Uni.C.A.

Direct Assistance and Reimbursement / Indirect Form

Previmedical®
Servizi per la Sanità Integrativa

Uni.C.A.

Previmedical
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1 INTRODUCTION

UNI.CA is a non-profit association that aims at guaranteeing policyholders with a supplementary health care treatments on top of the National Health Service.

UNI.CA provides policyholders with **two types of health care treatments:**

a) direct health care:

policyholders can access health services provided by the medical facilities belonging to the UNI.CA. Health Network through Previmedical SpA, a specialized Company managing the Network, with direct payment to the affiliated structures for the amount due for the service received by the Insured, ***who therefore must not pay in advance any sum except for any due deductibles and / or overdraft;***

b) reimbursement / indirect health care:

policyholders are entitled to reimbursement of expenses incurred for services received from health facilities of their own choice and not included in the health network made available by the Fund (exception made for accessing the network without having previously contacted the Operations Center), within the limits established by your Health Plan.

Indirectly, the Patient must anticipate the sum to which deductibles apply depending on the plan.

Special cases:

- **Convalescence and stay homes, health co lonies and nursing homes with dietary and aesthetic or deputy purposes long-term care (RSA)**: services provided by these structures are not included, as they are not considered "health institutes"; the same applies to gyms, gymnastic-sports clubs, beauty studios, health hotels, medical hotel, wellness centers even if with an adjoining medical center.
- **Physiotherapy and rehabilitation treatments** i.e. the services of physical medicine and rehabilitation to recover the functions of one or more organs or systems affected by illness or accident indemnifiable under the policy. It is necessary to rely on doctors or professionals with a degree in physiotherapy or similar title recognized in Italy. These services must be carried out exclusively at Medical Centers managed by a Health Director.
- **Hospitalization services abroad**, direct or indirect (except, of course, for services resulting from an accident or disease that began abroad);it is recommended to communicate in advance, with adequate notice, the intention, specifying the characteristics of the planned surgery and, briefly, the reasons of the choice. This preliminary contact may also simplify the subsequent liquidation procedure of the reimbursement request.

Previmedical will be able to:

- verify the possibility to review prices proposed to the Insured by the foreign health facility;
- check the possibility of having a direct or indirect agreement with the foreign medical facility;
- propose the Insured any alternatives, from an health point of view, at a lower cost or more logistically convenient

WHERE TO RECEIVE INFORMATION

All Health Plan information are available and constantly updated on the website

- **www.unica.previmedical.it**

After authentication, one's personal area gives access to:
- the list of affiliated facilities, doctors and services;
- service pre-authorization functionality, to be performed as described in chapters below

Refunds requests

- **GROUP INTRANET UNICREDIT** the personal area is accessible through the portal Welfare> Health section
- **EASYUNICA APP** access the same functionalities; login credentials are the same already used to access the website (not the same used to access via Group Intranet UniCredit)
- **"FOLLOW YOUR DOSSIER"**, a service that guarantees "free" and prompt updates on the status of the reimbursement request, via SMS to your mobile.

For additional details on the service, please refer to next page 16 "FOLLOW YOUR DOSSIER®"

Policyholders have the opportunity, when interested in a Facility which is not yet part of the Network, **to report such Facility for the Network** to evaluate the possibility of cooperation; to this end, Previmedical needs to receive the suggestion via email to:
ufficio.convenzioni@previmedical.it

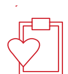
2 DIRECT ASSISTANCE SCHEME

DIRECT ASSISTANCE
Direct assistance services must first be authorized. Authorization is obtained contacting Previmedical S.p.A's Operations Center , in 3 different ways, given the urge of the request:

APP EasyUnica (fast)

Portale web (fast)

Contact number (possible slowdowns)



HOSPITALIZATION AND SURGERY

Before hospitalization / surgery

AUTHORIZATION

Before being hospitalized or undergoing surgery, the Patient must contact the Operations Center, in order to receive the authorization to direct assistance. Since the agreement with the health facilities may change over time, the mediation of Previmedical S.p.A.'s Operations Center, as main responsible to authorize direct assistance, is mandatory.

ONLINE PRE-AUTHORIZATION

If the Insured has **access to the internet**, he can carry out the online pre-authorization request filling-in some predefined fields:

HOW:
- access the personal area from the website www.unica.previmedical.it - INSURED AREA, under section "Request direct assistance authorization";
- select the name of the Insured who's requesting the service;
- access a form to search the facility where the service will be delivered.

The Insured must indicate:
- the type of healthcare facility (outpatient dept., clinic, dentist, laboratory, etc.);
- the regional area in which the facility is located

The Insured can also include some additional information on the Facility such as:
- the name
- municipality and postcode

DOCUMENTATION

The Insured must attach:
- prescription or medical certificate with reference to the service;
- diagnosis;
- the First Aid P.S. report, in case of an accident, as this requires objective documentation.

Once attached, the Insured, presses the confirmation button to send out the pre-authorization request to the Operations Center.

TIMING

With a minimum advance of 2 working days (48 h), the Operations Center guarantees the response (authorization / denial) on the direct assistance request:

- **if the request is received at least 7 working days prior to the event**, the Operations Center guarantees the response within 2 working days ;

- **if the request is received between 6 and 4 working days prior to the date of the event**, the Operations Center guarantees the response by 2 working days prior to the date of the event;

- **if the request is received between 3 and 2 working days prior to the date of the event,** the Operations Center guarantees the

response by 1 working day prior to the date of the event

If the request is **raised with short notice (less than of 2 working days – 48h)** this may result, when pre-authorization is denied, in a last-minute communication by the Operations Center.

It should anyway be noted that **in the kick-off phase of the Health Plans,** it may not be possible to comply with the above-mentioned service levels until **the process personal data acquisition is complete**. For this reason, all Patients who want to benefit from a DIRECT assistance service should to contact the Operations Center with due advance.

CHECK AND CONFIRM

The Insured will receive the result (authorization/ denial of hospitalization/surgery) of the insurance-technical analysis carried out by the Operations Center **through SMS or e-mail as indicated in the first contact phase**. The result is also accessible from the RESERVED AREA.

The Operations Center, after the successful medical-insurance analysis, **authorizes the Affiliated Facility to provide the service** to the Insured under direct assistance, with consequent payment by Previmedical, giving evidence of any expenses not covered by the health plan.
On the day of the appointment, the Insured must **provide evidence of the authorization received from the Operations Center or the authorization code received via SMS or e-mail.**

PRE-AUTHORIZATION VIA PHONE (possible waiting time)

The Insured can receive a pre-authorization by reaching out to these dedicated numbers:

- **800.90.12.23 from land line and mobile phones (toll free number)**
- **0039 0422.17.44.023 from abroad**

The Operations Center is available 24hours, 365 days a year.

DOCUMENTATION

The Insured must **provide the Operations Center** the following details:

- Name and surname of the requester of the service
- Name of the chosen Facility
- Type of service (exam/visit/..)
- Diagnosis
- Date of the appointment
- Preferred channel to receive the authorization code (SMS or e-mail).

The Insured should send through fax to the Operations Center using number 0422.17.44.523 or, by replying to the email sent by the Operations Center:

- prescription or medical certificate with reference to the service
- diagnosis;
- the First Aid P.S. report, in case of an accident, as this requires objective documentation.

TIMING

With a minimum advance of 2 working days (48 h), the Operations Center guarantees the response (authorization / denial) on the direct assistance request:

- **if the request is received at least 7 working days** prior to the event, the Operations Center guarantees the response within 2 working days;

- **if the request is received between 6 and 4 working days** prior to the date of the event, the Operations Center guarantees the response by 2 working days prior to the date of the event;

- **if the request is received between 3 and 2 working days** prior to the date of the event, the Operations Center guarantees the response by 1 working day prior to the date of the event;

If the request is raised with short notice **(less than of 2 working days – 48h)** this may result, when pre-authorization is denied, in a last-minute communication by the Operations Center.

It should anyway be noted **that in the kick-off phase of the Health Plans**, it may not be possible to comply with the above-mentioned service levels until the process personal data acquisition is complete. For this reason, all Patients who want to benefit from a DIRECT assitance service should to contact the Operations Center with due advance.

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The Operations Center, after the successful medical-insurance analysis, **authorizes the Affiliated Facility to provide the service to the Insured under direct assistance**, with consequent payment by Previmedical, giving evidence of any expenses not covered by the health plan.

On the day of the appointment, the Insured must **provide evidence of the authorization received from the Operations Center or the authorization code received via SMS or e-mail.**

URGENT PROCESS PRE-AUTHORIZATION

The urgency procedure, which allows you to benefit from the network services even without respecting the 48-hour notice period, is only **limited to pathologies/diseases in the acute phase and in the cases of physical injuries** due to accidental, violent and external causes.

The emergency procedure cannot be activated in relation to health services provided abroad, for which the Insured will in any case be required to previously receive the authorization from the Operations Center.

DOCUMENTATION

To activate the emergency procedure, **call the Operations Center** 800.90.12.23 - 0039/0422.17.44.023 (from abroad);
the Operations Center will **forward the dedicated form to be filled-in by the healthcare facility providing the service.**

The completed form must be sent to the Operations Center through fax (0422.17.44.523) or in response to the email sent by the same Operations Center, attaching:

- medical prescription containing the diagnosis and the type of pathology for which the service is requested, clearly certifying the state of urgency such as to make the requested healthcare service essential, in order to obtain an authorization in derogation to the standard procedure;

- in the event of an accident, the First Aid P.S. report logged within 24 hours after the event, as it must be documented.

In case of impossibility to get in touch with the Operations Center, the Insured can request authorization within 5 days after the beginning date of hospitalization and in any case before the discharge from the Affiliated Facility. At the same time, the Insured must send the above-mentioned documentation to the Operations Center.
It is understood that **the final evaluation about the existence of the urgency, with respect to the individual case, will be subject to the evaluation of the Operations Center.** The activation of the urgency procedure remains subject to the outcome of this assessment.

TIMING

The Operations Center is committed to manage urgent requests received within 24 working hours of notice; the Operations Center also undertakes to manage urgent requests that are received with less than 24 hours notice, without in this case being able to guarantee the successful authorization.

AFTER HOSPITALIZATION / SURGERY

After the service has been performed, **the Insured must countersign the invoice issued by the Affiliated Facility,** which reports any due amount (for any overdrafts, deductibles, services not covered by the relevant Health Plan), also any expenses that are not strictly related to hospitalization, such as telephone, television, bar, medical records, administrative rights, etc.
Previmedical will pay the expenses within the established terms upon reception of the invoice by the Health Facility of and of the required medical documentation (medical prescription, diagnosis and / or diagnostic question, medical record containing also the next medical history and remote). The Insured will receive appropriate documentation as proof of the successful settlement.

SPECIAL CASES:

- **ASSESSMENTS / PHYSICAL THERAPIES**

Expenses for **hospitalizations and / or Day Hospital treatments, not linked and made necessary by illness or accident**, during which only physical examinations or therapies are carried out will be recognized as reimbursement / indirect assistance within the terms and limits provided for by the extra-hospital guarantees.
These services indeed, due to their technical nature and with reference to the clinical situation, can also be carried out in a medical clinic without any risk or particular inconvenience for the patient.

- **HEALTH SERVICES UNDER NATIONAL HEALTH SERVICE (SSN)**

If the **Insured decides, in case of hospitalization in which, to benefit from structures of the National Health Service (SSN) or private structures accredited by the SSN and all hospitalization expenses were incurred by the SSN, a daily indemnity will be paid for each day of hospitalization** (permanence in the emergency room P.S. is excluded), within the terms of the Health Plan.

To gain the reimbursement, the Patient must follow the procedure described in chapter 3 “HEALTH SERVICES UNDER REIMBURSEMENT/ INDIRECT”.

- **FAILURE TO ACTIVATE THE OPERATIONAL CENTER**

If the Insured **accesses an affiliated Health Facility, without complying with the obligations of pre-authorization request** from the Operations Center, **the service will be considered as provided in reimbursement / indirect form.** The Insured will be requested to pay in advance and may be reimbursed, if within the terms and limits of the Health Plan.

2.2 SPECIALIST VISITS, DIAGNOSTIC TESTS AND OUTPATIENT TREATMENTS

BEFORE RECEIVING THE SERVICE

AUTHORIZATION

Before receiving the service, the Insured must contact the Operations Center to receive authorization to perform the service in direct form.
Since the agreement with the health facilities may change over time, the mediation of Previmedical S.p.A.'s Operations Center, as main responsible to authorize direct assistance, is mandatory.

ONLINE PRE-AUTHORIZATION

If the Insured has access to the internet, he can carry out the online pre-authorization request filling-in some predefined fields:

HOW:

- access the reserved from the website www.unica.previmedical.it - INSURED AREA, under section "Request direct assistance authorization";
- select the name of the Insured who's requesting the service;
- access a form to search the facility where the service will be delivered.

The Insured must indicate:

- the type of healthcare facility (outpatient dept., clinic, dentist, laboratory, etc.);
- the regional area in which the facility is located

The Insured can also include some additional information on the Facility such as:

- the name
- municipality and postcode

Once the search is completed, the patient will be able **to view the list of the network Facilities** for the selected type with the possibility to select one.

DOCUMENTATION

The Insured **must attach**:

- prescription or medical certificate with reference to the service;
- diagnosis;
- the First Aid P.S. report, in case of an accident, as this requires objective documentation.

Once attached, the Insured, presses the **confirmation button** to send out the **pre-authorization** request to the Operations Center.

TIMING

With a minimum advance of 2 working days (48 h), the Operations Center guarantees the response (authorization / denial) on the direct assistance request:

- **if the request is received at least 4 working days** prior to the event, the Operations Center guarantees the response within 2 working days ;
- **if the request is received between 3 and 2 working days** prior to the date of the event, the Operations Center guarantees the response by 1 working day prior to the date of the event

If the request is raised with **short notice (less than of 2 working days – 48h)** this may result, when pre-authorization is denied, in a last-minute communication by the Operations Center.

It should anyway be noted that **in the kick-off phase of the Health Plans**, it may not be possible to comply with the above-mentioned service levels until **the process personal data acquisition is complete.** For this reason, all Patients who want to benefit from a DIRECT assistance service should to contact the Operations Center with due advance.

VERIFY AND CONFIRM

The Insured will receive the result (authorization / denial of hospitalization / surgery) of the insurance-technical analysis carried out by the Operations Center through SMS or e-mail as indicated in the first contact phase. The result is also accessible from the RESERVED AREA.

The Operations Center, after the successful medical-insurance analysis, authorizes the **Affiliated Facility to provide the service** to the Insured under direct assistance, with consequent payment by Previmedical, giving evidence of any expenses not covered by the health plan.
On the day of the appointment, the Insured must **provide evidence of the authorization received from the Operations Center or the authorization code received via SMS or e-mail.**

PRE-AUTHORIZATION VIA PHONE (possible waiting time)

The Insured can receive a pre-authorization by reaching out to these dedicated numbers:

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- 0039 0422.17.44.023 from abroad

The Operations Center is available 24hours, 365 days a year.

DOCUMENTATION

The Insured must **provide the Operations Center** the following details:

- Name and surname of the requester of the service
- Name of the chosen Facility
- Type of service (exam/visit/..)
- Diagnosis
- Date of the appointment
- Preferred channel to receive the authorization code (SMS or e-mail).

The Insured should send through fax to the Operations Center using number 0422.17.44.523 or, by replying to the email sent by the Operations Center:

- prescription or medical certificate with reference to the service
- diagnosis;
- the First Aid P.S. report, in case of an accident, as this requires objective documentation.

TIMING

With a minimum advance of 2 working days (48 h), the Operations Center guarantees the response (authorization / denial) on the direct assistance request:

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- **if the request is received between 3 and 2 working days** prior to the date of the event, the Operations Center guarantees the response by 1 working day prior to the date of the event

If the request is raised with **short notice (less than of 2 working days – 48h)** this may result, when pre-authorization is denied, in a last-minute communication by the Operations Center.

It should anyway be noted that **in the kick-off phase of the Health Plans,** it may not be possible to comply with the above-mentioned service levels until the **process personal data acquisition is complete**. For this reason, all Patients who want to benefit from a DIRECT assistance service should to contact the Operations Center with due advance.

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The Insured will receive the result (authorization / denial of hospitalization / surgery) of the insurance-technical analysis carried out by the Operations Center **through SMS or e-mail as indicated in the first contact phase**. The result is also accessible from the RESERVED AREA.

The Operations Center, after the successful medical-insurance analysis, **authorizes the Affiliated Facility to provide the service to the**

Insured under direct assistance, with consequent payment by Previmedical, giving evidence of any expenses not covered by the health plan.

On the day of the appointment, the Insured **must provide evidence of the authorization received from the Operations Center or the authorization code received via SMS or e-mail.**

URGENT PROCESS PRE-AUTHORIZATION

The urgency procedure, which allows you to benefit from the network services even without respecting the 48-hour notice period, is only **limited to pathologies/diseases in the acute phase and in the cases of physical injuries** due to accidental, violent and external causes.
The emergency procedure cannot be activated in relation to health services provided abroad, for which the Insured will in any case be required to previously receive the authorization from the Operations Center.

DOCUMENTATION

To activate the emergency procedure, **call the Operations Center**
800.90.12.23 - 0039/0422.17.44.023 (from abroad); the Operations Center **will forward the dedicated form to be filled-in by the healthcare facility providing the service.**

The completed form must be sent to the Operations Center through fax (0422.17.44.523) or in response to the email sent by the same Operations Center, attaching:

- medical prescription containing the diagnosis and the type of pathology for which the service is requested, clearly certifying the state of urgency such as to make the requested healthcare service essential, in order to obtain an authorization in derogation to the standard procedure;

- in the event of an accident, the First Aid P.S. report logged within 24 hours after the event, as it must be documented.

In case of impossibility to get in touch with the Operations Center, the Insured can request authorization within 5 days after the beginning date of hospitalization and in any case before the discharge from the Affiliated Facility. At the same time, the Insured must send the above-mentioned documentation to the Operations Center.

It is understood that **the final evaluation about the existence of the urgency, with respect to the individual case, will be subject to the evaluation of the Operations Center.** The activation of the urgency procedure remains subject to the outcome of this assessment.

TIMING

The Operations Center is committed to manage urgent requests **received within 24 working hours of notice**; the Operations Center also undertakes to manage urgent requests that are received with less than 24 hours notice, without in this case being able to guarantee the successful authorization.

BOOKING VISITS OF CONTROL AND PREVENTION HERPES ZOSTER

The Insured is required to:

- identify the Network Facility by **accessing the Reserved Area on the Previmedical website or through the "EasyUnica" Mobile App, using the search function;**

- contact the Affiliated Facility directly, **checking the availability of the service** and booking it;

- **request online the pre-authorization through the Reserved Area on the Previmedical website or through the "EasyUnica" Mobile App, using the available interactive functions.**

The Insured will receive the authorization, through the channel indicated in the online pre-activation phase (SMS or E-mail).

About the timing of pre-activation, the Insured must follow the procedure described in the chapter ONLINE PRE-ACTIVATION / TIMING.
The Insured is required to give a minimum notice of 2 working days (48 hours).
Each Insured can **carry out up to 1 control visit per month**, once a year for each specialization. These visits **do not foresee any overdraft and/or deductible application; the coverage cap of the policy is not impacted by these.**

N. B. Before carrying out the Herpes Zoster prevention it is advisable to consult your ASL or your family doctor to verify the presence of contraindications or possible important side effects, due to age and / or state of health.

AFTER RECEIVING THE SERVICE

Once the service has been performed, the Insured must countersign the invoice issued by the Affiliated Facility, in which the possible share to be paid by the same will be explained (for any overdrafts, deductibles, services not covered by the reference Health Plan), Previmedical provides for the payment of the expenses within the foreseen terms, upon receipt by the Healthcare Facility of the complete invoice and any further supporting documentation. The Insured will receive appropriate certification proving that the liquidation has taken place

SPECIAL CASES:

- The Insured must **notify in advance the Operations Center to report any changes and/or additions to the authorized service** so that, once the administrative and technical medical checks have been carried out, the authorization can be issued.

- **The prescription must have been issued by a different doctor than the one delivering the service (directly or indirectly), or, if the prescribing doctor also provided the services, the same must be certified by sending the report or a report containing the diagnosis.**

- The Operations Center, within the terms and limits set by the Health Plan, **will authorize** the Insured only as the administrative and medical insurance checks of the request have returned a successful outcome. For example, in the event of a request for specialist visits, general practitioners' services will not be considered as acceptable.

- **FAILURE TO ACTIVATE THE OPERATING CENTER**

If the Insured accesses affiliated health facilities without complying with the obligations of preventive request of authorization from the Operations Center, the service will be considered received under the healthcare system in a reimbursement/indirect form, with advance payment by the Insured and reimbursement to the same, if provided for in their Health Plan, within its terms and limits.

- **HEALTH SERVICES UNDER NATIONAL HEALTH SERVICE SSN**

The expense paid upfront by the Insured, without applying any overdraft / deductible will be reimbursed for the services provided for by the Health Plan, within the limits of assistance provided for each individual type of service. To obtain a reimbursement, the Insured must follow the procedure described in chapter 3 “HEALTH BENEFITS UNDER REIMBURSEMENT/INDIRECT SYSTEM”.

3 REIMBURSEMENT / INDIRECT FORM

REIMBURSEMENT / INDIRECT ASSISTANCE
At the end of the treatments cycle, as soon as all documentation has been collected, the Insured can request a refund filling in the refund request form and submitting it, along with the due documentation:

online

on paper

3.1 REIMBURSEMENT REQUEST ON LINE

The Insured can submit the **refund request online**, **submitting the related medical documentation and invoice.**

The documentation is transmitted through an optical scanning system, which allows it to be considered legally equivalent to the original. The company reserves the right to carry out, with the doctors and health facilities, all the necessary checks in order to prevent possible abuse of the use of this channel. The transmission of information takes place with the guarantee of a very high degree of confidentiality and security (SSL 128 bit prot.)

3.2 REIMBURSEMENT REQUEST ON PAPER

Following the visit/control/service event, the Insured must download the refund request form available on **www.unica.previmedical.it, fill it out entirely and attach a copy of the aforementioned supporting documentation.**
The form with all the attachments must be sent to the following address:

Previmedical
C/0 CSU - BOLOGNA (POSTA INTERNA)
oppure a
Ufficio Liquidazioni UNI.C.A. - Previmedical/ Casella Postale n. 142 31021 Magliano Veneta (TV)

MEDICAL DOCUMENTATION AND SETTLEMENTS

> MEDICAL DOCUMENTATION
The Insured must attach (also for services under the SSN)

a) prescription or medical certificate stating:
- the diagnosis
- the First Aid (P.S.) report, in the case of an accident, as it must be objectively documented.
- In the case of injury dental treatment, the same must be consistent with the injuries suffered and the injury must be objectively proven with suitable supporting documentation (First Aid P.S.report, OPT, X-rays and photographs).
- In addition, the settlement documentation must show details of the treatments performed

The prescription must have been issued by a different doctor than the one delivering the service (directly or indirectly), or, if the prescribing doctor also provided the services, the same must be certified by sending the report or a report containing the diagnosis.

b) complete medical record and hospital discharge form (S.D.O) in case of hospitalization with both overnight and day hospital stays (Day Hospital)

Please mind that permanence in the First Aid (P.S.) room is not considered like an hospitalization or like a Day Hospital.

c) medical report certifying the pathology and required services provided, in the case of outpatient surgery, with any histological evidence, if performed

d) certificate of the ophthalmologist, optician optometrist with orthoptist qualified, certifying the modification of vision, in case of purchase of lenses, including contact lenses (however, excluding "disposable" ones), if the insurance policy option provides for them. The document must mention if referring to a prescription for first

lenses; the certificate of conformity issued by the optician, as per Legislative Decree of 24.02.97 n.46, is mandatory, as well anything else necessary for the correct settlement of claims.

> EXPENSE DOCUMENTATION (invoices, notules, receipts)

a) issued by:

- Healthcare Institute, from Medical Center, intended as the Facility, even if not used for hospitalization, not aimed at the treatment of problems of an aesthetic nature, organized, equipped and authorized according to the current legislation, to provide complex diagnostic or therapeutic health services (instrumental diagnostic tests, laboratory analyzes, use of electro-medical devices, physiotherapy and rehabilitation treatments) and equipped with Health Management.

- The invoice issued by a Medical Center or a specialist doctor (with the revenue stamp of € 2.00 DPR 642/72 if the amount exceeds € 77.47), must clearly and legibly report the specialization of the professional which should also be consistent with the diagnosis.

b) for the reimbursement of expenses incurred for health services under the SSN system, the Insured is requested to provide proof of an invoice or receipt issued, upon payment, by the Local Health Provider (ASL) or Health Facility accredited with the SSN. **Such document should report reference to the service received or the payment receipt issued by an automatic collector (Punto Giallo)** including also the appointment note issued by the ASL at the time of booking or performance of the service.

Previmedical will verify that the service (whose reference can be retrieved as a specific code in the documents) is one of those included in the Health Plan (for example, the costs incurred for prevention and / or control services are excluded)

3.3 ACCESS YOUR DOSSIER

By accessing the Reserved Area from the website www.unica.previmedical.it (RESERVED AREA), the subscriber, after authentication, can also access the on-line consultation function to check the status of the reimbursement requests.

The “FOLLOW YOUR DOSSIER” service is available if a mobile number has been provided to Uni.CA.
Through this service, the Insured will automatically receive via SMS all the details related to the settlement. In particular, following the activation of the service, the Insured will receive an update notification of the processing status of his dossier in relation to the following operational steps of the refund process:
- reception of the refund request by the settlement office;
-preparation of the payment order for the refund request;
- possible suspension of the procedure, if the documentation attached to the refund request is incomplete;
-possible denial of the request for non-refundable cases.

BEWARE OF...

• All documentation must be **fiscally valid** according to the laws in force.
• Any documentation **written in a language other than Italian**, English, French and German must be accompanied by a translation into Italian or English.
• Expense documents that show cancellations and **corrections are not allowed.**
• If the Insured submits **the original medical documentation**, rather than a copy, as an attachment to the paper reimbursement request, Previmedical will not return the original documents, but in case of need, the policy holder may raise a request for conforming copy through the dedicated form email located in the reserved area.
• If the Insured **receives refund from Funds or Companies**, it is necessary to send the settlement documentation of these along with copies of the invoices related to the reimbursed funds.
• for the correct evaluation of reimbursement request or checks on the documentation, **the original documents can be requested** at any time.
• If **Previmedical requests to integrate the documentation of the reimbursement practice,** the same must be sent by the Insured **within 60 days** of receiving the request, otherwise the right to reimbursement will lapse.

4 ACCOUNT, STATEMENT, QUOTES AND RECALL SERVICE

FORM MAIL

To enhance the assistance service, for some types of requests, a special ticketing service function (so-called FORM MAIL) is available on the Reserved Area , replacing the assistance service via e-mail (assistenza.unica@previmedical.it) .
Accessing the reserved area of the website www.unica.previmedical.it (RESERVED AREA) upon authentication, the Insured can use the “Do you need assistance? Open a Ticket” function by clicking on the icon at the top of the user bar.
For additional details on the functionalities, please refer to the user manual.

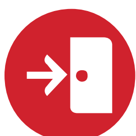
CONSULTS OR SETTLEMENT TERMS

The consults should refer only to hospitalizations (i.e. the most important and most costly services). The consult must be requested in writing, using the dedicated function “do you need assistance? Open a ticket” available on the Reserved Area and selecting request type CONSULT, with a notice of at least 15 days (anyway, the sooner the consult is requested, the better). The medical documentation related to the service (reports, preventive assessments, medical documentation that prescribes the surgery or hospitalization) must be sent to documents.unica@previmedical.it, inserting “CONSULT” in the subject of the e-mail. The consults, regarding the coverage or the settlement conditions (for example, for the existence of compensation limits), will be provided within 8 days from the request, or from the receipt of the additional documentation requested, based on the documentation and will not be valid in case of modification of the surgery or treatment actually received during hospitalization and compared to what was initially assumed.

BENEFIT ACCOUNT EXTRACT FOR THE PURPOSE OF INCOME STATEMENT

Every year, an account statement of the benefits reimbursed both directly and refunded (already paid by the insurer in the previous fiscal year) is performed by Previmedical on behalf of Uni.CA, to allow Insureds to prepare for fiscal year closing activities.

During the tax return activity processing, the client can use the documentation issued annually by the Cassa together with copies of the expense documentation to provide evidence of the incurred expenses.



RECALL SERVICE

The RECALL service can be activated by the Insured on working days only and when all the telephone lines of the Operations Center are busy (toll-free number 800. 90. "12. 23 from landlines and cell phones). the Insured, after the recorded message must leave his / her data (surname, name, telephone number) so that the operators can call back within the next 24 working hours.
The Control unit will make 2 call attempts, in the event that the Insured does not answer, Previmedical sends and SMS to the telephone number, it is therefore recommended to indicate a mobile number to be more easily reachable and be notified via SMS.
For each call, the Previmedical operator waits for an answer from the Client for 20 seconds, after which the system closes the call.
Only when the contact is unsuccessful (for example: the number is busy), the Control unit will make 3 call attempts.

1- It is specified that the RECALL service must not be used in case of medical emergencies (pathologies / diseases in the acute phase or in case of physical injuries caused by an unforeseen, violent and external event) for which the procedure is envisaged (direct / indirect Guide to the Insured).

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Previmedical
Servizi per la Sanità Integrativa