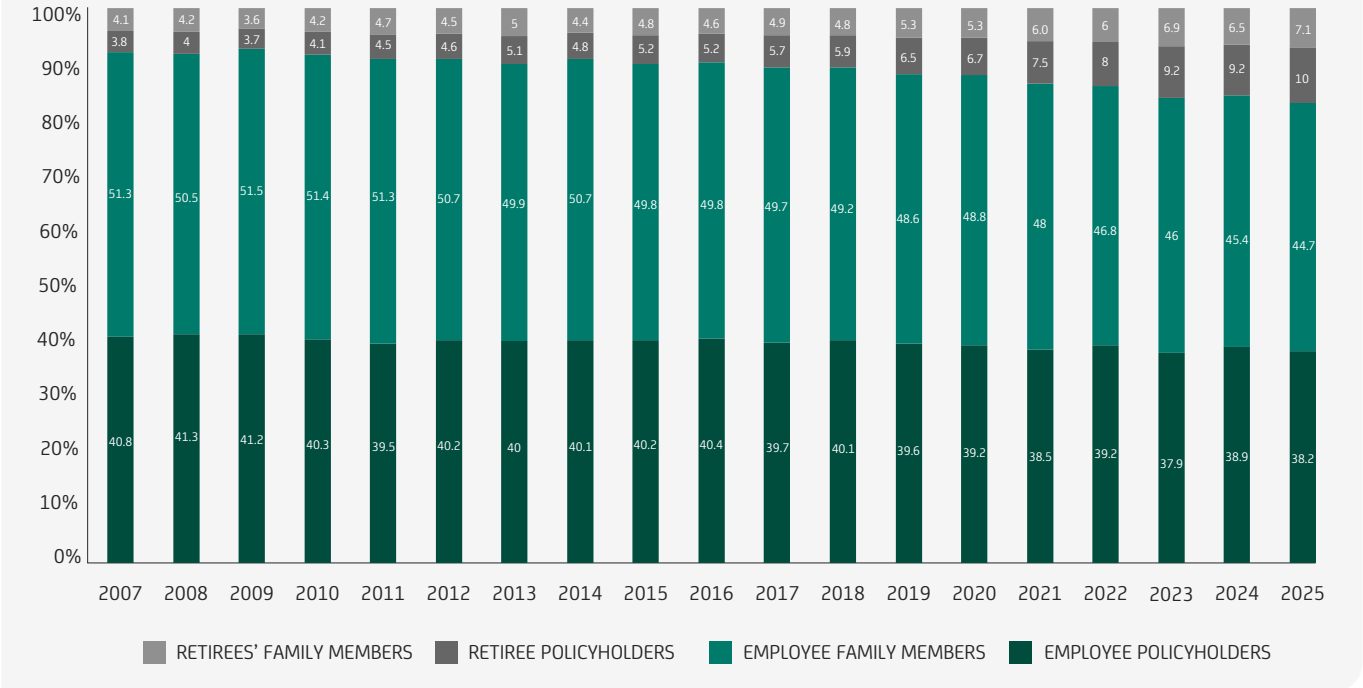


Table 11 - **Percentage changes by type of member from 2007 to now**



The graph shows an increase in retired members over time, consistent with the dynamics linked to company workforces.

5 Coverage offered to members

Health Plans 2026-2027

During the financial year, renewing health insurance coverage required significant effort, given the complex situation of the reference market.

The national healthcare system continues to be plagued by structural challenges—such as lengthy waiting lists, a shortage of medical and nursing staff, difficulty finding general practitioners, and the growing reliance on private services—which fuel an ever-increasing demand for supplemental healthcare, resulting in rising costs and increased scrutiny by insurance companies when renewing health policies.

In this scenario, the Fund's primary objective was to ensure the stability and quality of healthcare provision. The negotiation was very positive as it allowed the overall level of coverage to remain unchanged for all members, introducing some improvements and, at the same time, preserving the economic sustainability of the Health Plans through targeted rationalisation measures. Furthermore, as a confirmation of our commitment to health protection, the check-up campaign has been renewed for the two-year period 2026-2027.

The basic insurance framework, already solid, has been further refined with the strengthening of DSA coverage and the increase in maximum coverage for maternity and oncology care.

Regarding dental services, in order to ensure their sustainability in the medium to long term, it was necessary to slightly adjust the contributions—which had remained unchanged for over ten years—without modifying the regulatory framework for the guarantees.

The check-up campaign has been renewed for the two-year period 2026-2027

Prevention: 2024-2025 campaign results

The prevention campaign, launched in October, ended on 30 June 2025.

The initiative, organised in collaboration with insurance partner Generali, featured numerous new features compared to previous editions, designed to more closely address people's health needs, with check-ups designed to identify the main risk factors and detect diseases early. The initiative included services divided into three phases (called modules), which interested parties could choose from based on their healthcare needs, with no obligation to use them in full:

1st MODULE

Blood tests

2nd MODULE

Cardiac prevention for men and breast cancer prevention for women

3rd MODULE

Possibility to choose a performance package from 9 available packages

The results achieved in terms of membership demonstrate the high appreciation of the members, who, over the years, have shown ever greater attention to the prevention programmes offered by the Fund.

The beneficiaries of the prevention campaign were **28,470, of whom 25,055 were employees** (including **early retirees**) **and 3,415 retirees/survivors**, with a higher proportion of female employees aged over 40 (70.2%).

71,285
Check-ups performed

25,055
employees/early retirees

3,415
retirees/survivors

Further details are highlighted in the tables below.

Table 12 - **Users as at 30/06/2025 by gender and age group**

Users	Active	%	Retirees	%	Total	%
OVER 40	21,739	63.1%	3,415	34.1%	25,154	56.6%
F	11,387	70.4%	1,538	39.6%	12,925	64.4%
M	10,352	56.6%	1,877	30.7%	12,229	50.1%
UNDER 40	3,316	55.9%	-	-	3,316	55.9%
F	1,779	62.9%	-	-	1,779	62.9%
M	1,537	49.5%	-	-	1,537	49.5%
Total	**25,055**	**62.0%**	**3,415**	**33.9%**	**28,470**	**56.5%**

The highest incidence of users is recorded for Active Female Employees over 40 years of age (70.4%).

Table 13 – **No. of modules used as of 12/31/2024 by age group**

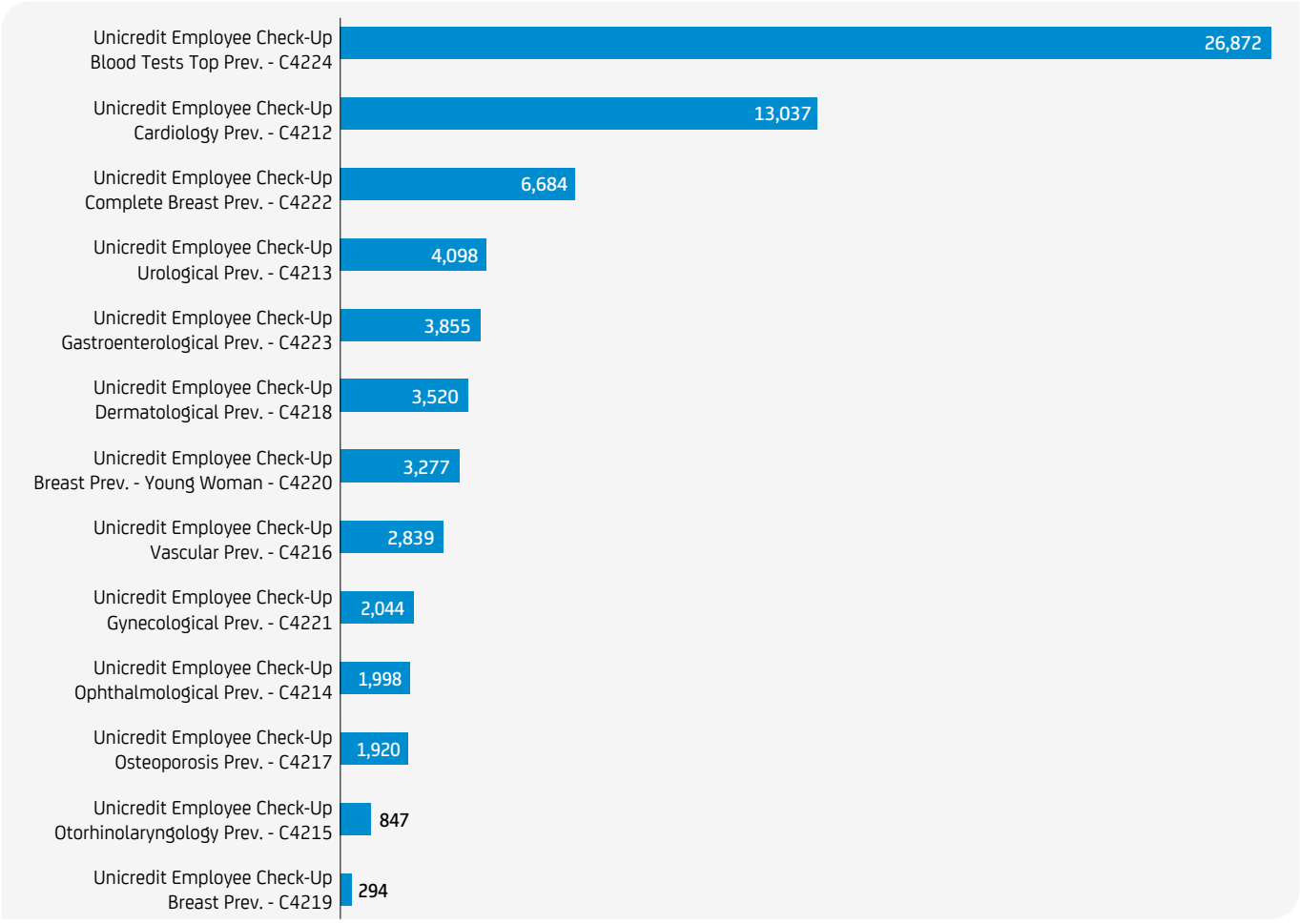
Under 40

Type	No. of modules used
Total modules	5,639
People with 1 module	993
People with 2 modules	2,323

Over 40

Type	No. of modules used
Total modules	65,646
People with 1 module	2,170
People with 2 modules	5,476
People with 3 modules	17,508

Table 14 – **Distribution of check-ups used as by type**



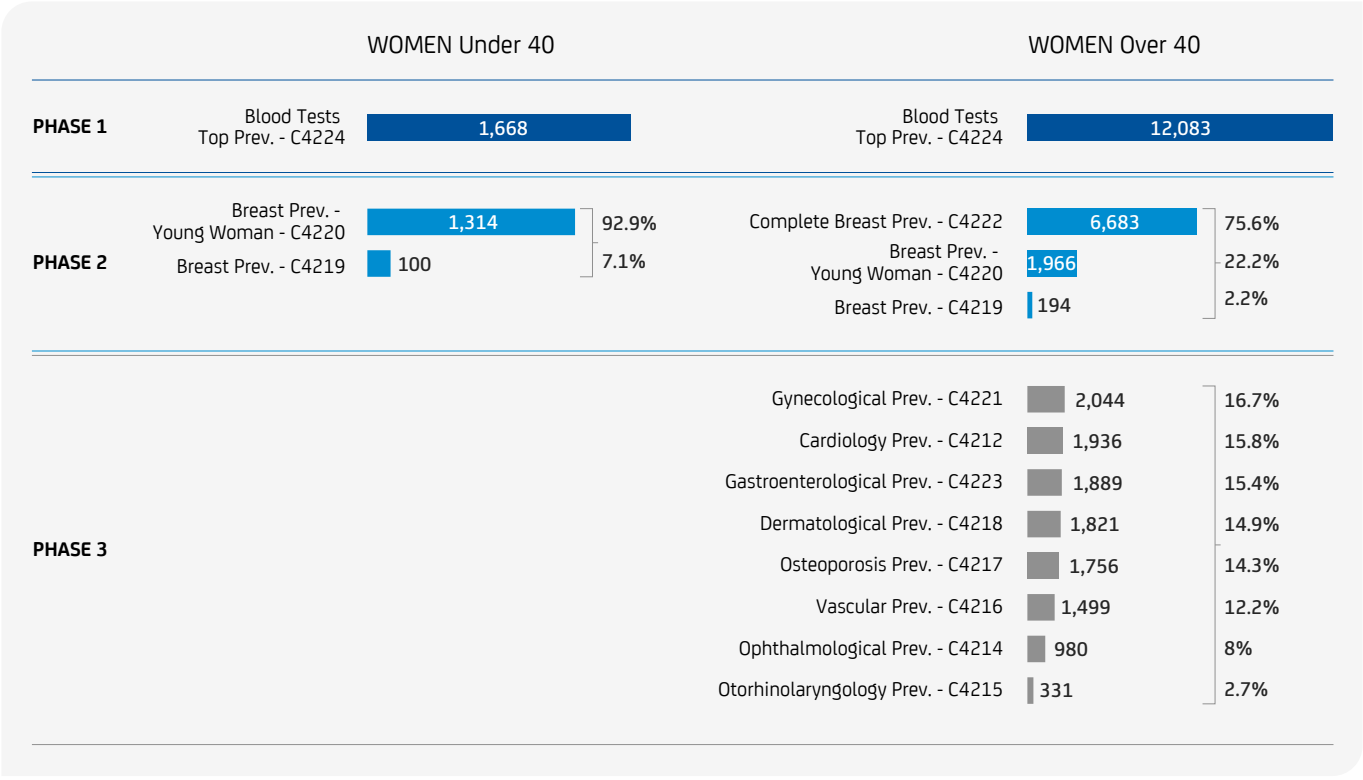
Women
36,264

Women	Under 40	Over 40
Phase 1	1,668	12,083
Phase 2	1,414	8,843
Phase 3	-	12,256
Total	**3,082**	**33,182**

Men
35,021

Men	Under 40	Over 40
Phase 1	1,492	11,629
Phase 2	1,065	10,036
Phase 3	-	10,799
Total	**2,557**	**32,464**

Table 15 - **Distribution of check-ups used by type and gender**



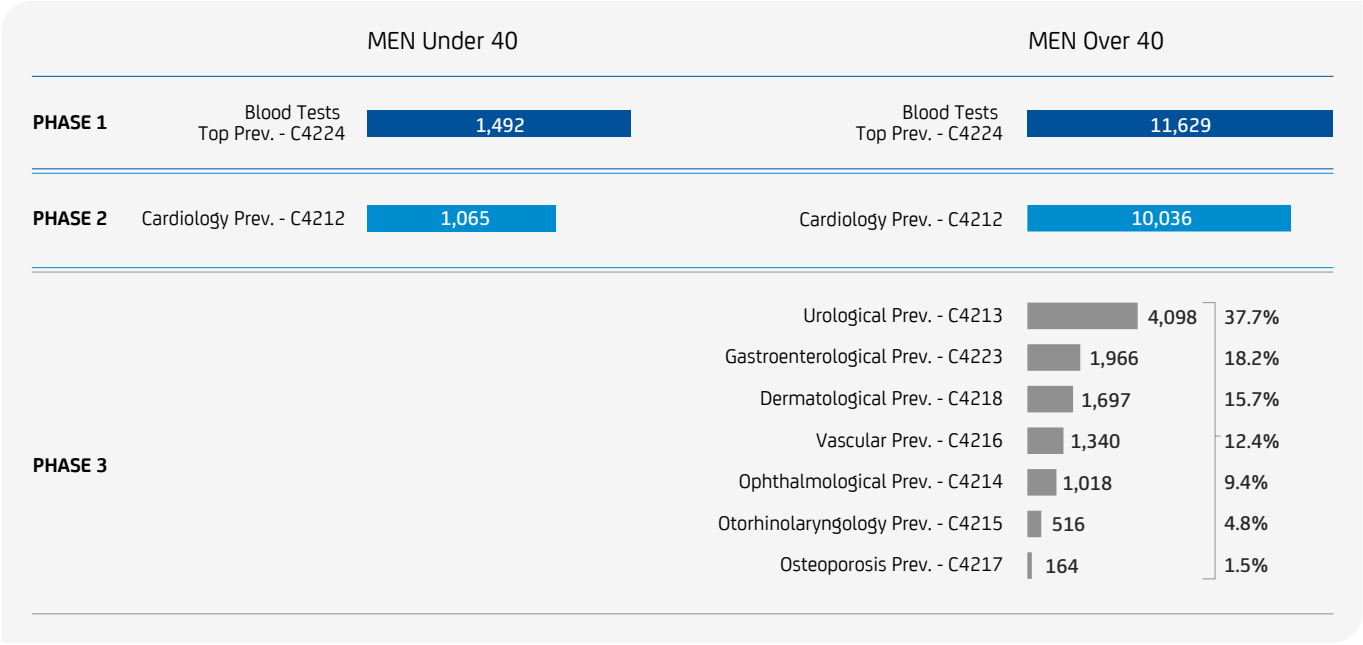


Table 16 – **Distribution by Region**

Region	Services in Facilities in the Region	% of total Services	Region of Residence Insured Persons
Lombardy	19,609	27.5%	12,188
Lazio	9,331	13.1%	9,089
Veneto	8,382	11.8%	4,758
Piedmont	8,139	11.4%	5,024
Emilia Romagna	7,839	11.0%	5,338
Sicily	4,952	6.9%	4,261
Campania	2,792	3.9%	2,038
Tuscany	1,933	2.7%	1,339
Friuli - Venezia Giulia	1,649	2.3%	1,059
Apulia	1,580	2.2%	1,288
Liguria	1,186	1.7%	839
Marche	903	1.3%	617
Umbria	780	1.1%	698
Trentino - Alto Adige	616	0.9%	421
Sardinia	452	0.6%	392
Abruzzo	378	0.5%	321
Calabria	364	0.5%	299
Molise	242	0.3%	197
VALLE D'AOSTA	102	0.1%	112
Basilicata	56	0.1%	115
Overseas	-	-	18
Total	**71,285**	**-**	**50,411**

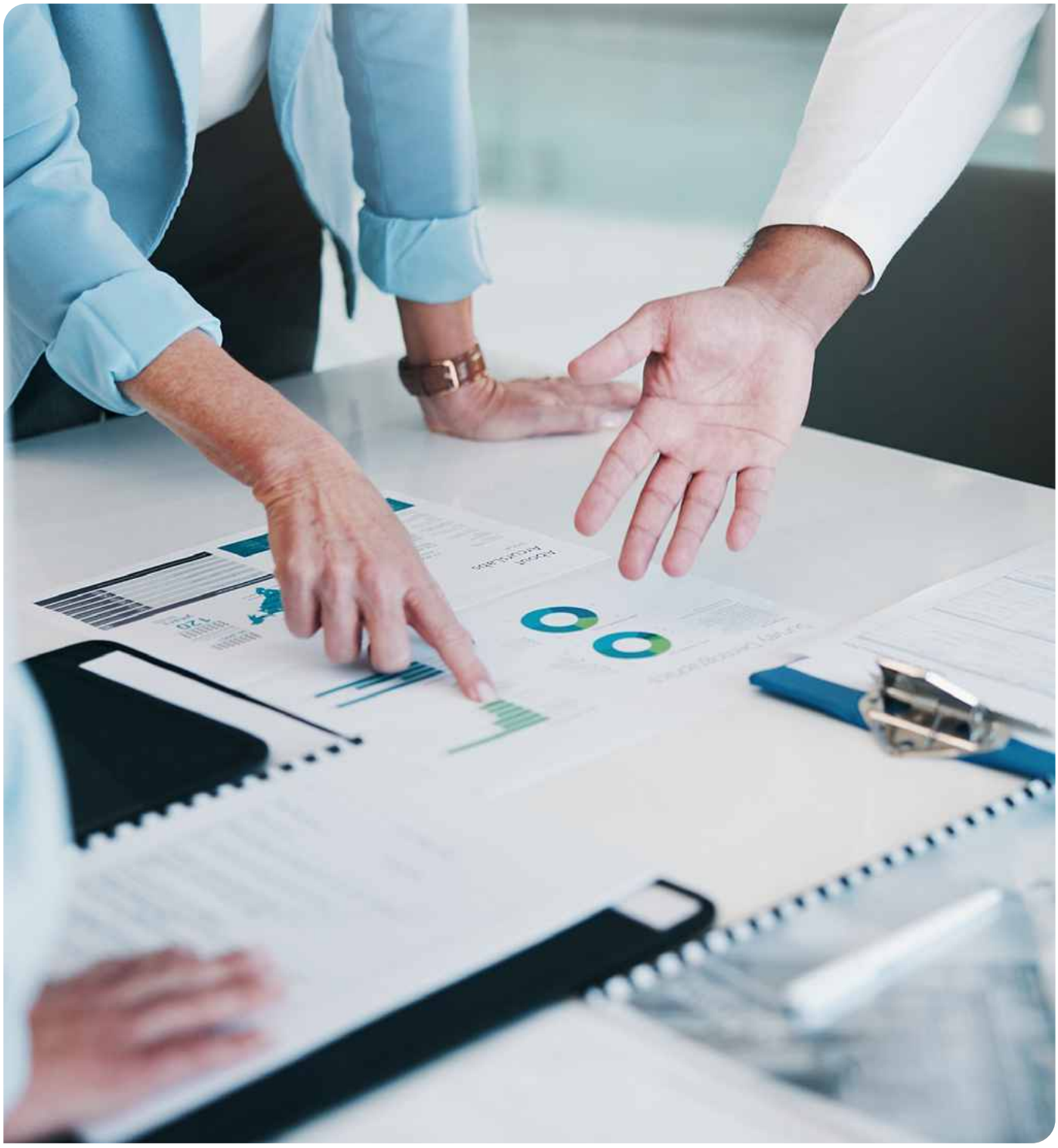
81.7% of the services (58,252) were concentrated in 6 regions and the volume of services per region was found to be substantially proportional to the distribution of the insured by residence.

Other directly financed initiatives

Also in 2025, the Association accepted some requests from members for the provision of extraordinary contributions in the face of particularly complex health situations. This is in strict compliance with the provisions of the specific Policy, approved in 2019 by the Board of Directors, which provides for the disbursement of contributions to support members' health needs not covered by the insurance policies taken out.

The aim of the Policy is to offer help to members forced to meet the cost of treatment for particularly serious conditions, sometimes over an extended period of time, where this could cause financial difficulties for their families.

A total of €8,200 was disbursed in 2025.



Complaints reporting and management procedures

For the benefits provided by a Generali insurance policy, there is a specific reporting and complaints procedure that provides policyholders with a dedicated channel for receiving assistance or requesting information, for example, regarding the terms and conditions of the policy, the reasons for the rejection of a claim, the cancellation of a direct claim, the criteria for settlement or authorisation, the status of a claim, or the payment of the settled amount. It is also possible to use a tracking function within the user's secure area on the Company's website, where you can view the status of your claims and send messages to the claims handler to obtain information about a specific claim.

For any insurance complaints, there is a special form on the Generali website.

This approach is in line with the provisions of the IVASS regulations to which the Insurance Company is subject with regard to complaints.

For complaints relating to dental services provided through AON, it is possible to submit a first-level complaint, which is handled by the provider itself. In the event of an unsatisfactory outcome, the process provides for the possibility of filing a second-level complaint, this time handled by the Uni.CA Management.

With regard to claims for services guaranteed by insurance policies managed by **Generali**:

the Company handled 283 insurance complaints;

it also handled 298 reports that could not be classified as insurance complaints, but as enquiries about cases authorised directly or settled indirectly;

finally, it also handled 11,239 enquiries received through the Uni.C.A. Reserved Area on the Generali portal.

Table 16 - **Complaints and reports to Generali**

Table 16.a - **Insurance complaints: focus on call centres and settlements**

COMPLAINTS INCIDENCE as of 12/31

Contacts	Contacts
Complaints	14
Calls Received	251,343
Incidence	0.006%

Settlement	Settlement
Complaints	269
Requests Received	520,861
Incidence	0.05%

Compared to the calls received by the insurance company's call centre, the incidence of complaints received was equal to 0.006%; a similar figure was equal to 0.05% with reference to the registered settlement requests.

Table 16.b - **Focus on reports** [1]

# Complaint Reason	Data as at 31/12/2025
Miscellaneous	100
Request Rejected	76
Excess Issues	68
Settlement Dispute	17
Problems with Direct	13
Demands	12
Maximums	7
Access to the Reserved Area	5
Grand total	**298**

[1] received by the Generali Complaints Office but not classifiable as complaints

Table 16.c - **Information requests made through the Generali Reserved Area**

Request Reason and Type	#Ticket
Settlement Information	**5,811**
Rejection Reason or criteria for settlement Direct Out-of-Hospital	3,988
Rejection Reason or criteria for settlement Direct Hospitalisation	101
Rejection Reason or criteria for settlement Out-of-Hospital Reimbursement	1,506
Rejection Reason or criteria for settlement Hospitalisation Reimbursement	216
Policy Information	**3,261**
Clarifications on Policy Conditions	1,306
Family Unit Verification	182
Clarifications on Coverage Selection	448
Information on Affiliated Facilities and Doctors	1,325
Case Status	**2,087**
Direct Service Request	859
Case Status or Direct Demand Out-of-Hospital	421
Case Status or Direct Demand Hospitalisation	70
Case Status or Demand Out-of-Hospital Reimbursement	447
Case Status or Demand Hospitalisation Reimbursement	86
Services Reimbursement Request	204
Consultation	**80**
Missing Policies Check	80
Grand total	**11,239**

Regarding claims managed by the provider **Aon/Pronto-Care**, 163 requests were processed, of which 18 first-level complaints were processed and 145 requests for clarification.

Table 17 - **First-level complaints handled by Aon Pronto Care**

Outcome	Number of complaints	% of total
Positive outcome	14	8.59%
Partially positive outcome	2	1.23%
Negative outcome	2	1.23%
Clarifications provided	145	88.96%
Total outcomes	**163**	**100.00%**

At the second level, only one complaint was handled by the Fund[1].

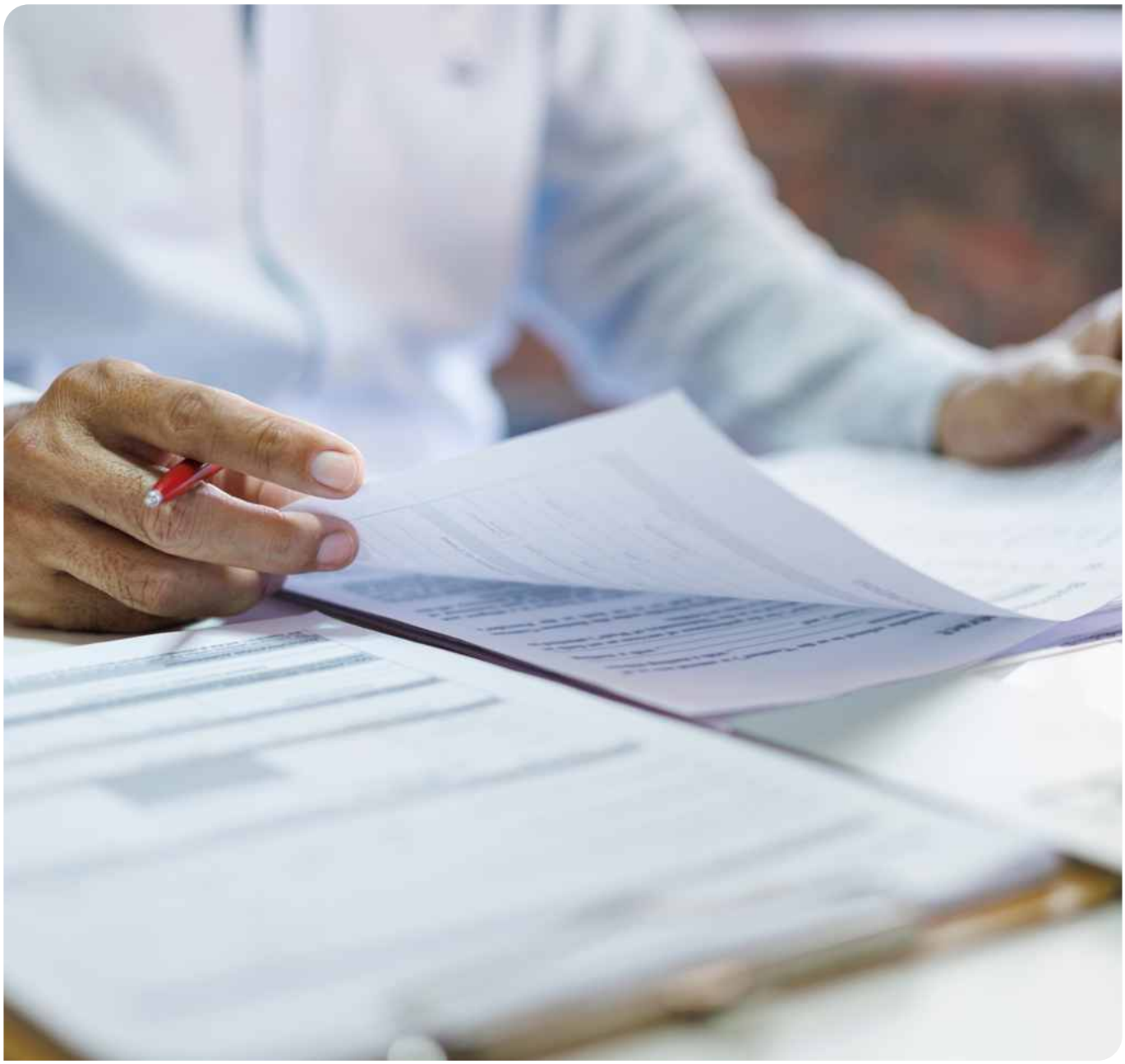
The illustrated reporting/complaints procedure has proved to be an excellent tool for monitoring the service to members, allowing any anomalies in the service and in the management of coverage by providers to be intercepted and dealt with in a timely manner.

Audit of membership database.

The purpose of this activity, now consolidated and structured over time, is to ensure the complete accuracy, both formally and substantively, of the information contained in the Fund's registry. Specifically, the tests aim to ensure that only eligible individuals are registered and that all statutory and contractual conditions for membership are strictly adhered to.

Over the years, this set of control activities has proven not only to be an essential safeguard for the accuracy of the registry, but also an effective tool for monitoring its evolution over time. This level of accuracy also has a direct impact on the technical performance of the coverage: indeed, following the adjustments made to the declared household figures, it has been possible to ensure that contributions due are in line with service use.

Random checks continued, and whenever discrepancies with regulatory provisions or policy requirements were identified, the necessary alignment and regularisation actions were initiated and completed. These interventions have contributed to maintaining a high level of reliability of the registry and to protecting the overall sustainability of the services provided by the Fund.



6 Loss ratios

Basic health cover (insurance policies)

With reference to the basic non-dental health coverage guaranteed by insurance policies, the loss ratios recorded over the years, i.e. the percentage incidence of claims paid on the premiums (after deduction of taxes) paid to the insurance company in the year in question, tend to show an unfavourable trend.

The average for the period 2007-2025 is **102.4%**.

In recent years, the negative trend in the loss ratio has been attributed to the increase in healthcare costs ('medical inflation') and the need for members to resort to private cover due to difficulties with the public health system and long waiting lists. The exception to this was in 2020, when the country was under lockdown due to the pandemic emergency. However, it should not be forgotten that more care was required due to the effects of the pandemic, during which there was no regular access to healthcare facilities. This resulted in the exacerbation of existing health conditions or the development of treatable diseases that could have been prevented with access to healthcare.

Compared to the past, a counter-trend was recorded in the years 2024 and 2025, with loss ratios estimated below 100%: in 2025 the estimated figure stands at **92.6%**.

This result, although not yet consolidated, is undoubtedly positive and linked to the actions shared with the Insurer when renewing the Health Plans for the two-year period 2024-2025. These measures are attributable, on the one hand, to the adjustment of insurance costs, supported by the increased contribution provided for in company-level collective agreements, and, on the other hand, to certain technical adjustments made to the cover which, although limited, have resulted in cost-saving measures in areas of particularly high expenditure (e.g. adjustment of excesses on certain benefits; elimination of inappropriate guarantees in relation to actual healthcare needs ensuring a better balance between costs (premiums paid) and benefits (benefits reimbursed).

The average for the period 2007-2025 is

102.4%

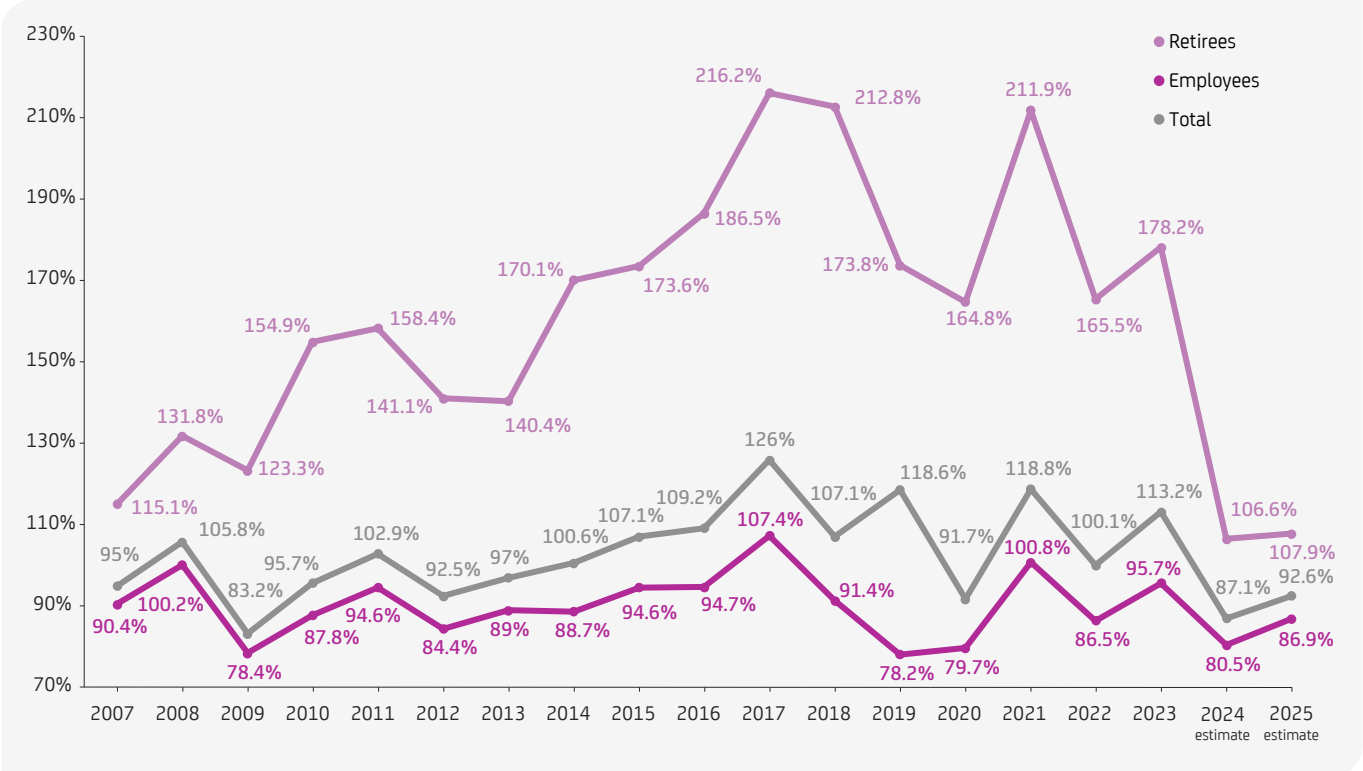
Compared to previous years, the estimated loss ratio for 2025 stands at

92.6%

The tables below show data on the ratio of claims to premiums over the years, broken down by employees and retirees and aggregated by geographical area and by age group.

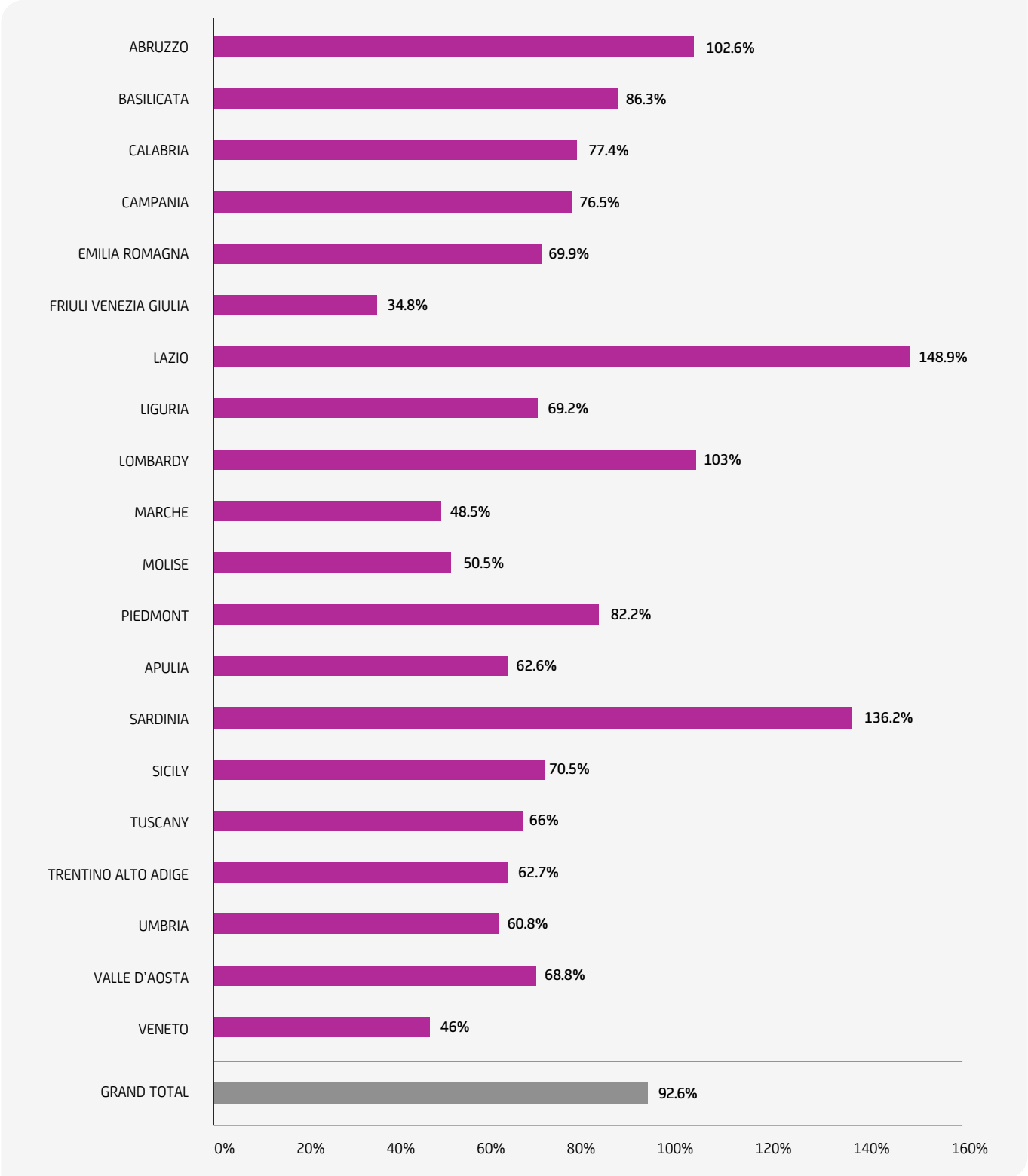
Figure 18 - **Changes in loss ratio from 2007 to 2025**

Figure 19 - **Changes in loss ratio by member category from 2007 to 2025**



In the graph, peaks are generally recorded in the second year of the two-year health plan, given the continuity of coverage compared to the first year, when enrolment is finalised in the early months.

Figure 20 **Estimate of 2025 loss ratio of policies by region**



Data provided by Generali S.p.A.

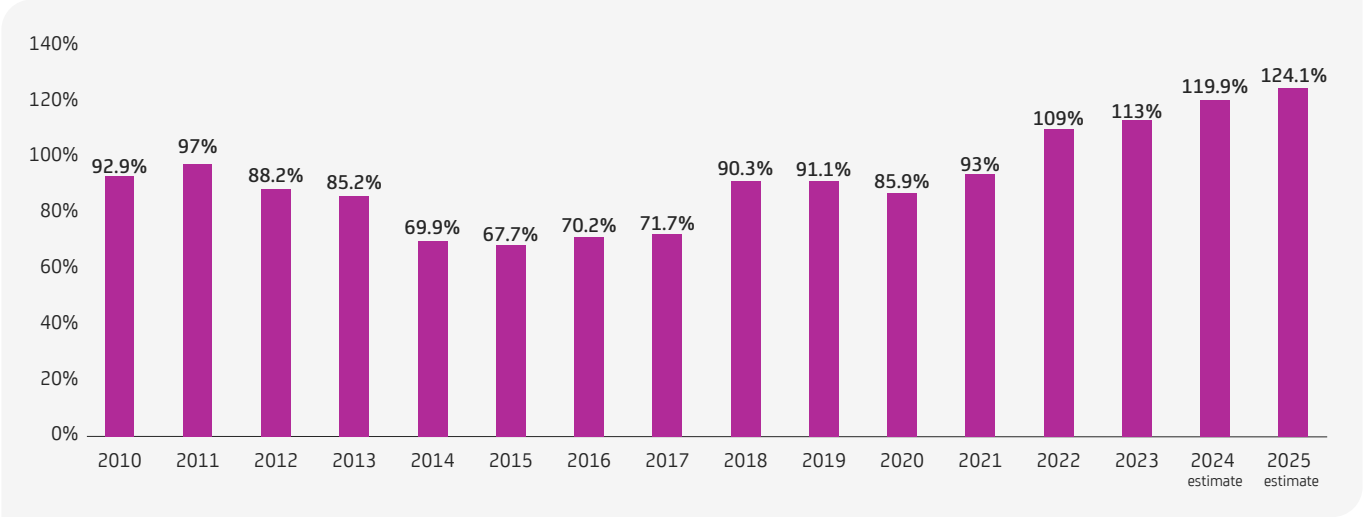
The region of Lazio once again recorded the highest imbalance in terms of usage of healthcare services, a trend that is traditionally driven by the high number of members (30% of whom are retirees) and the high concentration of healthcare facilities in this area. In contrast to the trend observed in 2024, however, the figures for Abruzzo and Sardinia are higher; this is likely due to increased use of healthcare services, probably linked to serious individual health issues requiring prolonged treatment, which has consequently had a negative impact on the generally low average figure based on a limited number of local members.

Dental coverage

In 2025, the estimated loss ratio confirms an unfavourable trend already detected starting from 2022. The year-end estimate, which also takes into account potential 'late' claims, could be higher than the corresponding figure for 2024.

Based on the analyses conducted, the expected trend is likely due to increased consumption of coverage, particularly the increased frequency of use of certain services with higher costs and performed through indirect methods, to the detriment of use of the network of contracted facilities/doctors, which apply a reduced fee schedule.

Table 21 – **Changes in the loss ratio of dental cover**



Data provided by Aon. The Treviso Dental policy operated by Generali S.p.A. is not considered.

7 Key operational and management data. Summary

With reference to non-dental insurance coverage, the Company's estimated expenditure for 2025 relating to paid benefits is approximately €64.5 million, corresponding to approximately 434,000 claims.

As for dental coverage, the estimated reimbursed expenses during the year amount to approximately 11 million, for a total of approximately 42,000 claims.

Among the activities managed, mention should be made of the collection of contributions from retirees, which amounted to approximately €19.2 million from 10,356 members. Following the failure to pay due contributions, the retirees in arrears (five positions) have been excluded from the Association, in compliance with the statutory provisions and the decisions of the Board of Directors.

€64.5 million
Estimated spending on non-dental insurance coverage for 2025

434,000
Corresponding claims

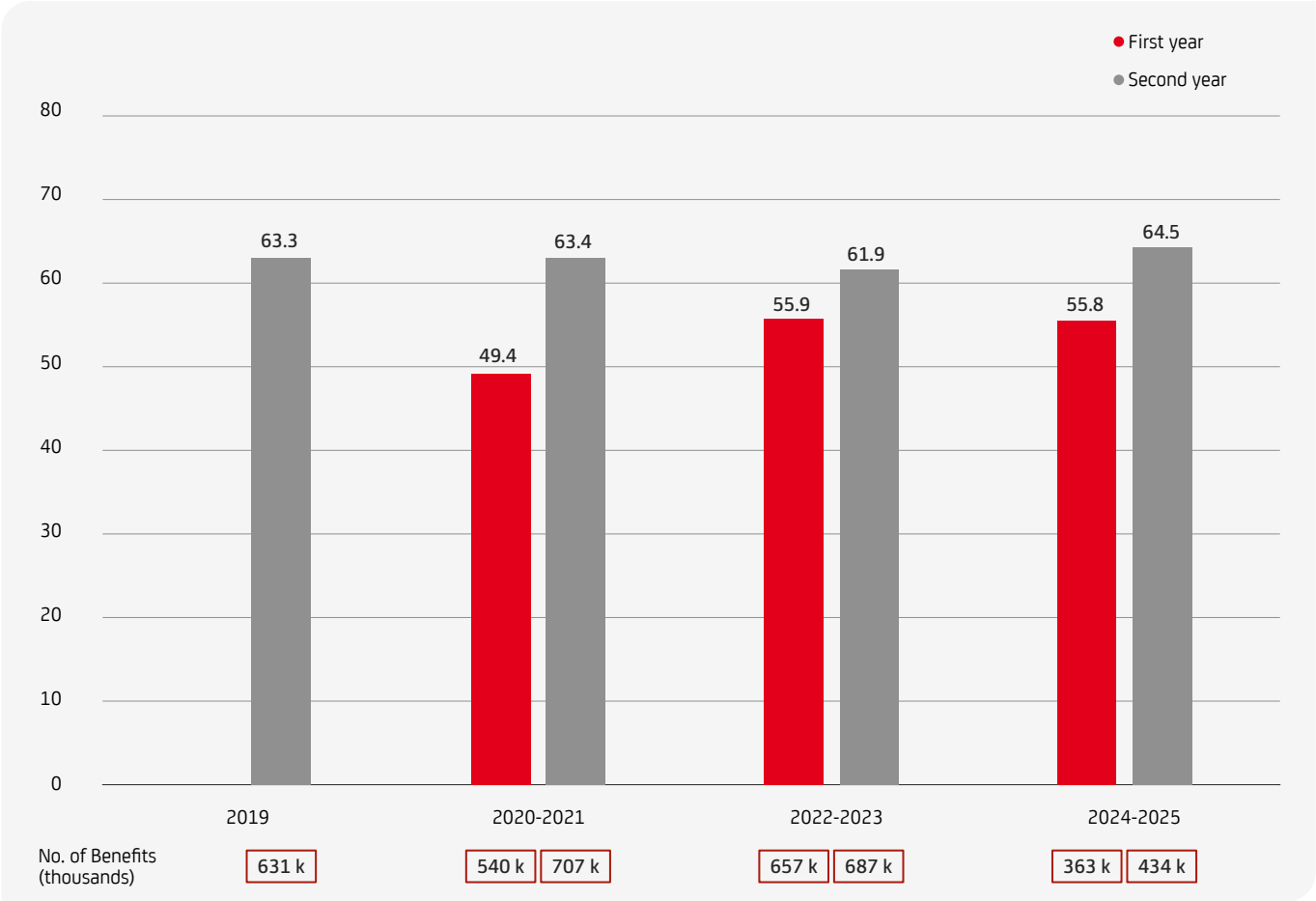
€19.2 million
Contributions collected from retirees from 10,356 members

8 Benefits provided: analysis and comparison with previous years

Performance of basic cover

Healthcare consumption has seen a growing increase since the post-Covid period. By 2025, consumption levels had returned to 2019 levels, as highlighted in the following table.

Figure 22 - **Trend in basic cover (claims in millions/ €)**



Data provided by Generali S.p.A.

In 2025, the second year of the two-year health plans, there was an increase in spending, estimated at €64.5 million: of these, approximately 42 million claims have been settled, corresponding to around 347,000 claims out of the estimated 434,000: the difference, both in terms of the amount paid out and the number of claims, compared with the figures shown in the table, relates to claims that the Company has statistically assessed as having occurred, but for which no claim for compensation has yet been received.

Analysis of the policy benefit usage data has highlighted the aspects shown in the following graphs, also through comparison with similar data for 2024 (please note that the 2025 and 2024 data are still estimated and not definitive as the two-year limitation period for reimbursement of insured healthcare services has not yet expired).

Figure 22.a - **Distribution of policy uses by gender**

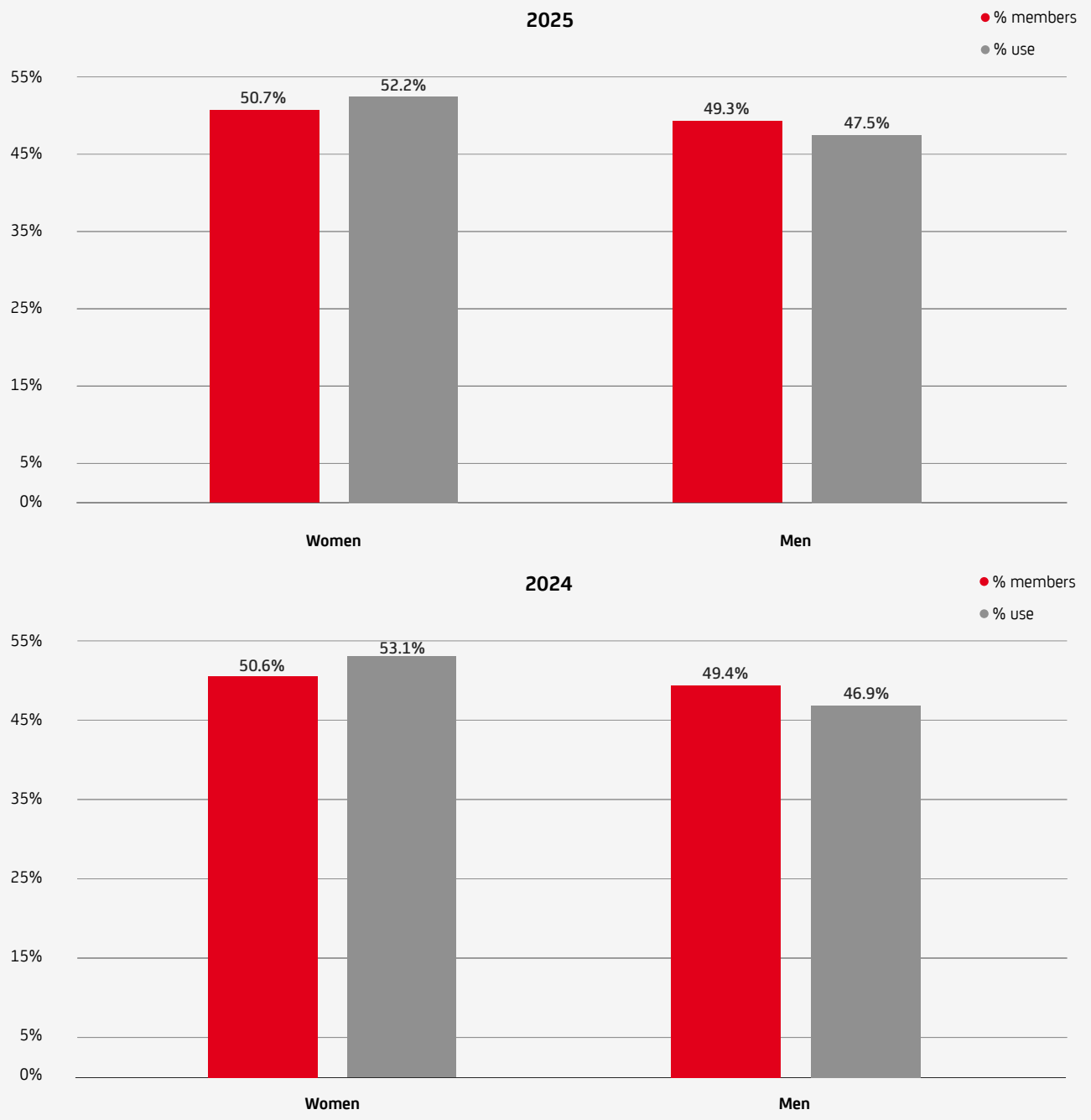
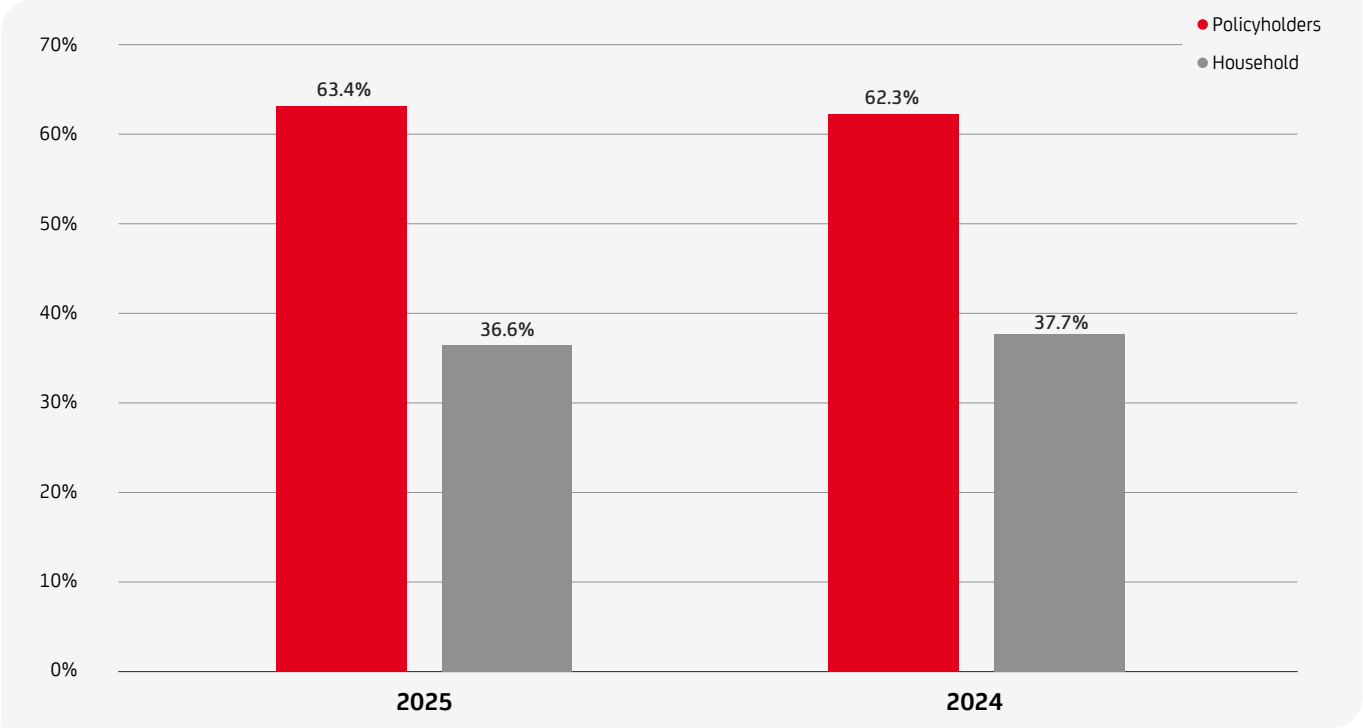
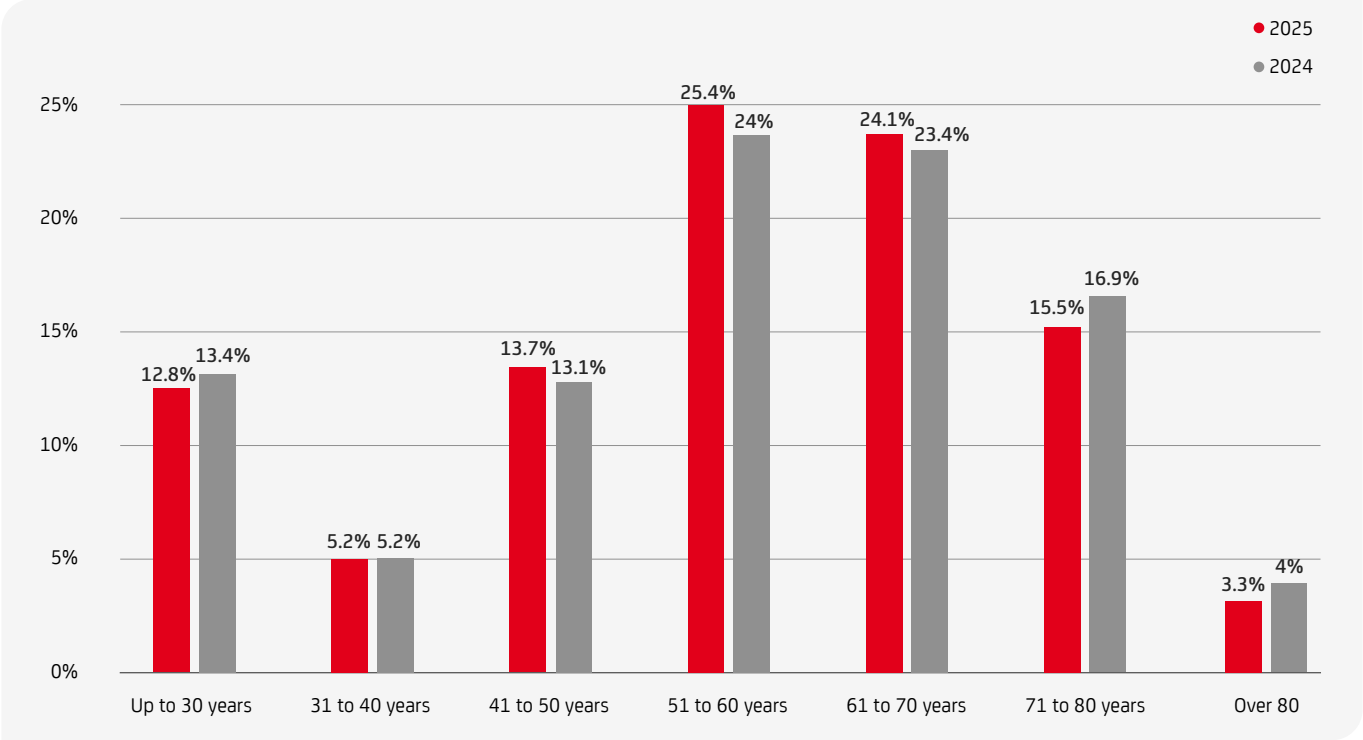


Figure 22.b - **Distribution of policy uses among policyholders and insured households**



Data provided by Generali S.p.A.

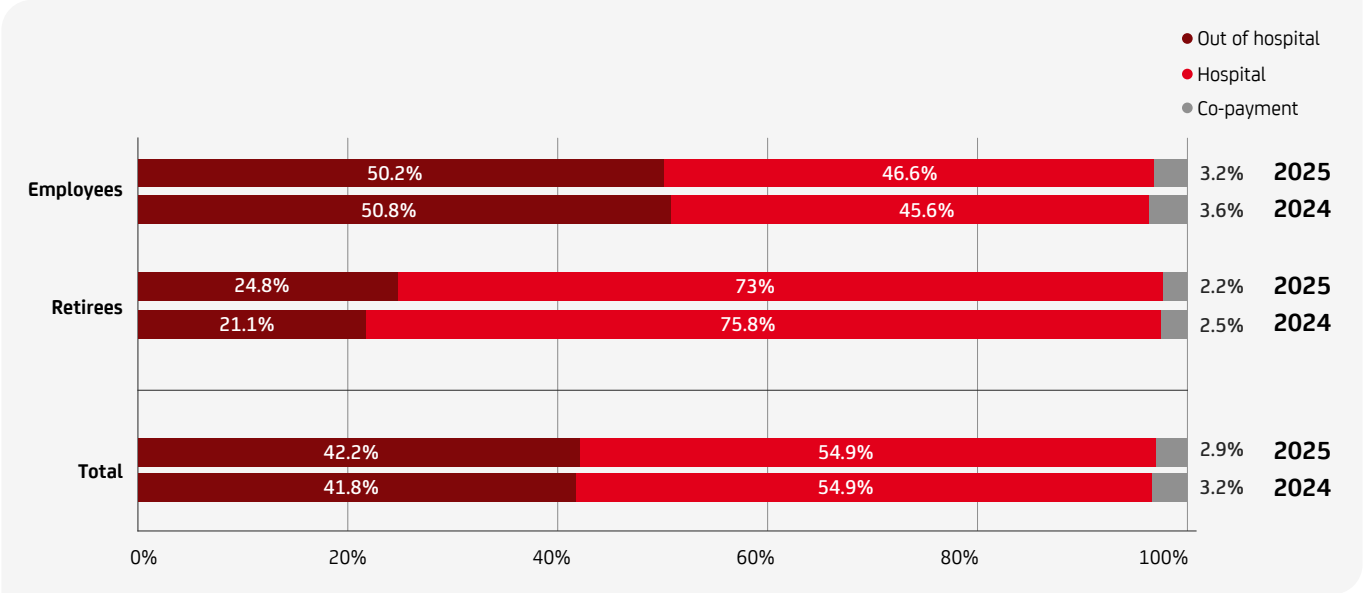
Figure 23 - **Distribution of policy uses by age group**



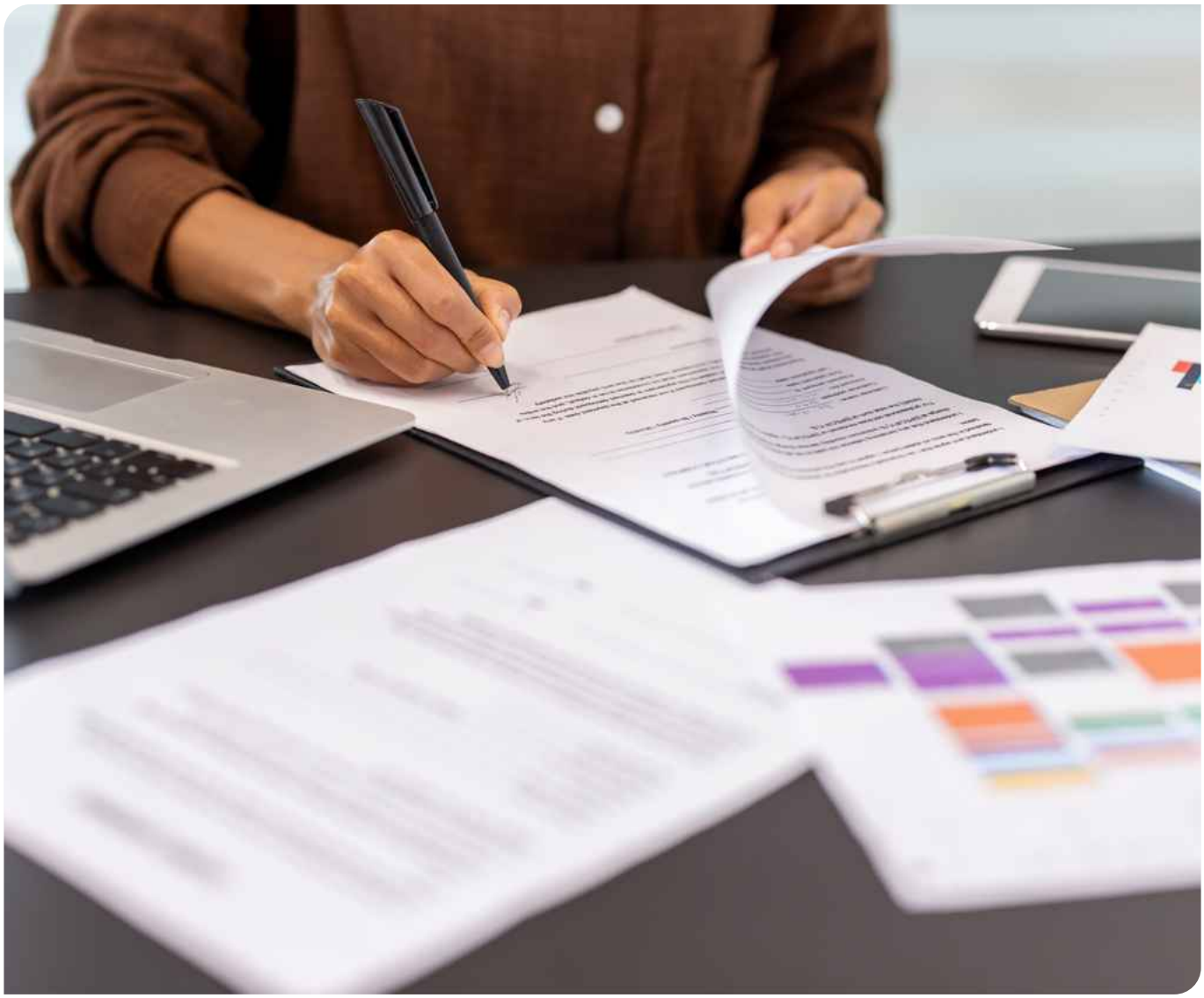
Data provided by Generali S.p.A.

A comparison of the data between the two years shows a substantial invariance of use distributed by age group; it is observed that as age increases, the use of the policy increases; an exception is the figure for the age group <30 years, which characterises all policies and is linked to examinations relating to minor children or, in any case, young members.

Figure 24 – **Distribution of uses by macro-areas of performance**

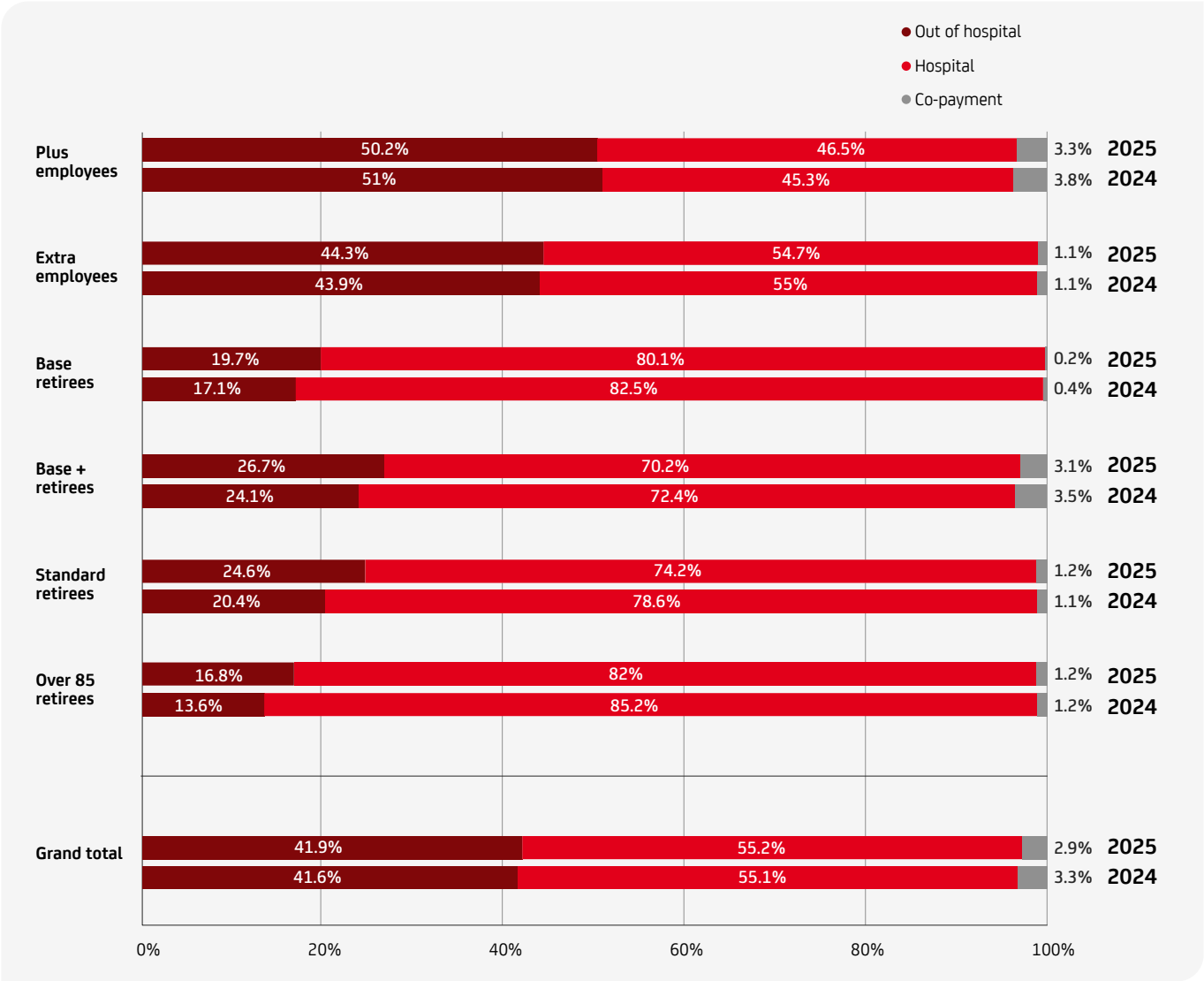


Data provided by Generali S.p.A.



The differing prevalence of claims between employees and retirees is confirmed: In the first instance, more claims are made for out-of-hospital services such as specialist appointments, exams, treatments and therapies. In the second case, however, it is hospital services such as admissions that account for the most claims. This is also confirmed by the following breakdown of macro benefits by type of policy.

Figure 25 - **Use by macro-service and type of basic policy**

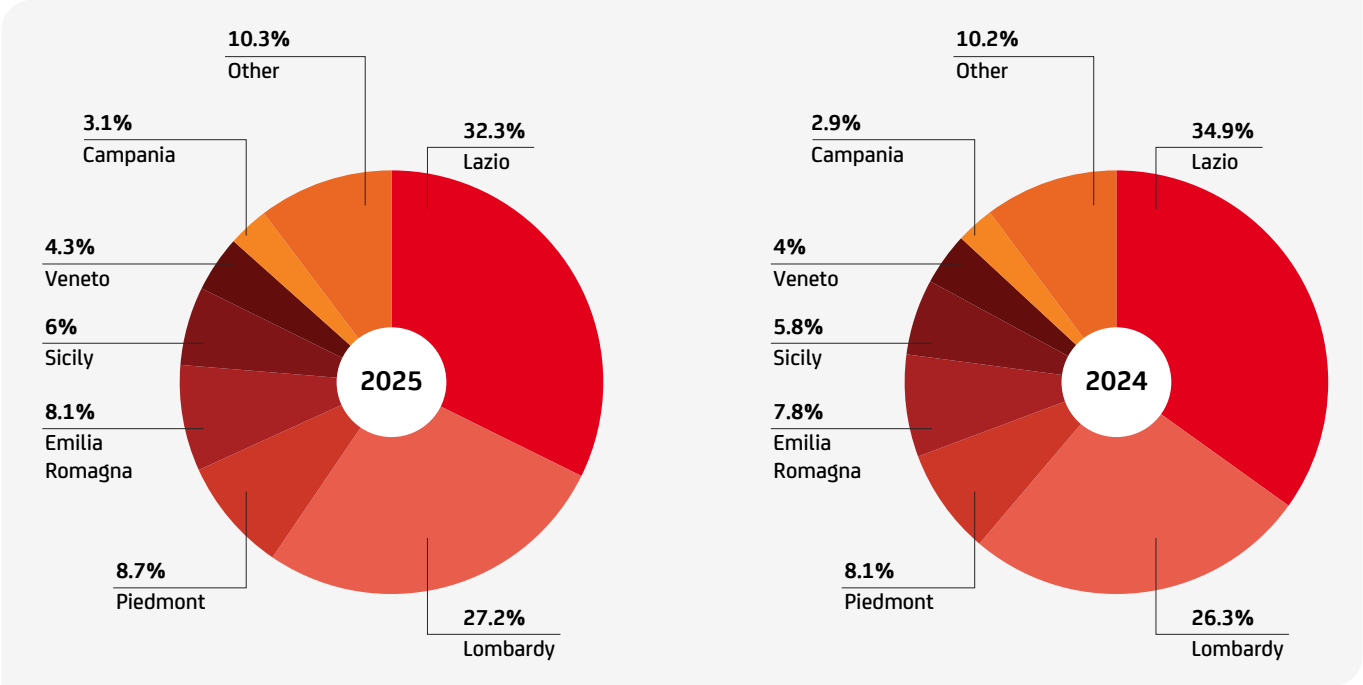


Data provided by Generali S.p.A.

The comparison of data between the two years shows substantially stable trends across the different benefit categories.

The following tables provide details, also at the level of individual regions, of the settlement of claims submitted.

Figure 26 - **Breakdown of settlements per region**



Data provided by Generali S.p.A.

Compared to 2024, the following trends are confirmed: Lazio (Central area) is the area with the highest number of paid claims, followed by Lombardy (North West area), basically the two regions with the highest number of members. With reference to Lazio, as mentioned above, this is a well-known phenomenon due to a series of factors such as the high availability of contracted healthcare facilities and the use of services mainly provided by hospitals due to the presence of a higher number of retirees.

Figure 27.a - **Distribution of settlements by region and per capita usage**

Region	Claims settled in €	No. of Users	Users % of total members[1]	Average per capita usage in €
Abruzzo	396,601	424	59.5%	935
Basilicata	120,590	123	50.8%	980
Calabria	301,581	443	61.6%	681
Campania	1,902,205	2,820	62.9%	675
Emilia Romagna	4,996,097	6,636	63.4%	753
Friuli Venezia Giulia	438,974	1,057	52.6%	415
Lazio	19,843,414	13,458	71.4%	1,474
Liguria	797,581	983	60.2%	811
Lombardy	16,705,395	16,201	65.3%	1,031
Marche	355,413	742	55.2%	479
Molise	125,730	252	58.5%	499
Piedmont	5,369,295	6,117	62.3%	878
Apulia	1,024,865	1,863	63.9%	550
Sardinia	680,317	469	56.7%	1,451
Sicily	3,644,063	5,346	61.1%	682
Tuscany	1,184,705	1,623	57.5%	730
Trentino Alto Adige	305,532	364	42.9%	839
Umbria	520,913	822	56.7%	634
Valle d'Aosta	101,550	120	49.8%	846
Veneto	2,612,606	5,667	56.4%	461
Grand total	**61,427,429[2]**	**65,530**	**63.3%**	**937**

[1] Total members 2025 = 103,457

[2] The amount includes the estimate of late claims made by the insurance company, excluding the additional reserve for benefits that have not yet occurred but are statistically possible to occur.

Data provided by Generali S.p.A.

Figure 27.b - **Breakdown of settlements by type of member and per capita usage**

Type of members	Claims settled in €	No. of Users	Users % of total members[1]	Average per capita usage in €
Employees and households	41,958,012	53,540	51.7%	784
Retirees and households	19,469,417	11,990	11.6%	1,624
Grand total	**61,427,429**	**65,530**	**63.3%**	**937**

[1] Total members 2025 = 103,457

Data provided by Generali S.p.A.

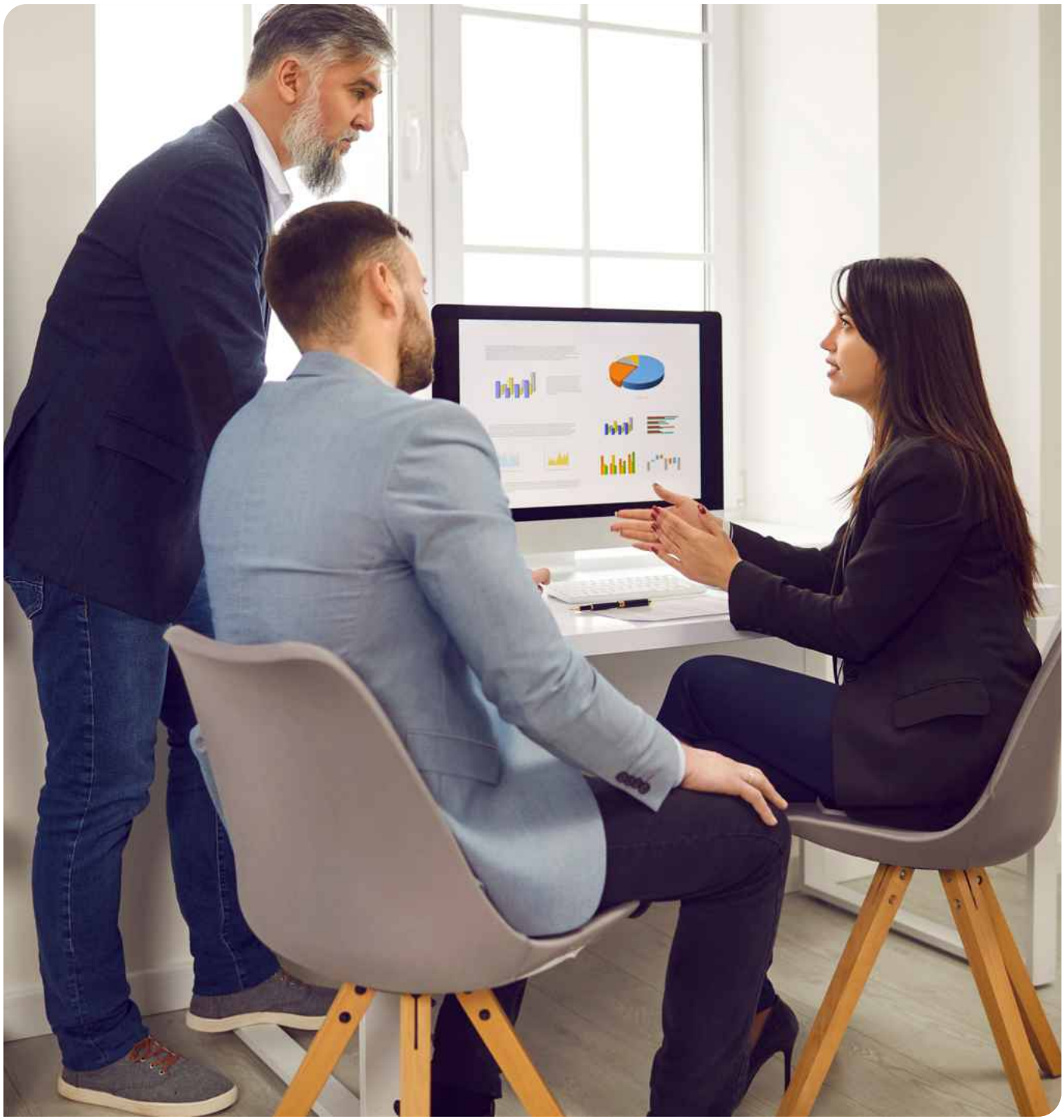
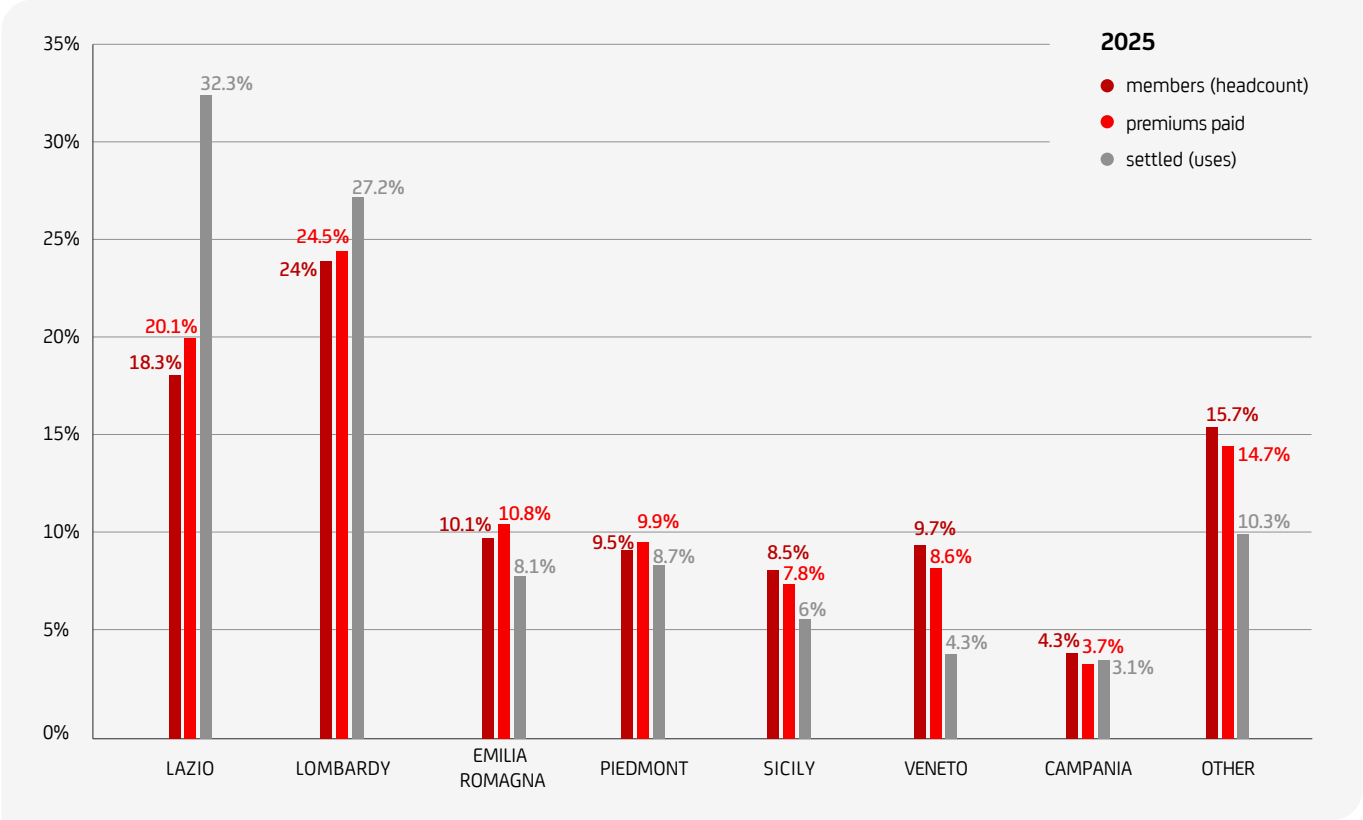
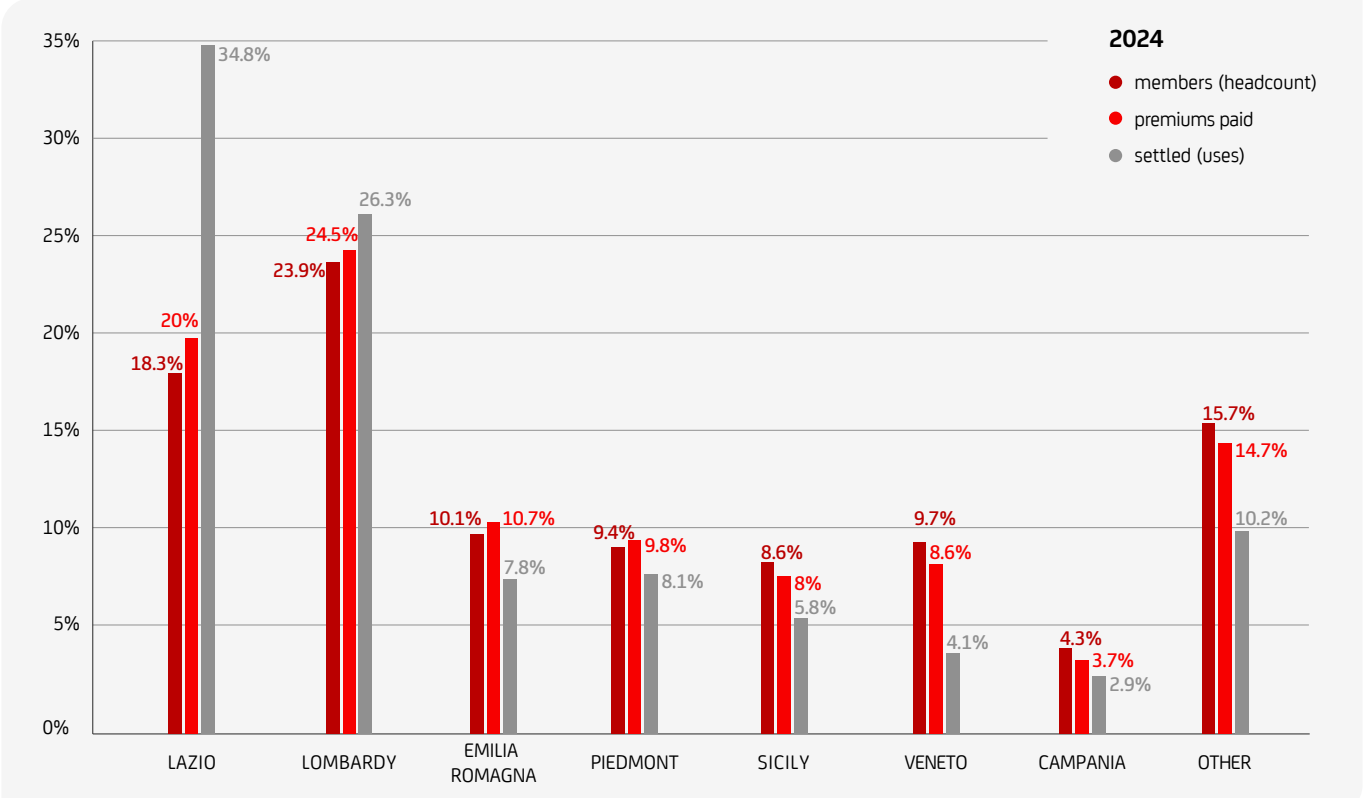


Figure 28 - **Distribution by region of settlements, premiums paid and members**

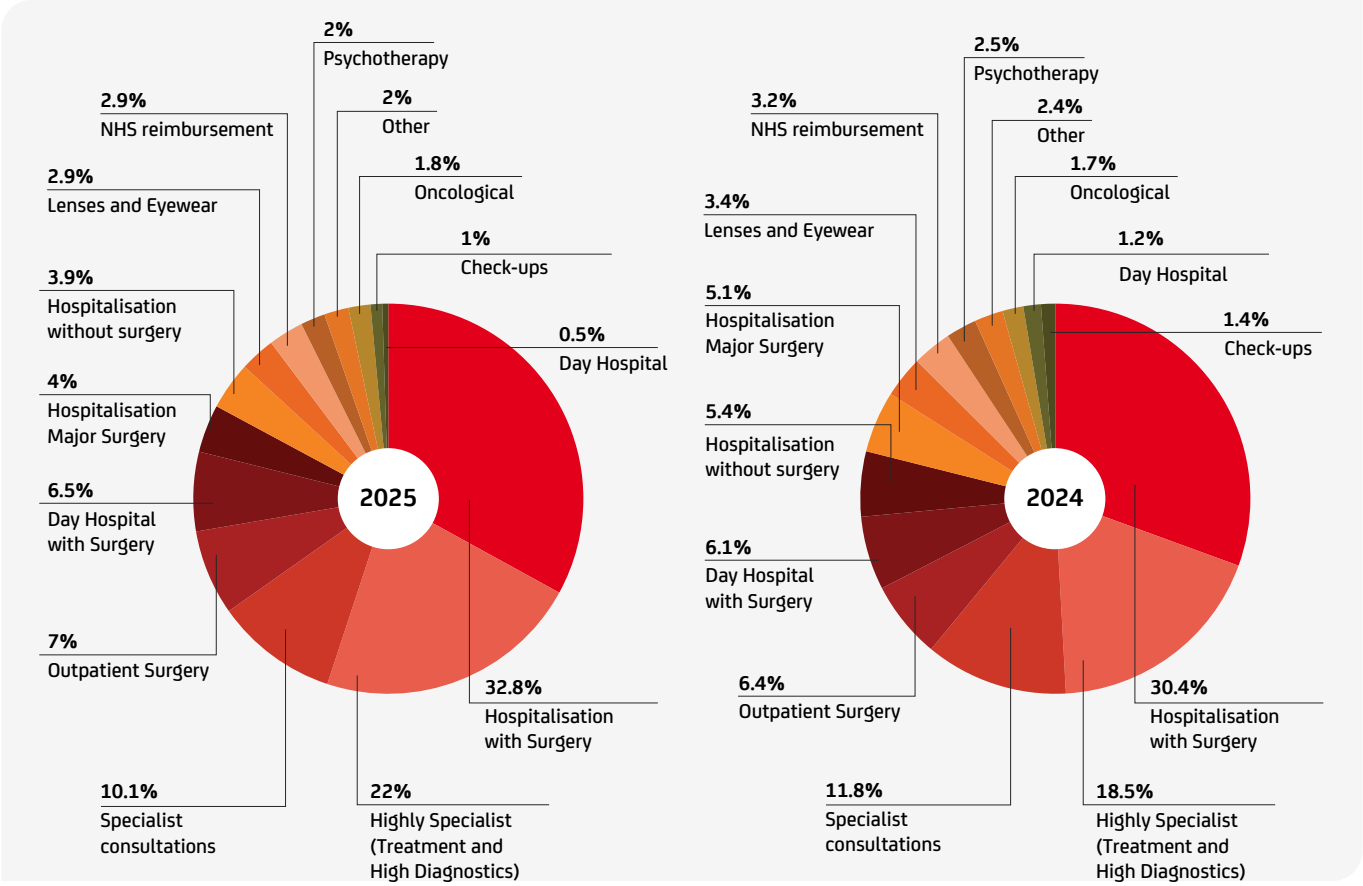




Data provided by Generali S.p.A.

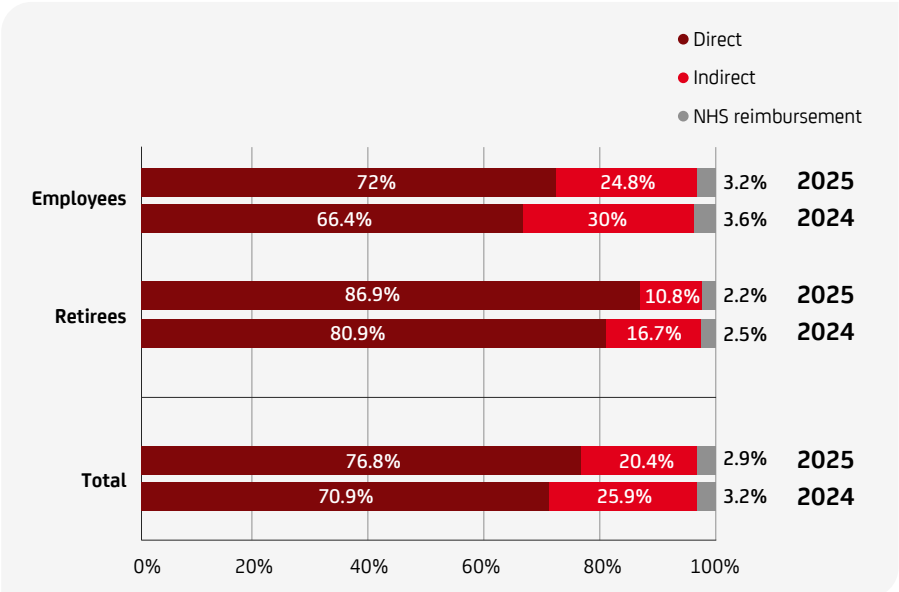
The distribution shown in 2025, almost similar to that of 2024, relates each region's claims, premiums and members to the respective totals of claims, premiums and members at the overall national level.

Figure 29 – **Distribution of claims settled by type of service**



Data provided by Generali S.p.A.

Figure 30 – **Breakdown of uses by access method to benefits**



Data provided by Generali S.p.A.

With regard to the delivery regime (see Table 30), there is confirmation of the greater recourse to direct services, i.e. at the affiliated network facilities, than to indirect form.

Table 31 – **Breakdown of settlements by macro-area and type of benefit – Payment rate per claim**

Service type - Hospital

Cover	Type of access	No. of Cases	Requested in €	Settled in €	% reimbursement
Hospitalisation with Surgery	D	7,763	13,678,581	12,310,802	90.0%
	I	1,301	1,179,977	779,362	66.0%
Surgical Day Hospital	D	2,065	2,456,330	2,261,878	92.1%
	I	194	262,431	132,395	50.4%
Outpatient Surgery	D	4,843	2,405,826	2,092,998	87.0%
	I	2,980	1,270,132	436,506	34.4%
Hospitalisation without surgery	D	573	1,022,500	928,793	90.8%
	I	507	448,855	350,517	78.1%
Medical Day Hospital	D	118	164,877	150,577	91.3%
	I	62	36,931	8,007	21.7%
OTHER (e.g. escort, transport)	D	279	46,284	35,738	77.2%
	I	3,068	886,731	875,158	98.7%
Total Hospital	-	**23,753**	**23,859,456**	**20,362,729**	**85.3%**

Type of service - Out-of-Hospital

Cover	Type of access	No. of Cases	Requested	Settled	% reimbursement
High diagnostics	D	13,148	3,851,313	3,258,042	84.6%
	I	3,212	919,822	425,311	46.2%
	NHS	2,163	91,349	91,120	99.7%
Medical tests/services	D	85,811	4,523,476	3,193,602	70.6%
	I	23,606	2,285,572	955,047	41.8%
	NHS	39,574	1,286,365	1,281,308	99.6%
Specialist consultations	D	42,403	4,061,522	2,747,992	67.7%
	I	42,931	6,639,307	3,468,750	52.2%
	NHS	13,548	387,737	387,041	99.8%
Oncological	D	3,146	789,419	774,502	98.1%
	I	2,055	349,196	337,452	96.6%
Preventive	D	5,347	491,853	490,031	99.6%
	I	1,443	152,501	98,084	64.3%
Orthopedic therapies	D	888	454,215	417,044	91.8%
	I	1,007	317,120	192,043	60.6%
	NHS	515	17,317	17,317	100.0%
Other therapies	D	9,693	39,441	36,632	92.9%
	I	14,513	2,840,110	1,405,674	49.5%
	NHS	37	1,402	1,402	100.0%
Lenses	I	12,992	3,678,084	1,716,431	46.7%
Prosthesis	I	589	306,822	233,029	75.9%
Total Out-of-Hospital	-	**318,621**	**33,483,942**	**21,527,855**	**64.3%**

Data provided by Generali S.p.A.

Settlement data as of 12/31/2025. The values within the individual types of benefits are ordered in decreasing order with respect to the direct form of access of the beneficiary.

Table 31 – **Breakdown of payments by macro-area and type of benefit – Payment rate per claim**

Type of service - Dental care

Cover	Type of access	No. of Cases	Requested	Settled	% reimbursement
Dental treatment due to injury	I	303	178,228	115,123	64.6%
Total dental treatment due to injury	**-**	**303**	**178,228**	**115,123**	**64.6%**

Benefit type - Other benefits

Cover	Type of access	No. of Cases	Requested	Paid	% reimbursement
Other benefits (optional supplementary cover)	D	55	43,572	39,022	89.6%
	I	4,082	491,762	250,069	50.9%
Total Other benefits	**-**	**4,137**	**535,335**	**289,091**	**54.0%**

Grand total

Type of benefit	No. of Cases	Requested	Settled	% reimbursement
Total Hospital	23,753	23,859,456	20,362,729	85.3%
Total Out-of-Hospital	318,621	33,483,942	21,527,855	64.3%
Total Dental treatment due to injury	303	178,228	115,123	64.6%
Total Other benefits	4,137	535,335	289,091	54.0%
Grand total	**346,814**	**58,056,960**	**42,294,799**	**72.9%**

Data provided by Generali S.p.A.
Settlement data as of 12/31/2025. The values within the individual types of benefits are ordered in decreasing order with respect to the direct form of access.
(*) The amount paid out includes approximately €860,000 relating to hospitalisations carried out by the National Health Service.

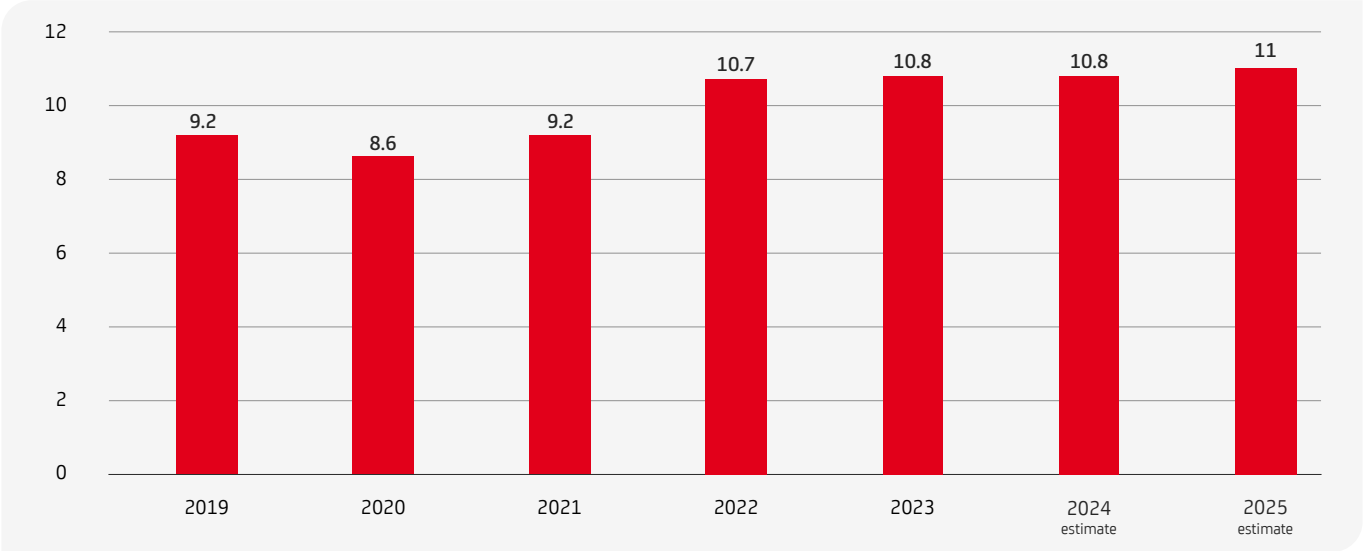
The table shows an excellent ratio between the compensation claimed by clients and the amount paid out by the insurance company – the so-called 'claims settlement rate' – which, for the year 2025, averaged around **73%**, with peaks of almost 100% for NHS reimbursements.

Trends in dental coverage

In 2025, the estimated closure cost for dental reimbursements is approximately €11 million, a slight increase compared to the previous year.

The following graph shows the amounts settled for each year. For 2025, the actual settlement figure is approximately €9.9 million and the difference from the amount shown below relates to the estimated 'late claims'.

Figure 33 - **Trend in dental coverage (claims in millions/€)**



As at 31 December 2025, 36,707 claims relating to that financial year and 5,518 claims relating to previous financial years had been paid, in accordance with the two-year limitation period applicable to healthcare reimbursements.

Figure 33.a – **% distribution of claims settled by the main services**

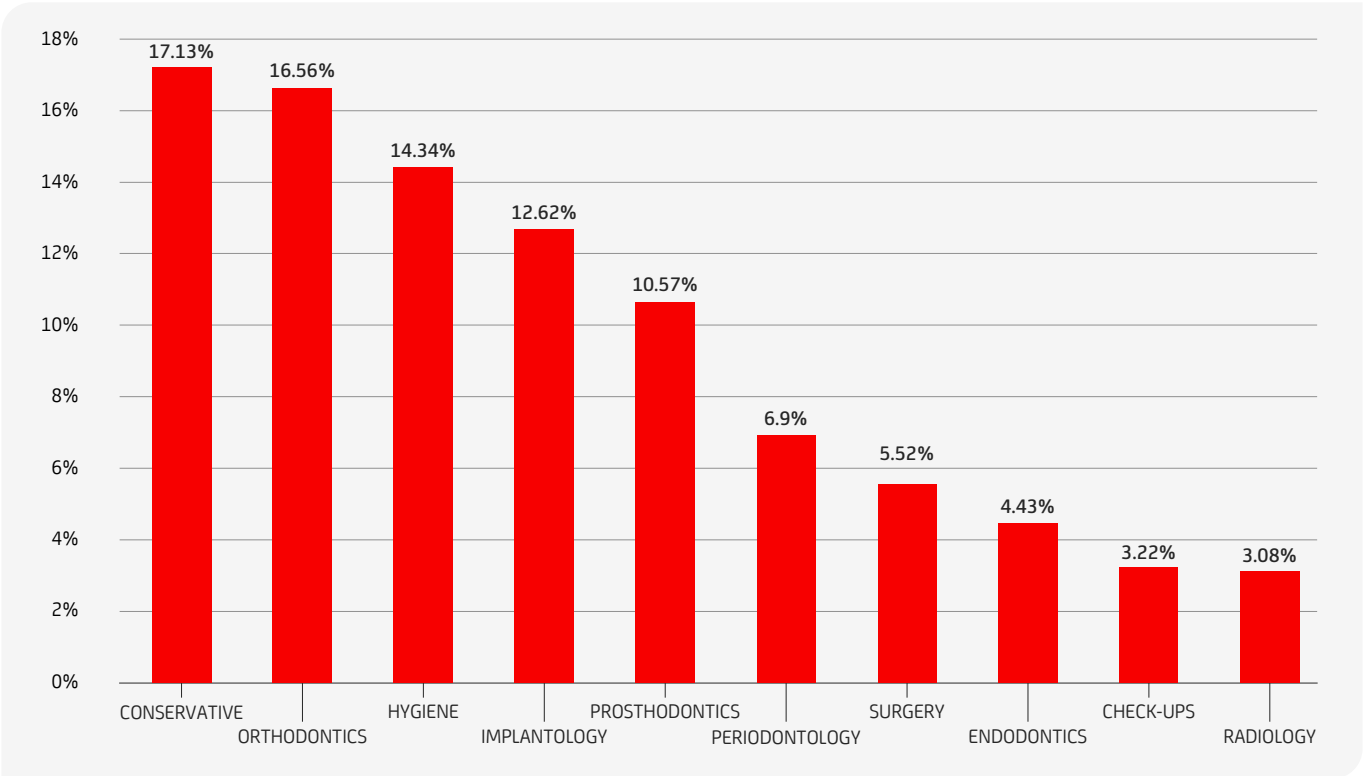
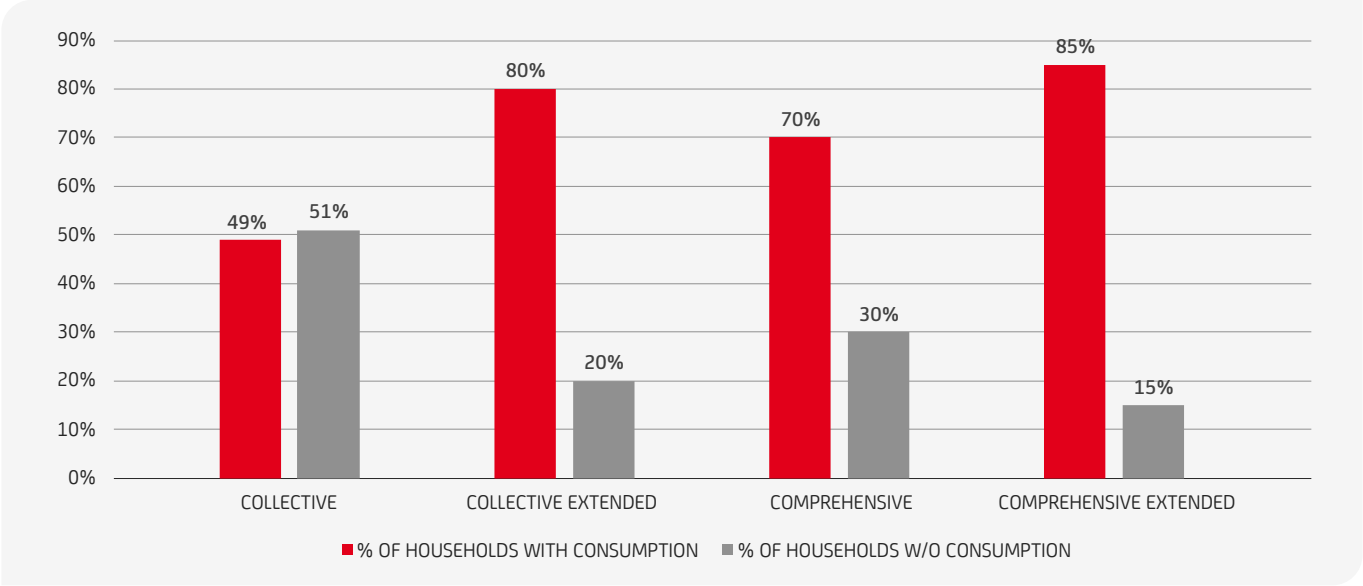


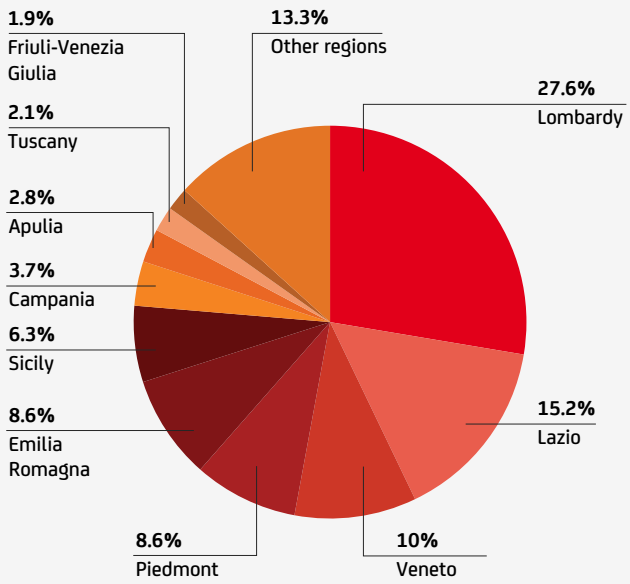
Figure 33.b - **Distribution of consumption by type of coverage**



The highest percentages of use of coverage for families are recorded for the plans dedicated to managerial staff (Comprehensive and Comprehensive extended) and for the plan that includes family members and is dedicated to non-managerial staff.

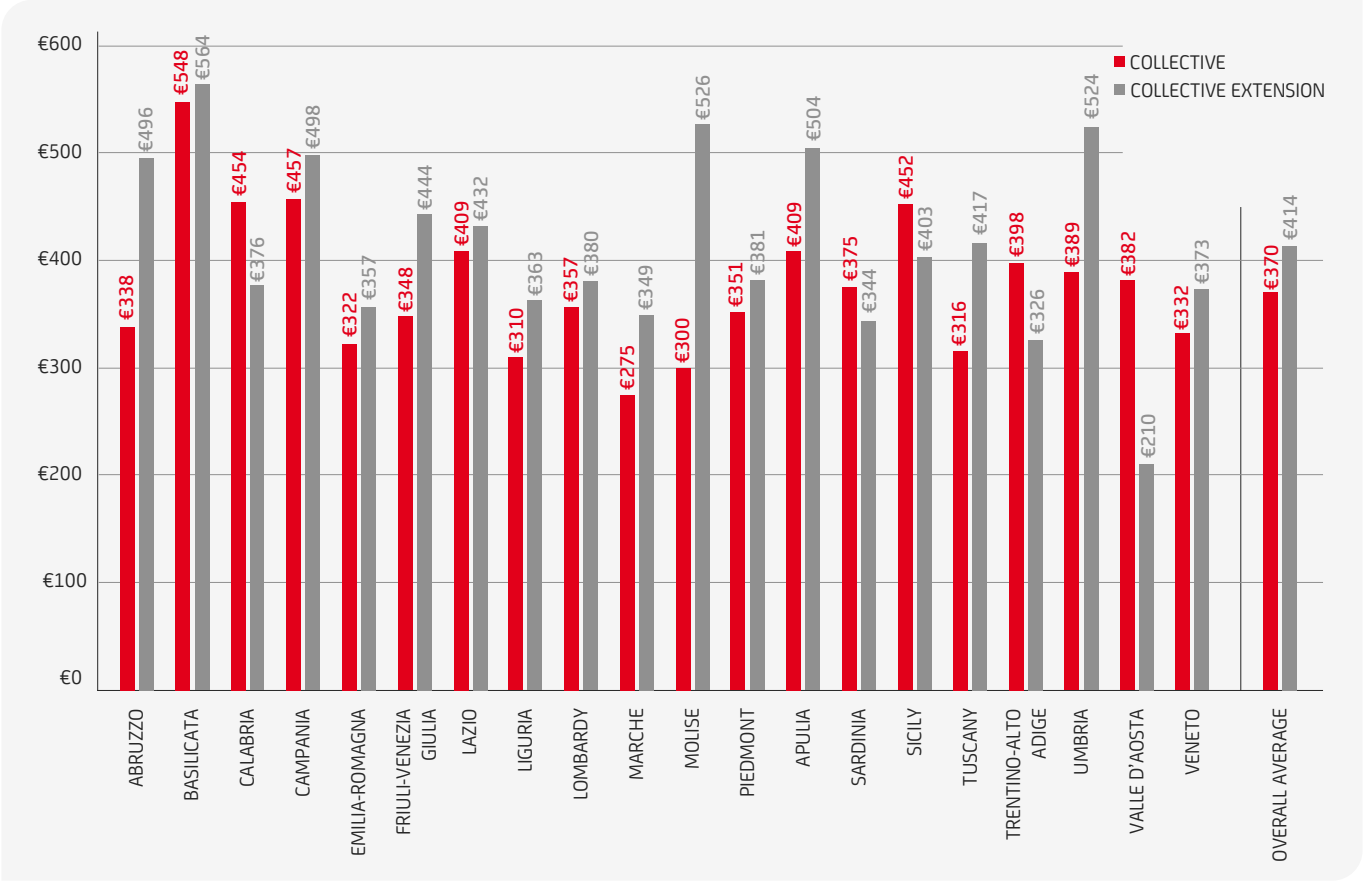
In general, dental coverage is used by 53.5% of employees and their families.

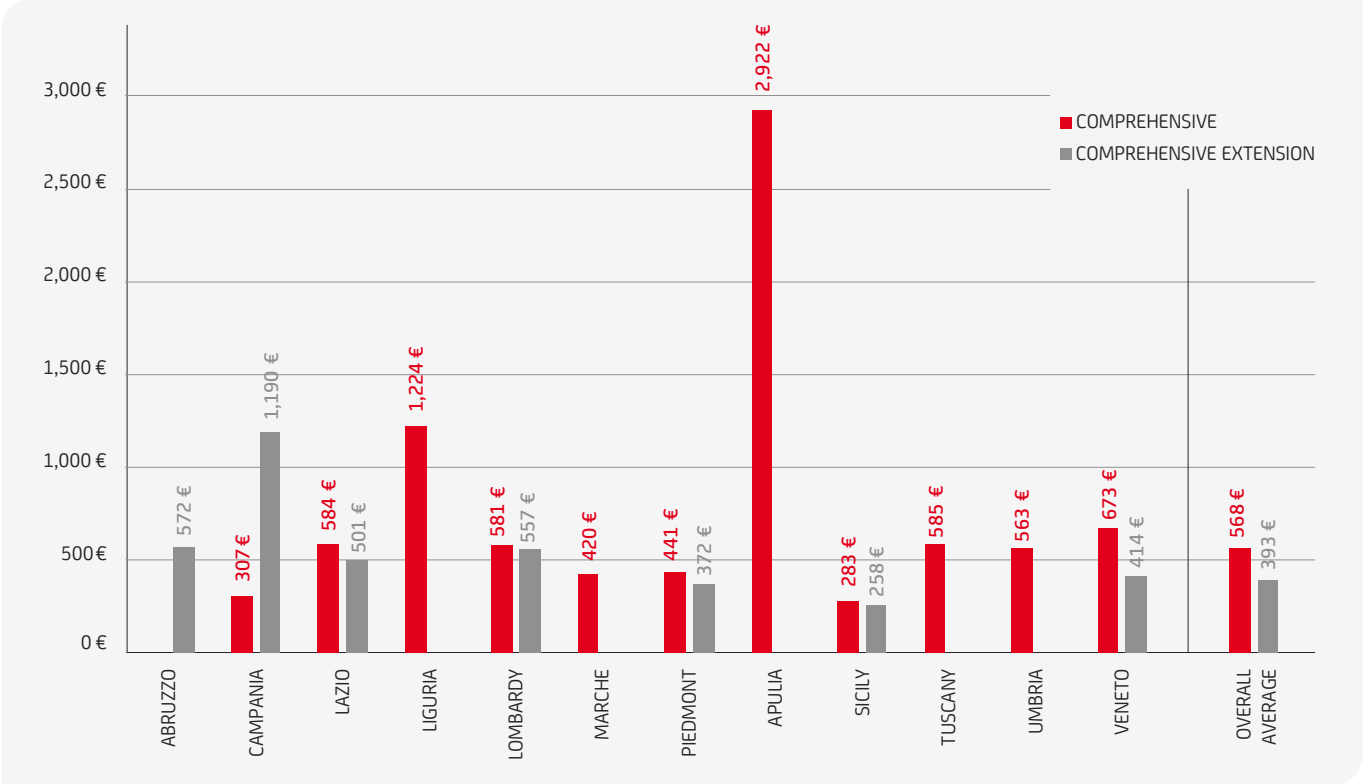
Figure 33.c – **% distribution of claims settled by region**



The graph highlights how the highest consumption is concentrated in the regions with the highest density of employee members.

Figure 33.d - **Average per capita amount of settlement by type of coverage**

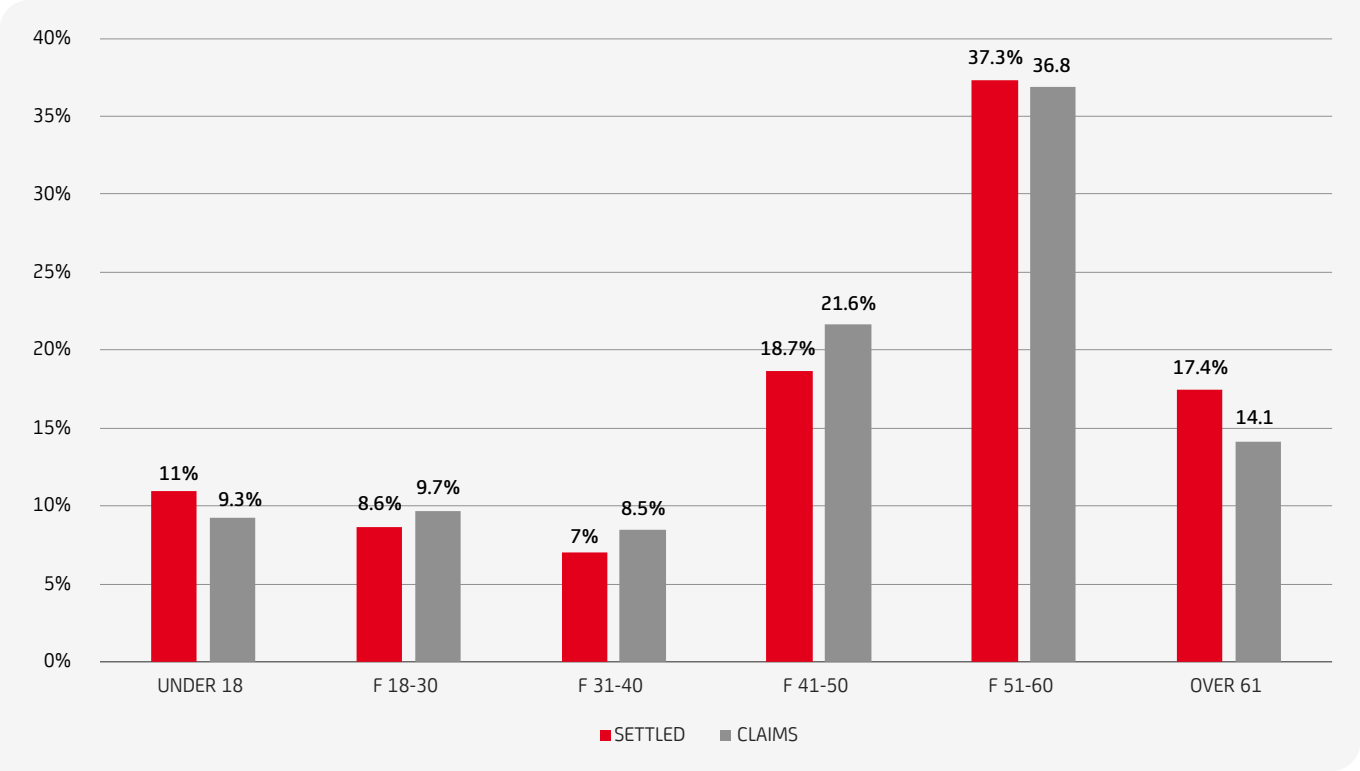




The second graph highlights only the regions in which uses by managerial staff were recorded.

Taken as a whole, in 2025 the coverage records an average settlement of €393.

Figure 33.e - **% distribution of claims settled and number of claims by age group**



The trend in consumption based on the age of the users is substantially similar to that recorded for non-dental basic coverage: the greatest use is recorded among older members due to their greater health needs, while for the adolescent age group the use is mainly concentrated on orthodontic and oral hygiene services.

Figure 33.f - **Access methods to benefits - Comparison of % of claims**

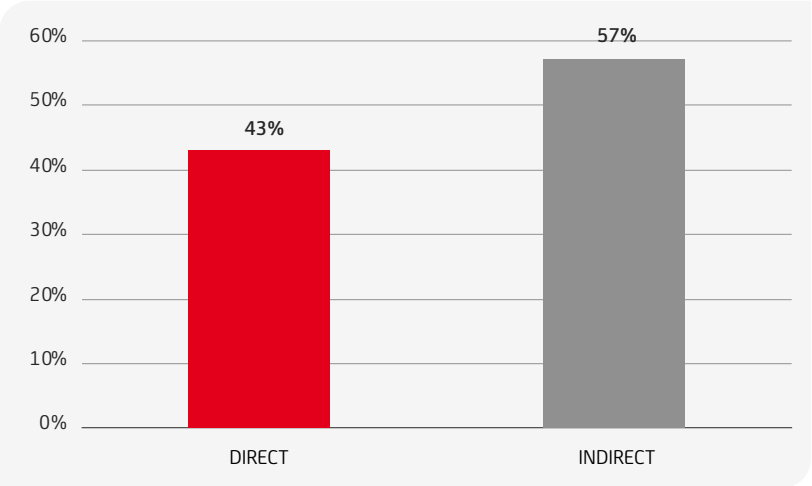
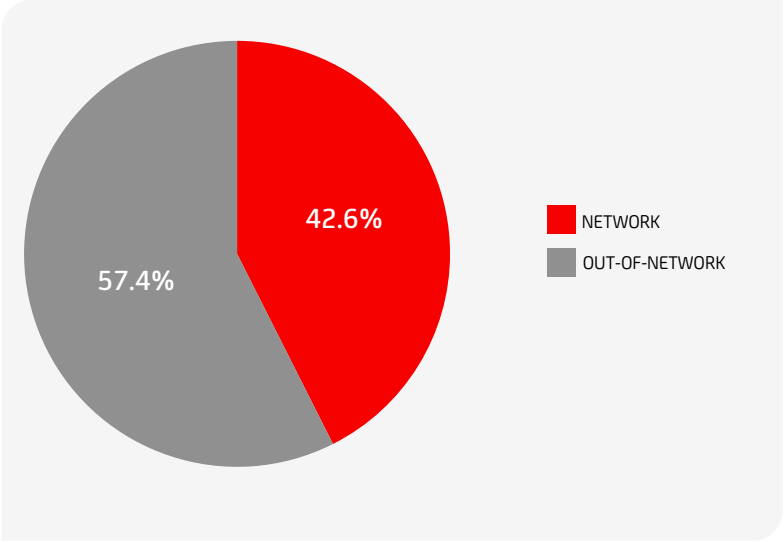


Figure 33.g - **Access methods to benefits - Comparison of % of users**



Figures 33f and 33g confirm the prevalence of access to benefits indirectly, both in terms of claims and users. This trend is showing a slight but constant growth starting from 2022, as highlighted in table 33h.

Table 33h - **Type of access to benefits: comparison over the years**

Year	% of users direct form	% of settlements direct form	% of users indirect form	% of settlements indirect form
2022	50.7%	52.2%	49.3%	47.8%
2023	51.0%	52.2%	49.0%	47.8%
2024	49.3%	48.0%	50.7%	52.0%
2025	48.9%	49.2%	51.1%	50.8%

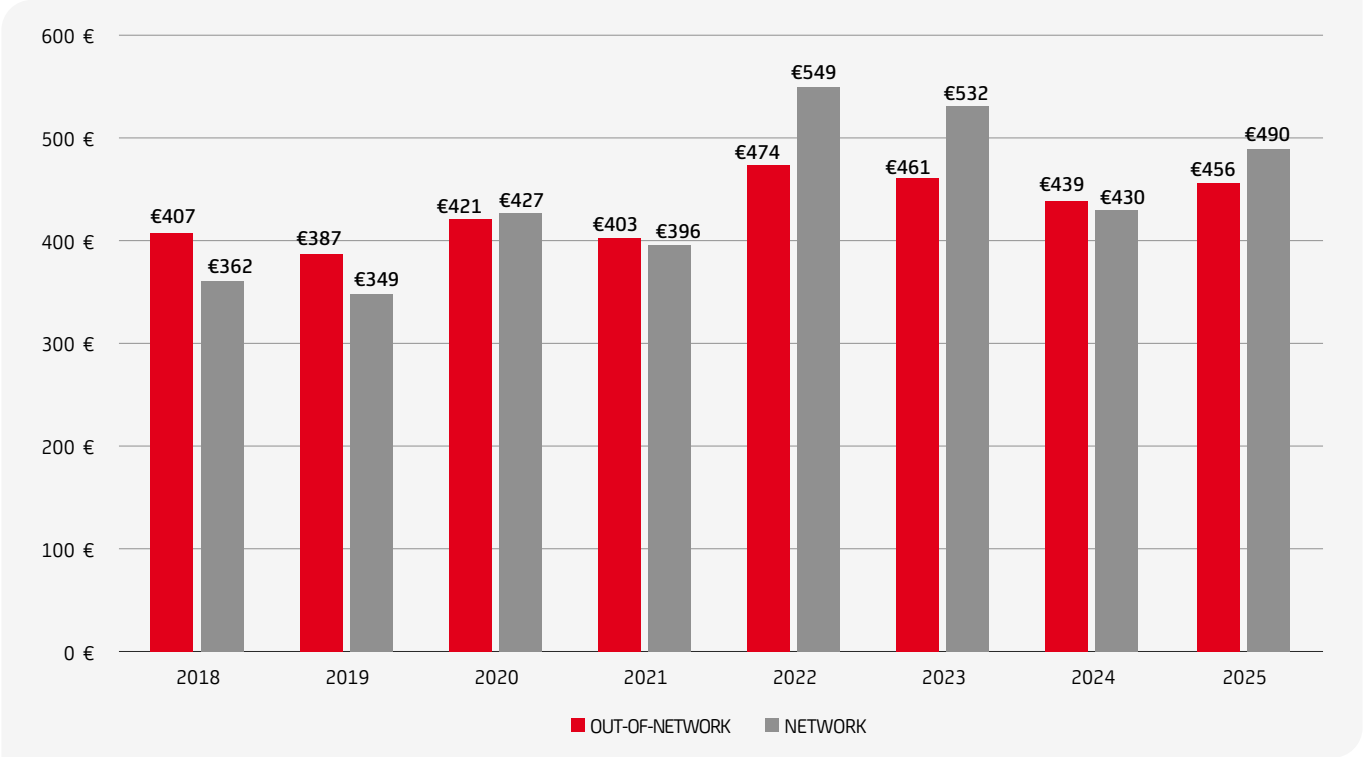
Table 33i - **Average amounts settled and average reimbursement % by type of access**

Type of access	Average turnover amount per household	Average amount settled per household	Average reimbursement %
Direct Form	€633	€490	77%
Indirect Form	€769	€456	59%

The table highlights an excellent percentage of reimbursement through the use of the direct form, equal to an average of 77%, which confirms the high level of the overall system of dental coverage offered to members; although lower, the analogous figure referring to indirect form consumption is still positive, which is affected by the greater 'weight' of the deductibles and excesses provided for in the individual coverage plans. The table confirms, in terms of average settlement, the higher reimbursement linked to direct form access.

In terms of average settlement, the following table confirms, in general, the higher reimbursement linked to direct form access.

Figure 33.l - **Comparison of average settlement per household, network and out-of-network**



Tables compiled on the basis of data provided by Aon. The Treviso Dental policy operated by Generali S.p.A. is not considered.

9 Exercise of Director's powers; legal disputes

In 2025, as no disputed claims were identified, the Director did not take any action within the scope of the powers delegated.

The only civil litigation, at first instance, in which the Association is involved but not as a plaintiff, has not yet been concluded.

The substantial absence of litigation, 19 years after the start of operations, is one of the Association's strengths, quality of the service provided and the coverage offered, as well as the effectiveness of its procedures for handling any complaints.

10 Application of the Sacconi Decree

For 2025, the proportion of resources allocated to healthcare services subject to restrictions under the Sacconi Ministerial Decree, as a percentage of the total resources committed to covering all services guaranteed to members, stands at 27.53%, which is therefore above the 20% limit set out in the aforementioned decree and which is binding for the purposes of the tax deductibility of contributions paid by members.

Table 32 - **Health benefits subject to restrictions pursuant to the Sacconi Ministerial Decree (in €)**

	Committed resources	Detailed compliant amounts	Total compliant amounts	% compliant benefits
SELF-INSURED DENTAL PLAN COVER	11,058,682	-	11,058,682	100%
POLICIES FOR DENTAL AND NON-DENTAL COVER	74,840,898	-	10,033,460	13.41%
Social benefits with health relevance	-	39,005	-	0.05%
Health benefits with health relevance	-	7,342,649	-	9.81%
Benefits aimed at health recovery	-	2,395,194	-	3.20%
Dental Care benefits	-	256,612	-	0.34%
LONG TERM CARE (CASDIC)	3,529,800	-	3,529,800	100%
TOTAL	**89,429,380**	**-**	**24,621,942**	**-**
RELATIONSHIP BETWEEN COMPLIANCE PERFORMANCE AND RESOURCES COMMITTED	**-**	**-**	**27.53%**	**-**

11 Association activities

'Health Benefits Dashboard'

the tool for collecting data on the benefits provided by supplementary funds

Throughout 2025, work continued on the 'Health Benefits Dashboard' project managed by the Health Fund Registry, with the aim of improving data collection on the services provided by supplementary funds.

The implementation of the 'Dashboard', which began several years ago, continued on an experimental basis, as did the discussions and technical coordination activities involving the health funds with Mefop, to align the Dashboard's performance with national standards.

The collaboration with Mefop and the Observatory of Private Consumption in Healthcare (OCPS) of CeRGAS- SDA Bocconi in Milan continued in 2025.

2025 represents a year of technical consolidation for the Dashboard, aimed at ensuring timely monitoring of the performance of supplementary healthcare funds, in accordance with the rules on the deductibility of contributions.

12 2026: activities related to the 1st quarter

In the first quarter of 2026, the Fund's work will focus on:

- activities related to the launch of the new two-year health plans, including the completion of registrations for the years 2026-2027 regarding retirees, survivors, early retirees and long-term absent staff, i.e. all those who did not register online in December 2025
- activities related to the installation of the updated corporate bodies
- preparation of the financial statements for 2025
- preparatory activities for the renewal of the Prevention Campaign
- update and alignment work related to the Health Benefits Dashboard

Financial statements as at and for the year ended 31 December 2025

FINANCIAL STATEMENTS AS AT AND FOR THE YEAR ENDED 31 DECEMBER 2025

13 Statement of financial position as at 31 December 2025

Assets	31.12.2025	31.12.2024	Change
Trade receivables	**1,735,520**	**68,405**	**1,667,115**
from Unicredit Group companies (for enrolled employees)	66,663	64,586	2,077
from contracted companies (for enrolled employees)	-	873	-873
from Retirees	-	2,946	-2,946
from Insurance company	1,668,857	-	1,668,857
Cash and cash equivalents	**62,717,476**	**63,475,612**	**-758,136**
Cash and other valuables	30	26	4
Bank deposits	62,717,446	63,475,586	-758,140
TOTAL ASSETS	**64,452,996**	**63,544,017**	**908,979**

Liabilities and net assets	31.12.2025	31.12.2024	Change
Reserve funds	**45,857,231**	**45,780,325**	**76,906**
Surplus/deficit for the year	76,906	17,520	59,386
Surplus/deficit from previous years	45,771,228	45,753,708	17,520
Residual assets of the former Bipop Carire health fund	9,097	9,097	-
Provisions for health campaigns	**6,611,124**	**9,846,979**	**-3,235,855**
Provisions for health campaigns	6,611,124	9,846,979	-3,235,855
Provisions for risks and charges	**8,400**	**8,400**	**-**
Provisions for lawsuits	8,400	8,400	-
Provisions for 'Requests for exceptional contributions'	**61,800**	**63,100**	**-1,300**
Provisions for 'Requests for exceptional contributions'	61,800	63,100	-1,300
'Liabilities arising from self-insured dental plans'	**11,270,210**	**7,654,175**	**3,616,035**
Technical provisions for self-insurance	7,600,000	4,000,000	3,600,000
Payables to members for dental coverage	3,670,210	3,654,175	16,035
Trade payables	**317,854**	**150,852**	**167,002**
Payables to Unicredit Group companies	-	2,400	-2,400
Insurance premiums	317,854	148,452	169,402
Sundry payables	**38,377**	**40,186**	**-1,809**
Suppliers for services received	38,377	40,186	-1,809
Tax payables	**-**	**-**	**-**
Payables to tax authority	-	-	-
Accrued expenses and deferred income	**288,000**	**-**	**-**
Deferred income	288,000	-	-
TOTAL LIABILITIES	**64,452,996**	**63,544,017**	**620,979**

14 Income statement for the year ended 31 December 2025

Costs	2025	2024	Change
Benefit expenses	**83,383,574**	**85,210,103**	**-1,826,529**
Insurance premiums	66,310,980	65,428,720	882,260
Self-insurance costs	11,283,049	11,202,304	80,745
Accruals to technical provisions for self-insurance	-	1,000,000	-1,000,000
Claims management costs	410,645	505,722	-95,077
Provisions for health campaigns	5,300,000	7,070,000	-1,770,000
Provisions for 'Requests for exceptional contributions'	6,900	2,800	4,100
Costs for Telemedicine service	72,000	-	72,000
Sundry expenses	-	557	-557
Financial expenses	**367**	**513**	**-146**
Bank fees and charges	367	513	-146
Sundry expenses	**6,193**	**9,433**	**-3,240**
Contingent liabilities	6,193	9,433	-3,240
Administrative costs	**93,494**	**132,062**	**-38,568**
Professional fees	50,999	80,840	-29,841
Miscellaneous	42,495	51,222	-8,727
TOTAL COSTS	**83,483,628**	**85,352,111**	**-1,868,483**
OPERATING SURPLUSES	**76,906**	**17,520**	**59,386**
TOTALS	**83,560,535**	**85,369,631**	**-1,809,096**

Revenue	2025	2024	Change
Member contributions	**81,772,651**	**82,712,394**	**-939,743**
From employers	50,705,359	52,442,833	-1,737,474
From members	30,995,292	30,269,561	725,731
Contributions for Telemedicine	72,000	-	72,000
Financial income	**1,781,710**	**2,614,362**	**-832,652**
Interest income	1,781,710	2,614,362	-832,652
Other income	**6,174**	**42,875**	**-36,701**
Penalties and expense recoveries	5,713	5,558	155
Recovery of sundry expenses and contingent assets	461	37,317	-36,856
TOTAL REVENUES	**83,560,535**	**85,369,631**	**-1,809,096**
OPERATING SHORTFALLS	**-**	**-**	**-**
TOTALS	**83,560,535**	**85,369,631**	**-1,809,096**

Employee section

Costs	2025	2024	Change
Benefit expenses	**63,400,165**	**66,797,300**	**-3,397,135**
Insurance premiums	47,807,638	48,873,481	-1,065,843
Self-insurance costs	11,283,049	11,202,304	80,745
Accruals to technical provisions for self-insurance	-	1,000,000	-1,000,000
Claims management costs	390,508	458,814	-68,306
Provisions for health campaigns	3,841,970	5,260,787	-1,418,817
Provisions for 'Requests for exceptional contributions'	5,000	1,500	3,500
Costs for Telemedicine service	72,000	-	72,000
Sundry expenses	-	414	-414
Financial expenses	**266**	**382**	**-116**
Bank fees and charges	266	382	-116
Sundry expenses	**-**	**433**	**-433**
Contingent liabilities	-	433	-433
Expenses for donations and gifts	-	-	-
Administrative costs	**67,774**	**98,267**	**-30,493**
Professional fees	36,969	60,153	-23,184
Miscellaneous	30,805	38,114	-7,309
TOTAL COSTS	**63,468,205**	**66,896,382**	**-3,428,177**
OPERATING SURPLUSES	**434,334**	**-**	**434,334**
TOTALS	**63,902,539**	**66,896,382**	**-2,993,843**

Revenue	2025	2024	Change
Member contributions	**62,610,644**	**64,706,005**	**-2,095,361**
From employers	50,705,359	52,442,833	-1,737,474
From members	11,833,285	12,263,172	-429,887
Contributions for Telemedicine	72,000	-	72,000
Financial income	**1,291,561**	**1,945,347**	**-653,786**
Interest income	1,291,561	1,945,347	-653,786
Other income	**334**	**28,688**	**-28,354**
Penalties and expense recoveries	-	920	-920
Surplus provisions from previous years	-	-	-
Recovery of sundry expenses and contingent assets	334	27,768	-27,434
TOTAL REVENUES	**63,902,539**	**66,680,040**	**-2,777,501**
OPERATING SHORTFALLS	**-**	**216,342**	**-216,342**
TOTALS	**63,902,539**	**66,896,382**	**-2,993,843**

Retiree section

Costs	2025	2024	Change
Benefit expenses	**19,983,409**	**18,412,803**	**1,570,606**
Insurance premiums	18,503,342	16,555,239	1,948,103
Self-insurance costs	-	-	-
Accruals to technical provisions for self-insurance	-	-	-
Claims management costs	20,137	46,908	-26,771
Provisions for health campaigns	1,458,030	1,809,213	-351,183
Provisions for 'Requests for exceptional contributions'	1,900	1,300	600
Costs for Telemedicine service	-	-	-
Sundry expenses	-	143	-143
Financial expenses	**101**	**131**	**-30**
Bank fees and charges	101	131	-30
Sundry expenses	**6,193**	**9,000**	**-2,807**
Contingent liabilities	6,193	9,000	-2,807
Expenses for donations and gifts	-	-	-
Administrative costs	**25,720**	**33,795**	**-8,075**
Professional fees	14,030	20,687	-6,657
Miscellaneous	11,690	13,108	-1,418
TOTAL COSTS	**20,015,423**	**18,455,729**	**1,559,694**
OPERATING SURPLUSES	**-**	**233,862**	**-233,862**
TOTALS	**20,015,423**	**18,689,591**	**1,325,832**

Revenue	2025	2024	Change
Member contributions	**19,162,007**	**18,006,389**	**1,155,618**
From members	19,162,007	18,006,389	1,155,618
Contributions for Telemedicine	-	-	-
Financial income	**490,148**	**669,015**	**-178,867**
Interest income	490,148	669,015	-178,867
Other income	**5,840**	**14,187**	**-8,347**
Penalties and expense recoveries	5,713	4,638	1,075
Surplus provisions from previous years	-	-	-
Recovery of sundry expenses and contingent assets	127	9,549	-9,422
TOTAL REVENUES	**19,657,995**	**18,689,591**	**968,404**
OPERATING SHORTFALLS	**357,428**	**-**	**357,428**
TOTALS	**20,015,423**	**18,689,591**	**1,325,832**

15 Notes

Introduction

Uni.C.A., UniCredit Cassa Assistenza, is a health benefits provider serving the employees of the UniCredit Group, established on 15 November 2006 and having its registered office in Milan.

It is a non-recognised association pursuant to article 36 et seq. of the Italian Civil Code.

Uni.C.A.'s purpose is to provide and manage health benefits to its individual members and their families, including in addition to those provided by the National Healthcare Service, in case of sickness, injury and other events that might require medical assistance or care, in accordance with collective labour agreements and/or company policies, within the framework of the laws applicable from time to time.

The corporate bodies and officers of the Cassa Assistenza are:

- the General Meeting of members
- the Board of Directors
- the Executive Committee
- the Chairman and Deputy Chairman
- the Board of Auditors

Basis of presentation of the financial statements

The financial statements consist of the statement of financial position, the income statement and the notes and are accompanied by the Board of Directors' report and the 'Report on operations'.

In accordance with article 19 of the Articles of Association, in the income statement, costs and revenues are divided into two distinct sections in relation to the nature of the members (Employees and Retirees/Survivors) with the exception of the costs incurred on behalf of third parties as a result of agreements and their recovery.

The 2025 financial year, the Association's nineteenth year of operation, closed with a surplus of €76,906 (€17,520 in 2024), which will be allocated to the Association's activities in subsequent financial years.

The financial statements are audited by the Board of Auditors.

As UniCredit Cassa Assistenza does not perform commercial activities, it is not registered for VAT and its income is exempt from income tax.

€76,906

Surplus at the end of the 2025 financial year

+€ 59,386 compared to 2024

The purpose of Uni.C.A. is to provide and manage healthcare services – including those that supplement the National Health Service – for its individual members and their families

Accounting policies

Costs and revenue are recognised on an accruals basis and in accordance with the matching principle, except for extraordinary revenue, which is recognised on a cash basis. In particular, costs and revenue resulting from ordinary operations are divided into two distinct sections based on the type of members to whom they refer: employees and retirees/survivors.

Assets

Receivables

Receivables are recognised at their expected realisable value

Trade receivables reflect sums due from companies for their employees and family members or retirees/ survivors in relation to enrolled retirees/family members.

Sundry receivables include sums due from third parties for charges incurred on their behalf and suspense account items.

Cash and cash equivalents are recognised at their nominal value and consist of bank deposits and cash and other valuables on hand.

Accrued income and prepaid expenses

These are calculated on an accruals basis and are treated in accordance with the matching principle.

Liabilities and net assets

Reserve fund

This item reflects the cumulative surpluses generated over the years until 31 December 2022.

Provisions for prevention campaigns regard provisions solely for use in funding health and/or prevention campaigns carried out over the years.

Provisions for risks and charges are established for any needs arising from disputed claims, lawsuits and for charges of a definite nature, which are certain or probable, connected with obligations already undertaken at the balance sheet date, but which will materialise in future years.

Provisions for Requests for exceptional contributions are set up to manage extraordinary contribution applications.

Liabilities relating to self-insured dental cover reflect sums set aside in technical reserves and direct and indirect payables due to members covered by the self-insured dental plan.

Payables

Payables are recognised at their nominal value.

Trade payables reflect sums owed to companies for their employees and family members or retirees/survivors in relation to enrolled retirees themselves and any registered family members; amounts owed to insurance companies on account of the insurance premiums to be paid; amounts owed to claims management companies and the contracted network, for invoices that have been received but not yet paid, as well as other liabilities of a definite nature and certain existence, representing obligations to pay fixed amounts.

This item consists of: payables due to members, entities, suppliers for invoices to be received or still unpaid in connection with services rendered in the year, as well as sums available to third parties or suspense account items.

Tax payables include sums due to the tax authorities.

Accrued expenses and deferred income

These are calculated on an accruals basis and are treated in accordance with the matching principle.

Costs

Benefit expenses include premiums due to insurance companies, costs incurred for uses related to self-insured benefits and operating costs, including provisions to the technical reserves necessary to manage the risks associated with self-insured cover. In addition, they include provisions for prevention campaigns, for litigation, for Requests for exceptional contributions, for the other initiatives approved by the Board of Directors and for direct reimbursements to members.

Financial expenses relate bank charges and fees.

Sundry expenses reflect the costs incurred on behalf of third parties and subsequently reimbursed on the basis of existing arrangements, contingent losses relating to previous years and donations to charities or research projects.

Administration expenses reflect costs incurred for special events, advice and opinions requested from external experts, as well as any other expenditure approved by the Board of Directors.

Revenue

Member contributions refer to regular contributions and any special contributions received during the year.

Financial income relates to interest income net of any tax withholdings.

Other income includes any income of a nature other than the above, such as releases from provisions and recoveries of costs incurred on behalf of third parties on the basis of existing arrangements, as well as excess provisions made.

Note

In the Employee/Retiree sections, costs and revenue that could not be attributed directly have been allocated in proportion to the contributions received, in order to calculate the related percentage share of the surplus/deficit for the year.

Notes to the Statement of Financial Position and the Income Statement

Assets

Assets	31.12.2025	31.12.2024	Change
Trade receivables	**1,735,520**	**68,405**	**1,667,115**
from Unicredit Group companies (for enrolled employees)	66,663	64,586	2,077
from contracted companies (for enrolled employees)	-	873	-873
from Retirees	-	2,946	-2,946
from Insurance company	1,668,857	-	1,668,857

This item comprises receivables from UniCredit Group companies (**€66,663**) relating to contributions and expense reimbursements that are entirely attributable to the 2025 financial year and which had been received or were in the process of being received at the start of 2026. The receivables from the insurance company (**€1,668,857**) refer entirely to the profit-sharing clause provided for in the appendix to the insurance policy concerning the check-up campaign, communicated by the insurance company, which were collected in January 2026.

Assets	31.12.2025	31.12.2024	Change
Cash and cash equivalents	**62,717,476**	**63,475,612**	**-758,136**
Cash and other valuables	30	26	4
Bank deposits	62,717,446	63,475,586	-758,140

Cash and other valuables include cash and revenue stamps on hand for immediate use. **Bank deposits** reflects the balance of current accounts held with UniCredit SpA. Financial statements.

Liabilities and net assets

Liabilities and net assets	31.12.2025	31.12.2024	Change
Reserve funds	**45,857,231**	**45,780,325**	**76,906**
Surplus/deficit for the year	76,906	17,520	59,386
Surplus/deficit from previous years	45,771,228	45,753,708	17,520
Residual assets of the former Bipop Carire health fund	9,097	9,097	-

The reserve fund amounts to **€45,857,231** including:

> the surplus for the year of €76,906;

> surpluses from previous years, totalling €45,771,228;

> the residual net assets transferred to the Association following the winding up of the former Bipop Health plan (FAP), amounting to €9,097.

Movements in the reserve fund for the year	Surplus/deficit for the year	Surplus/deficit from previous years	Residual assets of the former Bipop Carire health fund	Total reserve funds
Start of FY 2025	-	45,771,228	9,097	**45,780,325**
Accruals to provisions	-	-	-	-
Uses/transfers of provisions	-	-	-	-
Surplus for the year	76,906	-	-	**76,906**
Balance as at 31/12/2025	**76,906**	**45,771,228**	**9,097**	**45,857,231**

Liabilities and net assets	31.12.2025	31.12.2024	Change
Provisions for health campaigns	**6,611,124**	**9,846,979**	**-3,235,855**

Provisions for prevention campaigns reflect specific provisions made over the years.

The decrease in the provision refers to the use related to the 2024/25 check-up campaign.

Liabilities and net assets	31.12.2025	31.12.2024	Change
Provisions for risks and charges	**8,400**	**8,400**	**-**
Provisions for lawsuits	8,400	8,400	-

The legal dispute fund relates to prudential provisions relating to an ongoing dispute, already resolved favourably at first instance, against which the appellant has appealed.

Liabilities and net assets	31.12.2025	31.12.2024	Change
Provisions for 'Requests for exceptional contributions'	**61,800**	**63,100**	**-1,300**
Provisions for 'Requests for exceptional contributions'	61,800	63,100	-1,300

Provisions for 'Requests for exceptional contributions' concern funds set aside to address members' healthcare requirements not covered by the insurance policies entered into.

Movements in other provisions during the year	Provisions for health campaigns	Provisions for lawsuits	Provisions for 'Requests for exceptional contributions'	Technical provisions for self-insurance	Total other provisions
Start of FY 2025	9,846,979	8,400	63,100	4,000,000	**13,918,479**
Accruals to provisions	5,300,000	-	6,900	3,600,000	**8,906,900**
Uses/transfers of provisions	-8,535,854	-	-8,200	-	**-8,544,054**
Surplus provisions	-	-	-	-	**-**
Surplus for the year	-	-	-	-	**-**
Balance as at 31/12/2025	**6,611,124**	**8,400**	**61,800**	**7,600,000**	**14,281,324**

In accordance with applicable accounting standards, the allocation of costs relating to provisions for prevention campaigns cannot be directly attributable to employees or retirees and therefore, an allocation was made in proportion to the premiums paid. A one-off extraordinary provision of €3,600,000 has been allocated to the technical reserves for self-insurance relating to dental cover, and has been charged exclusively to the employees' section.

Liabilities and net assets	31.12.2025	31.12.2024	Change
'Liabilities arising from self-insured dental plans'	**11,270,210**	**7,654,175**	**3,616,035**
Technical provisions for self-insurance	7,600,000	4,000,000	3,600,000
Payables to members for dental coverage	3,670,210	3,654,175	16,035

Liabilities arising from the self-insured dental plan relate to cover whose risk is borne by the Association. They consist of:

> the technical reserve for the potential risk, totalling €7,600,000;

> sums due to healthcare/medical providers (i.e., where services are paid for directly by the Association) and members (i.e. in the form of claims for reimbursement), totalling €3,670,210.

Liabilities and net assets	31.12.2025	31.12.2024	Change
Trade payables	**317,854**	**150,852**	**167,002**
Payables to Unicredit Group companies	-	2,400	-2,400
Insurance premiums	317,854	148,452	169,402

The debt to the Companies of **€317,854** refers to the balance of insurance premiums for the year still to be paid.

Liabilities and net assets	31.12.2025	31.12.2024	Change
Sundry payables	**38,377**	**40,186**	**-1,809**
Suppliers for services received	38,377	40,186	-1,809

Sundry payables consist of payables to suppliers, including professionals to whom external consultancy services were entrusted, for services received and not yet invoiced in the amount of **€38,377**.

Liabilities and net assets	31.12.2025	31.12.2024	Change
Tax payables	**-**	**-**	**-**

This item represents the withholding tax to be paid in January of the following year and refers to invoices paid in December to professionals for services rendered. In 2025, there are no withholdings to be paid in the following year.

Liabilities and net assets	31.12.2025	31.12.2024	Change
Accrued expenses and deferred income	**288,000**	**-**	**288,000**
Deferred income	288,000	-	288,000

Deferred income refers entirely to the cost of the telemedicine service pertaining to the future financial year.

The income statement is divided into two distinct sections according to the type of member to whom the costs and revenue refer, with the exception of the costs incurred on behalf of third parties and the related recoveries, the related information is provided by item, with the subsequent presentation of the overall data followed by figures for the two sections.

Costs

Costs relating to welfare activities

These are the expenses incurred in connection with the Association's core activities, amounting to **€83,671,574** (€63,400,165 for employees and €19,983,409 for retirees) and are broken down as follows:

Costs	2025	2024	Change
Benefit expenses	**83,383,574**	**85,210,103**	**-1,826,529**
Insurance premiums	66,310,980	65,428,720	882,260
Self-insurance costs	11,283,049	11,202,304	80,745
Accruals to technical provisions for self-insurance	-	1,000,000	-1,000,000
Claims management costs	410,645	505,722	-95,077
Provisions for health campaigns	5,300,000	7,070,000	-1,770,000
Provisions for 'Requests for exceptional contributions'	6,900	2,800	4,100
Costs for Telemedicine service	72,000	-	72,000
Sundry expenses	-	557	-557

Employee section

Costs	2025	2024	Change
Benefit expenses	**63,400,165**	**66,797,300**	**-3,397,135**
Insurance premiums	47,807,638	48,873,481	-1,065,843
Self-insurance costs	11,283,049	11,202,304	80,745
Accruals to technical provisions for self-insurance	-	1,000,000	-1,000,000
Claims management costs	390,508	458,814	-68,306
Provisions for health campaigns	3,841,970	5,260,787	-1,418,817
Provisions for 'Requests for exceptional contributions'	5,000	1,500	3,500
Costs for Telemedicine service	72,000	-	72,000
Sundry expenses	-	414	-414

Retiree section

Costs	2025	2024	Change
Benefit expenses	**19,983,409**	**18,412,803**	**1,570,606**
Insurance premiums	18,503,342	16,555,239	1,948,103
Self-insurance costs	-	-	-
Accruals to technical provisions for self-insurance	-	-	-
Claims management costs	20,137	46,908	-26,771
Provisions for health campaigns	1,458,030	1,809,213	-351,183
Provisions for 'Requests for exceptional contributions'	1,900	1,300	600
Costs for Telemedicine service	-	-	-
Sundry expenses	-	143	-143

The item **Insurance premiums** amounts to a total of **€66,310,980** (employees €47,807,638, retirees €18,503,342) and includes premiums for the year relating to health insurance policies taken out with the insurance company.

Self-insurance costs amounts to **€11,283,049** (attributed to employees in full) and relates to the use of dental coverage in 2025 managed entirely through self-insurance.

Claims management costs of **€410,645** (employees €390,508, retirees €20,137) show the costs incurred for claims management activities carried out by the relevant providers.

The item **Provision for Health Campaigns**, totalling **€5,300,000** (attributed to employees in the amount of €3,841,970 and to retirees in the amount of €1,458,030) represents the expected charge for the new check-up campaign.

The item **Provision for 'Requests for exceptional contributions'**, for a total of **€6,900** (€5,000 employees and €1,900 retirees) includes the provision charged to the financial year relating to reimbursements to beneficiaries, resolved by the Board of Directors on the basis of the policy of the same name.

In 2025, no direct reimbursements of claims falling under the Director's autonomy or decided by the Board of Directors were accounted for.

No miscellaneous expenses were incurred during the financial year; in the previous year, these related to fees paid for medical consultations.

Costs	2025	2024	Change
Financial expenses	**367**	**513**	**-146**
Bank fees and charges	367	513	-146

Financial expenses (employees €266, retirees €101) consist of bank charges and fees relating to current accounts.

Costs	2025	2024	Change
Sundry expenses	**6,193**	**9,433**	**-3,240**
Contingent liabilities	6,193	9,433	-3,240

Among the **sundry expenses,** contingent liabilities of **€6,193** were recorded regarding unforeseen extraordinary items relating to the failure to collect contributions from retirees.

Costs	2025	2024	Change
Administrative costs	**93,494**	**132,062**	**-38,568**
Professional fees	50,999	80,840	-29,841
Miscellaneous	42,495	51,222	-8,727

These amount to **€93,494** and reflect the cost of legal opinions, tax and technical advice requested from external professionals, totalling €50,999 (employees €36,969, retirees €14,030) and sundry administrative costs amounting to €42,495 (employees €30,805, retirees €11,690).

It should be noted that the above administrative costs are the only ones borne by Uni.C.A., as all other administrative costs are borne directly by the UniCredit Group, as established in the Articles of Association.

Revenue

Contributions for healthcare activities

These represent contributions relating to the 2025 financial year and amount to **€81,772,651** (employees €62,538,644, retirees €19,162,007 and contributions for Telemedicine €72,000).

Revenue	2025	2024	Change
Member contributions	**81,772,651**	**82,712,394**	**-939,743**
From employers	50,705,359	52,442,833	-1,737,474
From members	30,995,292	30,269,561	725,731
Contributions for Telemedicine	72,000	-	72,000

Contributions in the employee section concern payments made by companies in favour of their employees (€50,705,359) and by employees (€11,833,285) who have added family members who are not legal dependents, paying the agreed sum directly.

This includes €8,852,700 of contributions paid for self-insurance dental coverage (€3,312,900 to be paid by the company and €5,639,800 to be paid by the members).

Contributions received for employees are also divided into ordinary contributions received from: UniCredit Group companies (€47,154,105) and affiliated companies (€338,354).

Contributions of €19,162,007 in the retiree section are paid only by the retirees themselves.

Revenue	2025	2024	Change
Financial income	**1,781,710**	**2,614,362**	**-832,652**
Interest income	1,781,710	2,614,362	-832,652

This item relates to interest accrued during the year on current accounts held with UniCredit SpA. It is shown net of 26% withholding tax and is divided between employees (€1,291,561) and retirees (€490,148). There was also a benefit in 2025 from favourable interest rate developments.

Revenue	2025	2024	Change
Other income	**6,174**	**42,875**	**-36,701**
Penalties and expense recoveries	5,713	5,558	155
Recovery of sundry expenses and contingent assets	461	37,317	-36,856

Other income includes:

> penalties and expense recoveries of €5,713 resulting from the regularisation of the registrations of some retired members;

> windfall income of €461 (€334 employees and €127 retirees) attributable to the adjustment of accounting items.

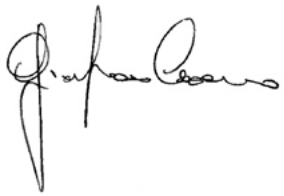
Other information

As at 31 December 2025, the Association had no employees but availed itself of the services provided by UniCredit Group employees, whose cost is allocated to the participating companies.

Members of the Board of Directors and the Board of Auditors do not receive any compensation.

Milan, 1 April 2026

The Chairman
Gianfranco Cascino



Board of Auditors' report

BOARD OF AUDITORS' REPORT

Dear Members of Uni.C.A. UniCredit Cassa di Assistenza per il Personale del Gruppo UniCredito Italiano:

Introduction

In the year ended 31 December 2025, the Board of Auditors carried out both the functions provided for in article 2403 et seq. of the Italian Civil Code and those provided for in article 2409-*bis* of the Italian Civil Code, as well as those provided for in the Association's Articles of Association.

This report contains:

> section A), with the 'Report of the independent auditor pursuant to article 14 of Legislative Decree 39 of 27 January 2010; and

> section B), with the 'Report pursuant to article 2429, paragraph 2 of the Italian Civil Code'.

A Report of the independent auditor pursuant article 14 of Legislative Decree 39 of 27 January 2010

Auditor's opinion on the financial statements

Opinion

We have audited the financial statements of Uni.C.A.- Cassa di Assistenza per il Personale del Gruppo UniCredito Italiano, consisting of the statement of financial position, the income statement and the notes, accompanied by the Board of Directors' report and the report on operations as at and for the year ended 31 December 2025.

In our opinion, the financial statements give a true and fair view of the financial position of the Association and of the results of its operations for the year ended 31 December 2025, in accordance with Italian law governing the preparation of financial statements.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (ISA) Italy, insofar as they are applicable to the audited entity. Our responsibilities under those standards are further described in the '*Auditor's Responsibilities for the Audit of the Financial Statements*' section of this report. We are independent of the Association in accordance with ethical and independence rules and principles applicable to the audit of financial statements under Italian law.

We believe that we have obtained sufficient appropriate audit evidence on which to base our opinion.

Responsibilities of the Directors and the Board of Auditors for the financial statements

The Directors are responsible for the preparation of the financial statements that give a true and fair view in accordance with Italian law and, within the terms provided by law, for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

The Directors are responsible for assessing the Association's ability to continue as a going concern and, when preparing the financial statements, for the appropriateness of the going concern assumption, and for appropriate disclosure thereof. The Board of Auditors is responsible, within the terms provided by law, for overseeing the Association's financial reporting process.

Auditor's responsibility for the audit of financial statements

Our task is to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with International Standards on Auditing (ISA Italia) will always detect a material misstatement when it exists. As part of an audit, carried out – to the extent applicable to the audited entity – in accordance with International Standards on Auditing (ISA Italia), we have exercised professional judgment and maintained professional scepticism throughout the audit.

Furthermore:

> we have identified and assessed the risks of material misstatement in the financial statements, whether due to fraud or error; as well as designed and performed audit procedures responsive to those risks;

> we have obtained sufficient appropriate audit evidence on which to base our opinion;

> we have gained an understanding of internal control relevant to the audit for the purpose of designing audit procedures that are appropriate in the circumstances and not for the purpose of expressing an opinion on the effectiveness of the Association's internal control;

> we have assessed the appropriateness of the accounting policies used and the reasonableness of accounting estimates and the related disclosures made by the Directors;

> we have reached a conclusion of the appropriateness of the directors' use of the going concern assumption: our conclusions are based on the audit evidence obtained up to the date of this report;

> we have evaluated the overall presentation, form and content of the financial statements, including disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves a fair representation;

> we have communicated with those charged with governance, identified at an appropriate level as required by ISA Italia, regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant shortcomings in internal controls identified during our audit.

Report on compliance with other legal and regulatory requirements

Opinion on the consistency of the Report on Operations with the Financial Statements: Article 14, paragraph 2(e), (e-bis) and (e-ter) of Legislative Decree 39/2010

The Directors of Uni.C.A. – UniCredit Cassa di Assistenza per il personale del Gruppo UniCredito Italiano - are responsible for the preparation of the Association's report on operations for the year ended 31 December 2025, including its consistency with the related financial statements and compliance with the applicable laws and regulations.

We have performed, insofar as applicable to the audited entity, the procedures required under audit standard SA Italia 720B, in order to express an opinion on the consistency of the report on operations with the Association's financial statements as at and for the year ended 31 December 2025 and its compliance with the applicable laws and regulations.

In our opinion, the report on operations is consistent with the Association's financial statements as at and for the year ended 31 December 2025 and complies with the applicable laws and regulations. With reference to the statement required by art. 14, paragraph 2(e-ter) of Legislative Decree 39/2010, based on our knowledge and understanding of the entity and its environment obtained through our audit, we have no matters to report.

B Report on oversight activities pursuant to article 2429, paragraph 2 of the Italian Civil Code

During the financial year ended 31 December 2025, we carried out our activities in accordance with the related statutory requirements and the rules of conduct for boards of auditors issued by the Governing Body of the Italian Accounting Profession.

B1. Oversight activities pursuant to article 2403 et seq. of the Italian Civil Code

We monitored compliance with the law and the Articles of Association and with best administrative practices. We attended the meetings of the Board of Directors and, on the basis of the information available, we did not identify any breaches of the law or the Articles of Association in relation to these meetings, or any transactions that were manifestly imprudent, risky, in potential conflict of interest or such as to compromise the integrity of the Association's assets.

During the meetings of the Board of Auditors and the Board of Directors, we obtained information on the general performance of operations and their foreseeable development, as well as on transactions of particular significance, due to their size or nature, carried out by the Association. Based on the information obtained, we have no specific observations to report. We have familiarised ourselves with and monitored, to the best of our ability, the functioning of the Association's organisational structure, including through the collection of information from the Management and the Board of Directors. In particular, as already reiterated in the Board of Auditors' report on the 2024 financial statements, as well as at the Board of Directors' meeting of 18 December 2025, the Board of Auditors highlighted to Management and the Board of Directors the persistence of weaknesses in the organisational structure. Aware of the important and pivotal role played by the Association within the UniCredit Group in the field of welfare, and in view of the specific and unique nature of the activities carried out, it is necessary to establish a more appropriate organisational structure that takes account of staff turnover, to have a suitable size in numerical terms, whilst maintaining the same level of professionalism in order to pursue its objectives. The Board has, on several occasions, expressed a favourable view of the professional calibre of the staff assigned to the Association. Therefore, in the Board's view, an adjustment to the accounting staff is now urgent, given that the Association's normal accounting activities must be guaranteed in any case. It also remains necessary and can no longer be postponed to adopt an accounting system appropriate to the size and complexity of the Association, so as to ensure orderly operations in compliance with regulations.

In this context, the adoption of an administrative and accounting system that better reflects the Association's actual circumstances is also appropriate in view of the requirements set by the Ministry of Health for more detailed and in-depth reporting to comply with the provisions of the Sacconi Decree. In this regard, it should be noted that this provision is already included in the Accounting Regulations, approved by the Board of Directors in 2022 in compliance with the provisions of Article 19 of the Articles of Association, and that the issue was highlighted in the previous report.

The Board of Auditors has verified compliance with the provisions of the 2009 Sacconi Ministerial Decree: the percentage of resources allocated to healthcare services restricted under the terms of that decree, in relation to the total amount of resources committed to covering all services guaranteed to members, is 27.53%, well above the 20% limit set by the decree itself. This will continue to guarantee members the tax deductibility of contributions paid for healthcare.

In 2025, the Association continued its participation in the pilot group of health funds and schemes for work relating to the 'Health Benefits Dashboard'.

No breaches of the Organisational Model were found, nor were any reports received from the recipients of the Model itself and/or from third parties.

During the financial year, no opinions required by law were issued by the Board of Auditors.

No complaints were received from members pursuant to Article 2408 of the Italian Civil Code.

No complaints were filed with the Court pursuant to Article 2409 of the Italian Civil Code.

During the supervisory activities described above, no other significant events emerged that would require mention in this report.

B2. Opinion on the financial statements

To the best of our knowledge, the Directors, in preparing the financial statements, have not departed from the provisions of article 2423, paragraph 5 of the Italian Civil Code.

The results of our audit of the financial statements are contained in Section A) of this report.

The table below provides financial highlights:

Operations management	2025	2024	Change
Assets	64,452,996	63,544,017	908,979
Reserve funds	(45,857,231)	(45,780,325)	(76,906)
Member contributions	81,772,651	82,712,394	(939,743)
Benefit expenses	(83,383,574)	(85,210,103)	(1,826,529)
Surplus for the year	76,906	17,520	59,386

Events in 2025 are described in full in the 'Report on operations', confirming the positive assessment of the Association's operating activities.

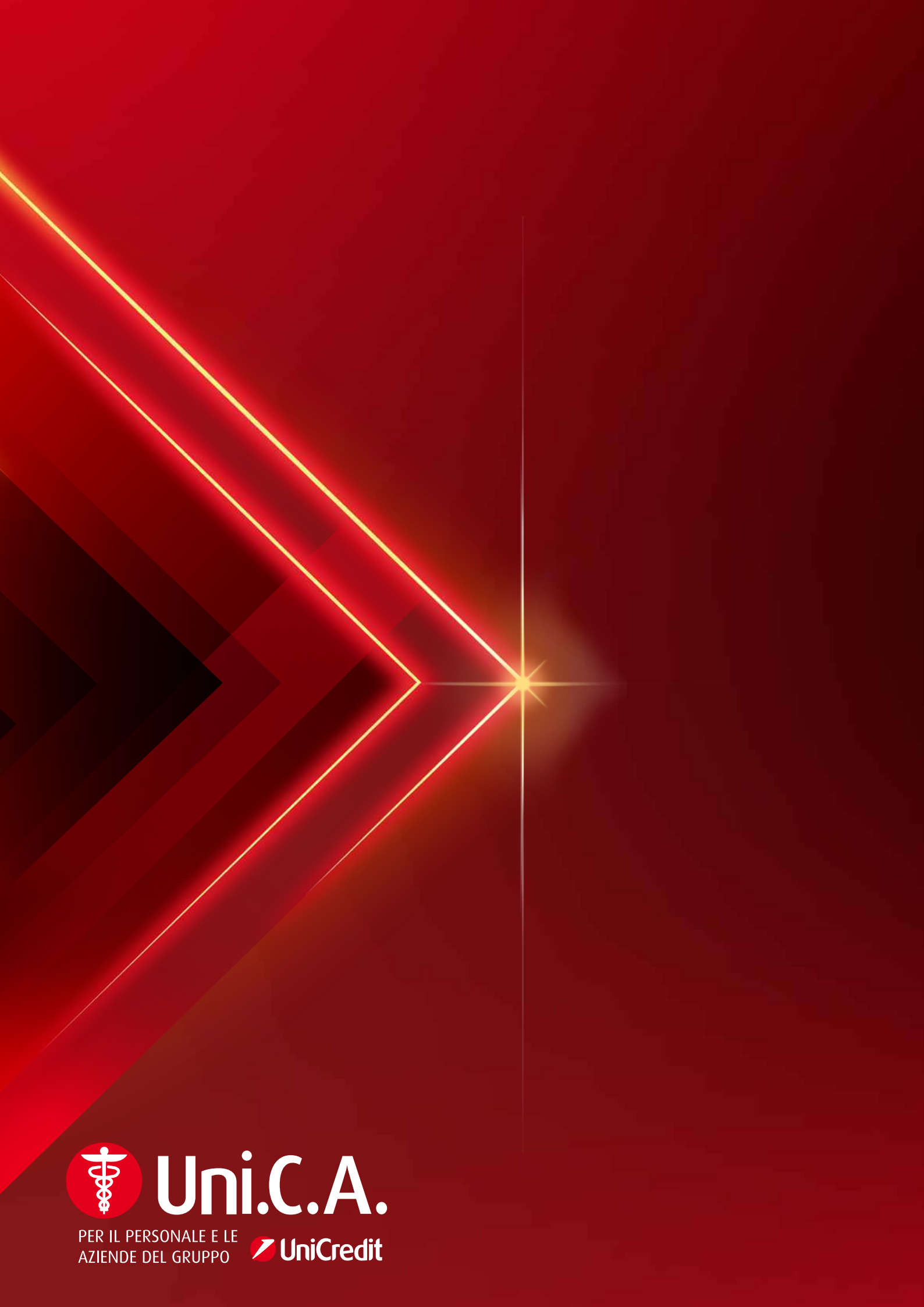
B3. Opinion and proposals regarding approval of the financial statements

Considering the results of our work, we see no reason to prevent Members from approving the Financial Statements for the year ended 31 December 2025 and the proposed appropriation of profit, as prepared by the Board of Directors.

On behalf of the Board of Auditors:

Claudio Aloisi - Chairman of the Board

Milan, 10 April 2026


Uni.C.A.
PER IL PERSONALE E LE
AZIENDE DEL GRUPPO
UniCredit