INTESA SANPAOLO RBM SALUTE

Insurance contract covering health costs

PID - Non-Life Product Information Document

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

Product: UNICA - EARTHQUAKES

Full pre-contractual and contractual information on the product is provided in other documents.

What kind of insurance is it?

The cover provides for the reimbursement of expenses for hospital services, only if made necessary by injury resulting from earthquakes of magnitude greater than 5.0 located in Italy by the National Seismic Network of INGV (Italian National Institute of Geophysics and Volcanology).

What is covered by the insurance?

- ✓ Indemnity in lieu for surgical or non-surgical hospitalisation and MS: the Company shall pay indemnity in lieu for each day of hospitalisation;
- ✓ Post-hospitalisation: the Company shall pay post-hospitalization expenses for diagnostic tests, medical, surgical and nursing services, as well as services aimed at recovering health such as physical therapy and rehabilitation treatments.

What is not covered by the insurance?

- × Insurance cover does not apply in other cases, such as:
  - accidents resulting from the practice of air sports and from participation in professional competitions and related training,
  - accidents, illnesses and intoxications resulting from alcoholism, abuse of psychotropic drugs, and use of narcotics (except for therapeutic administration) or hallucinogens.
  - expenses incurred for a series of medical services (including non-therapeutic voluntary abortion) or due to treatment and procedures for the consequences or complications of accidents or illnesses that are not covered under the policy.

Are there any cover limits?

- ! Cover provides for specific deductibles and coinsurance per benefit, which may result in the reduction or non-payment of compensation.

INTESA SANPAOLO RBM SALUTE

Where is the cover valid?

✓ The whole world. Damages are liquidated in Italy, in EUR. For expenses incurred abroad, reimbursements are made at the average exchange rate for the week in which the expense was incurred, as calculated from the ECB quotation.

What are my obligations?

- The Insured must make accurate and complete statements on the risk to be insured without reticence; during the course of the contract, they must report any changes that may lead to an increase in the insured risk. Failure to comply with these obligations may result in the complete or partial forfeiture of the indemnity and in the termination of the insurance.
- The Insured or his/her assignees must report the Claim to the Company as soon as they are able. Failure to comply with this obligation may result in the complete or partial forfeiture of the right to the repayment of expenses - If the Insured is reimbursed by Funds or Entities, s/he must send the documentation of liquidation of such Entities together with photocopies of the relative invoices
- In order to obtain the settlement of claims, it is necessary to present the medical documentation with the diagnosis in the name of the Insured.
- In the event of an accident, if a third party is liable for the damaging event, the Insured shall notify the Company of the name and address of the liable third party and to end the report from the Emergency Room.
- In the event of a road accident, when filing the first payment claim regarding medical services, the Insured is required to send the Company the accident report drawn up by the police or the CID Form (amicable accident report).
- If the Insured Person wishes to use an affiliated facility, or an affiliated doctor or dentist, s/he shall always use the direct care scheme.

When and how should I pay?

- The premium is annual and indivisible but it is divided into monthly instalments in advance as shown on the policy certificate.
- The Policyholder shall pay the premium to the Company by bank transfer.

When does cover begin and when does it end?

- Cover lasts 2 years; it shall take effect at 0:00 am on 01/01/2022 if the premium or the first premium instalment has been paid; otherwise it shall take effect at midnight on the day after payment. it expires at midnight on 31/12/2023.
- There is no tacit renewal.

How can I cancel my policy?

- This cover is not tacitly extended and, therefore, is automatically terminated upon its natural expiry.
- There are cases in which the Policyholder has the right to withdraw from the contract.

Insurance covering medical expenses

Additional product information document for non-life insurance products (Additional Non-Life PID)

Intesa Sanpaolo RBM Salute S.p.A.

Product: UNICA EARTHQUAKES

Last release 01/2022

This document contains additional and complementary information to that contained in the product information document for non-life insurance products (Non-life PID), in order to help the potential policyholder to understand in more detail the characteristics of the product, the contractual obligations and the financial situation of the Intesa Sanpaolo RBM Salute.

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

Intesa Sanpaolo RBM Salute S.p.A.
Registered office: via A. Lazzari n. 5, 30174 Venice – Mestre (VE) tel. +39 041 2518798
Internet website: www.intesasanpaolorbmsalute.com;
e-mail: info@intesasanpaolorbmsalute.com; certified e-mail: comunicazioni@pec.intesasanpaolorbmsalute.com
Authorised to carry out insurance business by ISVAP Order no. 2556.
Subject to the management and coordination of Intesa Sanpaolo Vita S.p.A., entered in the Register of Insurance and Reinsurance Companies under no. 1.00161 and belonging to the Intesa Sanpaolo Vita Insurance Group, entered in the Register of Insurance Groups under no. 28.

Financial data at 31 December 2020 Shareholders' Equity: 367,891,567.00 euros, of which Share Capital 160,000,000.00 euros. **Total equity reserves**: 146,026,695.00 euros.
The financial data (shareholders' equity, share capital, reserves and solvency ratio) are updated annually following the approval of the financial statements. They can be consulted at www.intesasanpaolorbmsalute.com (Corporate Information section).
Risk profiling results of Intesa Sanpaolo RBM Salute:

- Solvency Capital Requirement (SCR) = 143,283,029 euros
- Minimum Capital Requirement (MCR) = 35,820,757 euros
- Own funds eligible to cover SCR = 387,030,759 euros
- Own funds eligible to cover the MCR = 387,030,759 euros
- *Solvency ratio*: 270%

The contract shall be governed by Italian law.

What is covered by the insurance?

There is no additional information to that provided in the PID; the commitment of Intesa Sanpaolo RBM Salute is commensurate to the insured sums agreed with the policyholder.

What is NOT covered by the insurance?

Excluded risks	The following expenses are excluded from payment: 1) medical services for aesthetic purposes, except for the following plastic surgery procedures: • surgery, including cosmetic surgery, for children under the age of three;

- surgery following an accident eligible for compensation under the policy;
- reconstructive surgery following demolitive procedures or cancer surgery (limited to the anatomical site of injury) eligible for compensation under the policy;

2) hospitalisation during which only physical examinations or therapies, which, due to their technical nature, can also be carried out in an outpatient clinic, are carried out provided that this is permitted by the state of health of the Insured;
3) hospitalisation caused by the need for the Insured to receive care from third parties in order to carry out the elementary acts of daily life, as well as long-term hospitalisation, determined by the physical conditions of the Insured that no longer allow recovery with medical treatment and that make it necessary to stay in a nursing home for care or maintenance physical therapy;
4) intoxications and injuries resulting from:
   - alcohol abuse;
   - use of hallucinogens;
   - non-therapeutic use of psychotropic drugs and narcotics;
5) injuries suffered as a result of the Insured's own criminal actions wilfully carried out or attempted, as well as deliberately carried out or permitted against his/her person;
6) clinical check-ups;
7) acupuncture, except as provided in the various BASE Health Plans;
8) physical therapy services (where applicable) not provided by a medical specialist or by a professional with a degree in physical therapy or an equivalent qualification recognised in Italy, or provided in beauty or fitness centres;
9) physical therapy, except as provided in the various BASE Health Plans;
10) the direct or indirect consequences of transmutation of the nucleus of the atom as well as of radiation caused by the artificial acceleration of atomic particles;
11) the consequences of war, uprisings, and volcanic eruptions;
12) accidents resulting from the practice of air sports in general or any sport practised professionally;
13) accidents resulting from participation in races or competitions in cars that are not purely regularity races, or in motorbikes and motorboats, as well as related trials and training;
14) services provided in convalescent and residential homes, health camps and nursing homes for dietary and aesthetic purposes or long-term care facilities, insofar as they are not considered "healthcare facilities", as well as gyms, gymnastic and sports clubs, beauty studios, health hotels, medical hotels, and wellness centres even if they have an annexed medical centre.

Are there any cover limits?

The Policyholder/Insured must notify the Company in writing of the existence and subsequent stipulation of other insurance policies for the same risk; in the event of a claim, the Policyholder or Insured must notify all the insurers, indicating to each the name of the others, pursuant to Article 1910 of the Italian Civil Code. The above is also valid in the event that the same risk is covered by contracts stipulated by the Insured with Entities, Funds, or Supplementary Health Funds. The right of recourse of the Company is reserved.
The following are the ceilings/sums insured, coinsurance and deductibles for the various options. Unless otherwise indicated, the ceilings are per Year/Family Unit and the coinsurance/deductibles are per event.

HOSPITALISATION	
Ceiling A and B	€20,000.00 per event/family unit, increased to €40,000.00 for MS
A) Indemnity in lieu for surgical/non-surgical hospitalisation with the Italian National Health System.	
Ceiling	30 days per person/event
Surgical/non-surgical hospitalisation	€80 a day
MS	€160 a day

Pre/Post-op	100% - 90 days/90 days increased to 120 days in case of MS
B) Post-hospitalisation as private service in a public facility Conditions	90 days/90 days increased to 120 days in case of MS 100% only direct services

What are my obligations? What are the company's obligations?

What to do in case of a claim?	**Reporting a claim:** the Insured or his/her assignees must report the claim to Intesa Sanpaolo RBM Salute as soon as they can, in writing or via web (reserved area/mobile app). A claim for compensation may be submitted in the same manner.
	Direct/affiliated care: the Insured may access the health and dental services of the Network made available by Intesa Sanpaolo RBM Salute after activating the Operations Centre.
	Processing by other companies: not included.
	Limitation: the right to pay the premium instalments shall lapse one year after the individual due dates (Article 2952 of the Italian Civil Code). Other rights deriving from the insurance contract lapse in two years from the day of the accident.
Incorrect or reticent statements	The Policyholder and Insured must make accurate and complete statements without reticence; if they fail to do so, they may forfeit all or part of their right to compensation and the insurance may cease (Articles 1892, 1893 and 1894 of the Italian Civil Code). The Insured must notify Intesa Sanpaolo RBM Salute of any worsening of or reduction in risk.
Company obligations	The Company shall: **a) Direct care scheme** - provide authorisation, to the complete request and for which the technical, medical and insurance investigation has had a positive outcome. To this end, therefore, the Insured must take action with adequate advance notice and in any case with at least 2 days (48 hours) notice with respect to the last date provided for the response from the Operations Centre. **b) Payment scheme** - make payment to the Insured within 10 working days of receipt of the request for payment complete with all the necessary medical and expense documentation.

When and how should I pay?

Premium	Although the premium is annual and indivisible, it must be paid in monthly instalments in advance as shown on the policy certificate. The insured amounts and premiums are not indexed. Premium includes tax. The premium is paid by the Policyholder to Intesa Sanpaolo RBM Salute by bank transfer.
Refund	There is no refund of the premium since, in the event of loss during the year of the requisites to benefit from the insurance cover, the cover is active until the first useful expiry date.

When does cover begin and when does it end?

Duration	The insurance contract has a duration of 2 years starting at 00:00 am on 01/01/2022, if the premium or the first instalment of premium has been paid; otherwise it shall take effect at midnight on the day following payment. Cover expires at midnight on 31/12/2023. There are no waiting periods (when cover is not active).
Suspension	If the Policyholder fails to pay the premiums or the following premium instalments, the insurance cover shall is suspended from midnight of the 15th day after the expiry date and shall resume effect from midnight of the day following payment. Subsequent deadlines must, however, be met (Article 1901 of the Italian Civil Code). Once the terms have expired, Intesa Sanpaolo RBM Salute may terminate the contract by registered letter and is still entitled to claim the expired premiums.

How can I cancel my policy?

Change of mind after signing	The Policyholder is not entitled to change of mind after signing.
Termination	In addition to the cases of termination provided for by law, the Policyholder may withdraw immediately and without charge - by registered letter with acknowledgement of receipt - in the case of events that demonstrate a situation, albeit preliminary, of financial instability for the Company, such as: (a) no or inadequate technical provisions; (b) no or inadequate solvency margin; (c) requests by IVASS requiring the Company to prepare a financial recovery plan to restore its solvency margin; (d) determination by IVASS of serious financial losses; (e) initiation of the Extraordinary Administration. In this case, the premium instalments not yet paid shall not be due to the Company. The Policyholder may also withdraw unilaterally at the end of the first year of cover in the event of manifest inadequacy of the standard of service rendered by the Company with respect to the level of service guaranteed, which is demonstrated by the application of the maximum penalty set out therein.

Who is this product for?

This insurance product is for:

- UniCredit Group personnel already covered by the BASE Health Plans provided by Uni.C.A.
- their respective family members, provided they are enrolled with Uni.C.A.

who wish to obtain the reimbursement of health expenses incurred as a result of injury or illness

What costs do I have to cover?

There are no additional fees charged to the policyholder.

HOW CAN I FILE COMPLAINTS AND RESOLVE DISPUTES?	
To the insurance company	Complaints about the contract or an insurance service must be in writing and sent to the Intesa Sanpaolo RBM Salute S.p.A. Complaints Office either: - filling out the online form (https://www.intesasanpaolorbmsalute.com/reclami.html) - by ordinary or registered mail: Intesa Sanpaolo RBM Salute S.p.A. – Ufficio Reclami - Sede Legale - Via A. Lazzari no. 5, 30174 Venice – Mestre (VE) - by fax: 0110932609 - by email: reclami@intesasanpaolorbmsalute.com - by certified email: reclami@pec.intesasanpaolorbmsalute.com If you do not use the online form, you must indicate in your complaint to receive a clear and complete reply: - name, surname, address and date of birth of the Insured - name, surname, address of the person filing the claim, if other than the Insured (e.g., consumer association, lawyer, family member, etc.), with power of attorney signed by the Insured and a copy of the relevant ID document - case number - concise and complete statement of the facts and reasons for the complaint. Requests for clarification or information, claims for compensation for damages or fulfilment of contract, are not considered complaints. Intesa Sanpaolo RBM Salute shall reply to the complaint within 45 days of the date of its receipt.
To IVASS	In the event of an unsatisfactory outcome or late response, you can contact IVASS, Via del Quirinale, 21 - 00187 Rome, fax 06.42133206, certified e-mail: **ivass@pec.ivass.it**. More info at: **www.ivass.it**
BEFORE RESORTING TO A COURT OF LAW, alternative dispute resolution systems can be used, such as:	
Conciliation	With the necessary assistance of a lawyer, you can contact a Conciliation Body to be chosen from among those listed in the appropriate register kept by the Italian Ministry of Justice, available at **www.giustizia.it.** (Law no. 98 of 9/8/2013) in order to reach an agreement between the parties. An attempt at conciliation is a condition for proceeding with a civil case. A request for conciliation may be sent to: Intesa Sanpaolo RBM Salute S.p.A. Claims Department Via A. Lazzari no. 5, 30174 Venice – Mestre (VE) or by email: reclami@pec.intesasanpaolorbmsalute.com
Assisted negotiation	Through a request from your attorney to Intesa Sanpaolo RBM Salute. The assisted negotiation is optional and does not constitute a condition for admissibility of court proceedings.
Other existing alternative dispute resolution systems	For the resolution of cross-border disputes it is possible to submit a complaint to IVASS directly or to the competent foreign system by requesting the activation of the FIN-NET procedure or by the applicable regulations.

FOR THIS CONTRACT, THE COMPANY HAS AN INTERNET AREA RESERVED FOR THE POLICYHOLDER/INSURED (CALLED *INSURANCE HOME*), SO AFTER SIGNING YOU CAN CONSULT THIS AREA AND USE IT TO MANAGE THE CONTRACT ELECTRONICALLY.

INTESA SANPAOLO RBM SALUTE

INTESA SANPAOLO RBM SALUTE

Health Insurance Cover for
Unicredit S.p.A. Group
Associated with
Uni.C.A. Cassa Assistenza

TERMS AND CONDITIONS OF INSURANCE

Please read the insurance conditions carefully before taking out the policy

FORM FI 1349
Version 01/2022

Intesa Sanpaolo RBM Salute S.p.A.

INTESA SANPAOLO RBM SALUTE

CONTENTS

Terms and Conditions of Insurance from page 1 to 22:

Pursuant to article 166 of the Insurance Code (Legislative Decree no. 209 of 7 September 2005) and the Guidelines issued by ANIA following the outcome of the "Simple and Clear Contracts" Working Table (6 February 2018), the forfeitures, nullities, limitations of cover and charges to be borne by the Policyholder or Insured, contained in this contract, are shown with a specific font.

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To make the Terms and Conditions of Insurance clearer, these means were used:

Bold: words and concepts of particular importance
Grey background: forfeiture, nullity, limitation of cover, charges to be borne by the Policyholder or the Insured
Green box: examples

Section I

GLOSSARY

The Glossary is an integral and material part of the Terms and Conditions of Insurance. Unless otherwise stated, the terms and definitions listed below, which are marked with a capital letter, shall have the meaning given to each in this Glossary.

Terms stated in the singular include the plural, and vice versa. Terms denoting one gender include the other gender unless the context or interpretation indicates otherwise.

Insured: person who is covered by the insurance.

Insurance: the insurance contract.

Direct care: care at affiliated facilities/specialists included in the service agreement with Cassa Uni.C.A. with direct payment by the Company to the affiliated facilities/specialists of the amounts due for the care received by the Insured.

Nursing care: care provided by staff with a specific diploma.

Medical Record: a set of official documents valid as a public deed, drawn up during a hospital stay, whether same day or inpatient, containing the patient's full personal details, admission and discharge diagnoses, remote and recent clinical history, treatments carried out, surgical procedures performed, exams and clinical diary, discharge letter and the Hospital Discharge Summary (HDS).

Fund: Uni.C.A. Cassa Assistenza, Piazza Gae Aulenti n. 3, (Torre A), 20154 - Milan, TIN 97450030156; a welfare entity qualified[1] to receive contributions and to undertake the contracting of the health programme for tax and contribution purposes

[1] Article 51 "Determination of income from employment" of Italian Presidential Decree no. 917/1986.

TCIs: Terms and Conditions of Insurance.

Medical centre: A facility, even if not used as a hospital, not intended for the treatment of aesthetic problems, organised, equipped and duly authorised according to current legislation to provide diagnostic or therapeutic health services of particular complexity (diagnostic and instrumental examinations, laboratory analyses, use of electromedical equipment, physical therapy and rehabilitation treatments) and with hospital health management.

Company: Intesa Sanpaolo RBM Salute S.p.A.

Policyholder: Uni.C.A Cassa Assistenza, registered with the Italian Register of Health Funds.

Same-Day Hospitalisation: Stay in a healthcare facility that usually ends within a day following medical treatment or surgical procedures.

Affiliated surgical team: Each surgical team - as defined above - falling under the service affiliated with Cassa Uni.C.A.

Indemnity: the amount the Company owes the Insured in the event of a claim covered by these TCIs.

Accident: event due to a fortuitous, violent and external cause that produces objectively ascertainable bodily injuries. Therefore, in order for the event to qualify as an accident under the policy, three concomitant causes must occur:

- fortuitous means: the result of chance, accidental, unintentional, unforeseeable or unavoidable
- violent means: intense and capable of damage (thus excluding all slow degenerations, such as certain inflammations and fraying)
- "external" shall mean an "exogenous cause and not internal to one's own body (pre-existing pathological condition), or an event caused by an external force

Outpatient surgical procedure: surgical procedure performed without inpatient hospitalisation.

Magnitude: In most cases, the first estimate of magnitude provided by the Simica Control Room of the INGV (Italian National Institute of Geophysics and Volcanology) in Rome is the Richter scale or local magnitude (ML) scale. For events of magnitude greater than about 3.5, if data are available, the focal mechanism is calculated using the Time Domain Moment Tensor (TDMT, http://cnt.rm.ingv.it/tdmt) and the Magnitude Moment (MW) is also obtained

Illness: any alteration in health that is not due to an accident.

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Family Unit: The entire family unit as defined in Art. 5 "Insurable categories" of the Terms and Conditions of Insurance (also TCIs).

Basic Health Plan: the illness/accident policy underwritten by the Policyholder in favour of the Insured among those listed below:

- for staff in service: Nuova Plus, Extra, Extra4, Extra5
- for retired staff: Base, Base+, Standard, Plus, Extra, Over 85.

Premium: The amount that the Policyholder owes the Company.

Hospitalisation: an in-patient stay involving overnight stay at a healthcare facility.
Claim: the damaging event for which insurance cover is provided.

Affiliated Healthcare Facility: Each nursing home, institute, hospital - as defined above - that has an agreement with Cassa Uni.C.A. The list of Authorised Centres is available under "Strutture convenzionate" on the website www.unica.previmedical.it.

Physical Therapy and Rehabilitation Treatments: Physical and rehabilitation medicine treatments provided by a doctor or professional with a degree in physical therapy or an equivalent qualification recognised in Italy, at medical centres, aimed at enabling the recovery of the functions of one or more organs or systems affected by illness or accident eligible for compensation under the policy.

The definition - and therefore, the insurance cover - does not comprise services:

- aimed at the treatment of aesthetic problems
- treatments carried out with instruments whose pre-eminent use is in the field of aesthetic medicine.

Specialist Visit: health care service provided by a doctor with a specialisation, for diagnoses and prescriptions of therapies for which this specialisation is intended. Only traditional medicine visits are allowed as well as those carried out at the Insured's home in cases where the latter is unable to move.

Examinations by general practitioners are not considered specialist visits.

INTESA SANPAOLO RBM SALUTE

CHAPTER 1 – GENERAL RULES GOVERNING THE CONTRACT

Article 1. Information on Intesa Sanpaolo RBM Salute S.p.A.
Registered under number 1.00161 in the Register of Insurance Companies Authorised to carry out insurance business by ISVAP Order no. 2556 of 17/10/2007[2].

Website: www.intesasanpaolorbmsalute.com

Email: info@intesasanpaolorbmsalute.com

CERTIFIED E-MAIL: comunicazioni@pec.intesasanpaolorbmsalute.com

Article 2. Waiting period
Not included.

Article 3. Indexing of premiums and insured amounts
The premiums and insured amounts are not indexed.

Article 4. Limitation and forfeiture of rights under the contract
The right to pay the premium instalments shall lapse one year after the individual due dates[3].

Example: if the premium instalment is due 31 December 2022, Intesa Sanpaolo RBM Salute may require payment by 31 December 2023.

Other rights deriving from the insurance lapse in two years from the day of the accident.

Article 5. Insured categories
Mandatory cover is provided for:

- all Insured already covered by the Basic Health Plans provided by Uni.C.A.
- their respective family units, as identified in the definition of family unit, provided that they are enrolled with Uni.C.A. and provided that they are all already insured under the BASE Health Plans, upon payment of the corresponding premium.

[2] OJ 255 of 2 November 2007
[3] Article 2952 "Limitation in matters of insurance" of the Italian Civil Code

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Article 6. Declarations on circumstances concerning risk - Health Questionnaire

The Insured must make accurate and complete statements without reticence; failure to do so may result in the complete or partial forfeiture of the Indemnity and in the termination of the Insurance[4].

The Insured, his/her family members and assignees shall always allow the Company to verify, by means of investigations or checks, the truthfulness of all the declarations and data acquired (e.g. family ties, dependents), which are necessary elements for evaluating the validity of the Insurance for them.

The Insured must notify the Company of any worsening of or reduction in risk.

The Health Questionnaire does not to be completed.

Article 7. Commencement of Insurance – Tacit Renewal – Right to withdraw

7.1 Effective date

The Insurance lasts for 2 years and is effective:

- from 0:00 am on 01/01/2022 if the premium or the first premium instalment has been paid
- otherwise it shall take effect at midnight on the day after payment.

It expires at midnight on 31/12/2023.

7.2 Tacit renewal

The contract does not provide for tacit renewal, therefore, at the expiry of the contract, the insurance shall be devoid of further effect".

7.3 Right to withdraw

The Policyholder's right to withdraw is provided.

Article 8. Change of Insured – Premium adjustment

8.1 Inclusion of Insured during the year – New hires

Cover for the employee shall commence:

- **if his/her hiring is notified to the Company, by transmitting the Personal Details, within 90 days of hiring**: from the day of hiring
- **if his/her hiring is notified to the Company, by transmitting the Personal Details,**

after 90 days: at midnight on the day after notification.

Inclusions in the first half-year of cover (commencing on the effective date of insurance): 100% of the annual premium is due, for the entire period of cover.

[4] Articles 1892 "Incorrect statements and reticence with intent or gross negligence", 1893 "Incorrect statements and reticence without intent or gross negligence" and 1894 "Insurance in the name of or on behalf of third parties" of the Italian Civil Code.

Inclusions in the second half-year of cover (commencing on the effective date of insurance): 60% of the annual premium is due, for the entire period of cover.

8.2 Inclusion of family members during the year

Inclusion of family members as identified in the definition of a family unit at a time following the effective date of this insurance cover is permitted only in the following cases:

a) birth, adoption or custody of a child;
b) return to Italy of UniCredit employees who had previously expatriated (ex Expat), starting from the day of return, or, if later, from the day following the end of coverage provided for expatriate personnel;
c) marriage;
d) start of cohabitation for the cohabiting partner living together as man and wife and/or family member;
e) exclusion of a family member from other healthcare cover taken out by the employer.

In such cases, the insurance cover shall be effective from 12:00 pm on the date of the event, as per personal data certification and provided that the Company is notified within 90 days of that date, by means of a written communication to be sent to the Company.

The insured ceilings are to understood to be 100%.

8.3 Exclusions during the year

Termination of this insurance cover before its natural expiry date of 01/01/2024 is only possible upon the occurrence of the following events:

a) termination of the employee's employment for any reason;
b) death of the employee;
c) divorce/separation by court ruling for the employee's spouse;
d) the termination of cohabitation by the cohabiting partner and/or the family member who is not a dependent for tax purposes; in the case of a child who is not a dependent for tax purposes, cover may only be terminated if one of these two conditions also applies:
    - establishment by the child of his/her family unit (marriage/cohabitation as man and wife);
    - earning by the child in the tax year in which s/he leaves the family unit of a total income of more than €26,000 gross per annum;
e) inclusion of a family member in healthcare cover taken out by the employer;
f) exclusion of the employee resolved on in accordance with the Articles of Association and the Regulations by the Board of Directors of the Policyholder;
g) termination of BASE Health Plans.

In the aforementioned cases, the insurance ceases to be valid on the first annual expiry date following the occurrence of the event, also for any insured family members, and therefore no reimbursement of the premium shall be made, with the exception of the following cases:

- exclusion of the employee resolved on in accordance with the Articles of Association and the Regulations by the Board of Directors of the Policyholder;
- dismissals for just cause and subjective just reason
- establishment of an employment relationship with a company outside the UniCredit Group

in these cases cover ceases for the employee and any insured family members immediately upon the occurrence of the event.

Article 9. Territorial Validity

The insurance is valid worldwide.

Article 10. Policyholder's obligations to provide documents

The Policyholder shall give the Insured:

a) PID
b) Additional PID
c) Terms and Conditions of Insurance
d) Privacy Policy in Annex 6 to this Contract

The aforesaid documents are the only for which the Company assumes obligations with reference to the services indicated therein. The drafting of any other documents (e.g., operating guides) shall be evaluated and, if necessary, carried out by the Company, which shall not recognise the validity of documents relating to this Insurance, drawn up by others.

Article 11. Tax regime

Tax on Premiums: 2.50%
Tax on Indemnities: not included.

Taxes related to the Insurance shall be borne by the Policyholder also in the case of advance payment by the Company.

Article 12. Complaints

Complaints concerning a Contract or insurance service are to be sent to the Company in the manner set forth at www.intesasanpaolorbmsalute.com/Reclami

Article 13. Alternative dispute resolution systems: conciliation

For disputes related to this Contract (including disputes regarding its interpretation, validity, performance and termination) before proceeding through the courts, it is mandatory to submit the case to a Conciliation Body listed in the Register of the Italian Ministry of Justice and based in the place where the judicial authorities are territorially competent[5].

An attempt at conciliation is a condition for admissibility of court proceedings.

[5] Legislative Decree 28/2010 on conciliation aimed at reconciling civil and commercial disputes, as amended.

If the dispute is not settled by conciliation, the Company, Policyholder and Insured are free to resort to judicial authorities.

Article 14. Jurisdiction

For disputes related to this Contract (including disputes regarding its interpretation, validity, performance and termination):
- between the Company and the Policyholder: shall be settled by the judicial authority where the Policyholder has its registered office

- between the Company and the Insured: shall be referred to the judicial authorities at the place of residence (if in Italy) or domicile of the Insured or assignee.

The Company, Policyholder and Insured may always resort to conciliatory systems.

Article 15. "Home Insurance"

"EasyUnica" mobile app

The Insured may access "EasyUnica" to access the following features:
- display and modify personal and contact data
- display Operations Centre contacts
- search for affiliated Network facilities
- view the status and details of one's cases
- pre-activate direct care services.

The Insured already registered in the Reserved Area will use the same credentials (login and password) to access the services via the Mobile APP. Otherwise, the Insured must register for the Reserved Area. For all web functions (see specific documentation published on the websites www.unica.unicredit.it and www.unica.previmedical.it).

Article 16. Law applicable to the Contract – Reference to the provisions of the Law

The insurance shall be governed by Italian law. The provisions of the law shall apply for all matters not expressly governed by this contract.

It is understood that in the event that legislative changes occur that may require changes to the contractual terms and conditions, the Parties shall meet to define the new insurance terms and conditions.

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Section II

CHAPTER 1 - INSURED SERVICES

Article 17. Description of the insured services

The Company guarantees the following benefits, only if necessitated by injury resulting from earthquakes of Richter magnitude or local ML magnitude greater than 5.0, localized in Italy by the National Seismic Network of the INGV (Italian National Institute of Geophysics and Volcanology). These shall be eligible for payment under the terms of the contract for expenses incurred exclusively in the affiliated network or with the National Health Service by the Insured, directly or indirectly adhering to any of the BASE Health Plans.

Major Surgery means one of the procedures indicated in the BASE Health Plans, only if necessitated by injury resulting from earthquakes of a magnitude defined as in the preceding paragraph.

A) HOSPITAL SERVICES

A ITALIAN NATIONAL HEALTH SERVICE

In the event of hospitalisation or surgery paid for by the Italian National Health Service, an indemnity in lieu of the following amounts is paid for each day of hospitalisation (meaning that an overnight stay is included):

- €80 a day for surgical or non-surgical hospitalisation,
- €160 a day in case of Major Surgery,

These daily indemnities shall be paid up to a maximum of 30 days per person per event.

In addition, expenses related to diagnostic exams, medical, surgical and nursing services, and services aimed at recovering health such as physical therapy and rehabilitation treatments, carried out in the 90 days following the end of hospitalisation (increased to 120 days in the case of major surgery) and made necessary by the event that determined the hospitalisation, shall be paid without coinsurance.

Should hospitalisation occur as a private service provided in a public health facility, the Company shall provide for the payment only of the expenses indicated at letter B, also in the case of Major Surgery.

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B POST HOSPITALISATION IN A HEALTHCARE FACILITY FOLLOWING AN ACCIDENT WITH OR WITHOUT SURGERY (INCLUDING MAJOR SURGERY), SAME-DAY HOSPITALISATION WITH OR WITHOUT SURGERY, OUTPATIENT SURGERY

The Company shall cover the expenses for the following services rendered directly, without the application of deductibles and/or coinsurance to be borne by the Insured, also in the event of Major Surgery:

- diagnostic exams, medical, surgical and nursing services, and services aimed at recovering health such as physical therapy and rehabilitation treatments, carried out in the 90 days following the end of hospitalisation (increased to 120 days in the case of major surgery) and made necessary by the event that determined the hospitalisation, shall be paid without coinsurance.

Ceilings

For all of the services indicated: €20,000 per Family Unit and per event, increased to €40,000 in the case of Major Surgery.

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CHAPTER 2 - EXCLUSIONS AND LIMITS

Article 18. Exclusions

The following are excluded from cover:

1) medical services for aesthetic purposes, except for the following plastic surgery procedures:
   - surgery, including cosmetic surgery, for children under the age of three;
   - surgery following an accident eligible for compensation under the policy;
   - reconstructive surgery following demolitive procedures or cancer surgery (limited to the anatomical site of injury) eligible for compensation under the policy;
2) hospitalisation during which only physical examinations or therapies, which, due to their technical nature, can also be carried out in an outpatient clinic, are carried out provided that this is permitted by the state of health of the Insured;
3) hospitalisation caused by the need for the Insured to receive care from third parties in order to carry out the elementary acts of daily life, as well as long-term hospitalisation, determined by the physical conditions of the Insured that no longer allow recovery with medical treatment and that make it necessary to stay in a nursing home for care or maintenance physical therapy;
4) intoxications and injuries resulting from:
   - alcohol abuse;
   - use of hallucinogens;
   - non-therapeutic use of psychotropic drugs and narcotics;
5) injuries suffered as a result of the Insured's own criminal actions wilfully carried out or attempted, as well as deliberately carried out or permitted against his/her person;
6) clinical check-ups;
7) acupuncture, except as provided in the various BASE Health Plans;
8) physical therapy services (where applicable) not provided by a medical specialist or by a professional with a degree in physical therapy or an equivalent qualification recognised in Italy, or provided in beauty or fitness centres;
9) psychotherapy, except as provided in the various BASE Health Plans;
10) the direct or indirect consequences of transmutation of the nucleus of the atom as well as of radiation caused by the artificial acceleration of atomic particles;
11) consequences of war, uprisings, and volcanic eruptions;
12) accidents resulting from the practice of air sports in general or any sport practised professionally;
13) accidents resulting from participation in races or competitions in cars that are not purely regularity races, or in motorbikes and motorboats, as well as related trials and training;

14) services provided in convalescent and residential homes, health camps and nursing homes for dietary and aesthetic purposes or long-term care facilities, insofar as they are not considered "healthcare facilities", as well as gyms, gymnastic and sports clubs, beauty studios, health hotels, medical hotels, and wellness centres even if they have an annexed medical centre.

Article 19. Non-insurable Persons

No age limits are provided for.

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CHAPTER 3 - PAYMENT OF INDEMNITY

Article 20. Charges in the event of a claim and procedures to access services

20.1 Charges

Claim

The claim must be reported by the Insured or his/her assignees to the Company as soon as they have the opportunity to do so, and in any case within and not beyond the terms of limitation of the right. Failure to comply with this obligation may result in the total or partial loss of the right to payment of the expenses incurred, pursuant to Article 1915 of the Italian Civil Code.
If essential elements are missing, and the Insured is unable to make them available to the Company, the claim cannot be presented and is therefore rejected. "Claim" means a request for access to the Network to use services under the direct care scheme or to obtain Reimbursement or Indemnity (however named).
The Operations Centre avails itself of medical consultants in order to correctly frame the service requested from among the contractually provided covers. The medical consultants of the Operations Centre do not enter into the merits of the medical request (i.e., they do not evaluate the suitability of the plan of care prescribed by the attending doctor for the treatment of the pathology of the Insured), but simply ascertain that it is a covered Claim.

The Company shall reject a claim in the following cases in which the essential elements mentioned below are deemed to be lacking:

Direct care
- cover not included
- pathology missing or inconsistent with the service
- no documentation at all or illegible documentation
- no cover
- non-affiliated healthcare facility/physician or service not covered by agreement
- failure to indicate the affiliated facility or doctor
- expired medical prescription
- no indication of the service to be provided
- Depleted ceiling
- filing of multiple requests for the same service
- cancellation of the request for authorisation by the Insured

Reimbursement/Indemnity Compensation Scheme
- cover not included
- pathology missing or inconsistent with the service
- no documentation at all or illegible documentation
- no cover

- incorrect request entry
- expired medical prescription
- Depleted ceiling
- submitting a new claim for an invoice that has already been submitted for reimbursement/settled
- submitting a claim that has already been requested/settled
- cancellation of the claim by the Insured

The Company shall require the Insured to supplement the claim if:

- The supporting documentation is incomplete (e.g.: Medical record without hospital discharge form or not transmitted in certified copy or, in case of Outpatient Procedure, failure to send the medical report; no intraoral x-ray and photo materials for dental services; no emergency room certificate in case of services related to the Accident)
- the Insured to whom the Claim relates has not been correctly indicated. If the Insured fails to supplement the Claim within 60 calendar days of the Company's request for supplementation, the claim shall be rejected; the application can still be resubmitted.

Date of Claim

- Hospital services: the date of Hospitalisation or, if there was no Hospitalisation, of the same-day hospitalisation or of the outpatient surgical procedure
- out-of-hospital services: the date of the first medical service provided relating to the specific event
- physical therapy and dental services: the date of execution of the single service.

Reimbursement by Funds, Agencies or other Companies

If the Insured receives reimbursement from Funds, Agencies or other insurance companies, s/he must send the statement of settlement of the individual services from such entities and photocopies of the invoices relating to the reimbursement.

Language of documentation

Documentation drawn up in a language other than Italian, English, French or German must be accompanied by a translation into Italian. If there is no translation, any costs to translate it shall be borne by the Insured.

Visits by doctors commissioned by the Company

The Insured, his/her family members or assignees must allow visits by the Company's doctors and any investigations or checks that the Company may deem necessary; for this purpose they shall release the doctors who have examined and treated the Insured from doctor-patient confidentiality.
The assessment may be ordered

- not earlier than 48 hours after the claim has been filed

- within no more than 6 months from the acquisition of the complete documentation relating to the claim.

Death of the Insured

If during the validity of cover the Insured dies,

- his legal heirs shall promptly notify the Company
- the obligations provided for in this article must be fulfilled by the heirs entitled to claim reimbursement for claims made or yet to be made up to the expiry of the cover.

In this case, other documents must be submitted such as:

- death certificate of the Insured,
- certified copy of any will, or declaration in lieu of affidavit, with:
  o details of the will
  o declaration if the will is the last valid and has not been challenged
  o indication of the heirs to the will, their ages and capacity to act;
- if there is no will: a declaration in lieu of affidavit (in the original or certified copy) made by the interested party before a public official proving that:
  o the Insured died without leaving a will,
  o the personal details, age and capacity to act of the legitimate heirs,
  o that there are no other persons to whom the law attributes rights or shares of the estate
- if there are beneficiaries who are minors or lacking capacity: certified copy of the decree of the judge supervising a guardianship authorising the Company to liquidate the capital and the beneficiaries to collect their shares
- photocopy of a valid ID document and tax/health insurance card of each heir
- declaration signed by all the heirs, indicating the IBAN code of a single current account to which the transfers relating to the payment of claims filed or still to be filed up to the expiry of the cover as regulated in this Contract.

These provisions do not apply to the indemnity in lieu which is not transferable to the heirs in the event of the death of the Insured prior to resignation.

Private services at public facilities:

Services are considered private even if they are provided in public facilities.

Services between two insurance years

Services provided between two insurance years are included in the ceiling amount for the year in which the service is provided.
No invoices are allowed on account.

Pre- and post-inpatient/same-day hospitalisation expense limits

The expense limits (e.g., Deductible/Coinsurance/minimum not eligible for compensation) applied to expenses before and after inpatient/same-day hospitalisation are those provided under Hospitalisation cover, which differ according to the scheme for access to the single service chosen (Direct or Reimbursement).

Under Direct scheme, in the event that Hospitalisation does not take place, the services authorised as pre-hospitalisation are considered as out-of-hospital services, if provided for by the Contract. The Insurant is obliged to return to the Company, on written request, any amounts to be borne by the Insured deriving from the application of a different cover (e.g., due to a higher deductible or coinsurance or, in the case of a service not provided for, for the entire cost thereof). In the event that the service could not be included in the out-of-hospital services, the Insured is obliged, at the request of the Company, to reimburse the entire sum paid by the Company to the Affiliated Facility or to pay directly the amount due to the Affiliated Facility if the Company had not yet made the payment.

Taxes and administrative fees

The following shall be borne by the Insured:

- taxes and stamps
- administrative fees of any kind (e.g., for issuing copies of medical records).

20.2 Procedure to access services - Direct or mixed care scheme

a) Before the service

The Insured shall:

- collect all the documentation required, if requested by these TCIs, to perform the service under the Direct scheme (e.g., medical prescription with indication of the pathology);

- select the affiliated healthcare facility where the service is to be provided, by accessing the reserved area or mobile App, as well as by telephone contact with the Operations Centre (available **24 hours a day, 365 days a year)**. The Network is constantly evolving and affiliated facilities may change even during the period of cover. The list of affiliated facilities is available on the website www.intesasanpaolorbmsalute.it or mobile App;

- contact the selected Network facility and book the service to be provided;

- ask the Company for authorisation to provide the service booked, attaching all the required documentation (in the event of a telephone call, the operators will explain to the Insured how to send the documentation), with at least 48 working hours notice before the day on which the service will be provided.

It should be noted that, including for dental services, the Insured must from time to time request individual authorisation for each service to be provided, and that requests for authorisation received directly from dental practices shall not be considered.

Limited to physical therapy services, the Insured must request authorisation only for the first service provided for by the course of therapy or treatment plan; The remaining authorisations are instead requested directly by the Network's healthcare facility.

Authorisation may be requested through:

- mobile app
- web portal
- dedicated telephone numbers:
  - **800. 90.12.23** from landline and mobile phones (freephone)
  - **+39 0422.17.44.023** for calls from abroad.

Details to be provided

- surname and first name, date of birth and telephone of the Insured who needs the service;
- healthcare facility where the service is provided;
- service to be provided;
- date of the service
- diagnosis or diagnostic question.

Documents to be sent

- valid medical prescription (including electronic medical prescription) in accordance with the regional regulations in force from time to time, **containing the diagnostic question/diagnosis and the pathology for which the specified service is required.**

The prescription must be drawn up by a doctor other than the medical specialist who will (directly or indirectly) provide the service, or, if the prescribing doctor is also the provider of the services performed, the services must be certified by transmission of the relevant report.

For services other than hospitalisation, we may consider that reading the prescription is sufficient and do not require the prescription to be transmitted at this stage.

- **In the event of an accident, the following documents must also be submitted:**
- **emergency room report** within 48 hours of the event, as the accident must be objectively documented. If there are no Emergency Rooms in the place where the accident occurred, the Insured may submit a certificate issued by a substitute public medical facility (drawn up within 48 hours of the event).

For this insurance cover to be operative, the circumstance that the Emergency Room report contains the term "accident" does not in itself determine the eligibility of the claim to be paid under the policy; In order to determine whether there is an accident or not according to the policy it is necessary to examine what is written in the Emergency Room certificate and in the supplementary medical documentation, if any. Situations in which fortuitous, violent, and external illnesses and events coexist must be evaluated on a case-by-case basis in light of the medical documentation submitted.

The Company may request further documents if there are particular situations that make it necessary to carry out in-depth assessments and evaluations before settling the claim, for particular investigative requirements or to comply with specific legal provisions.

How to submit the documents:

- via web portal or mobile app
- by fax: **+ 0422.17.44.523**
- by replying to the e-mail received from the Operations Centre (in case of direct contact with the latter)

If the Operations Centre has positively concluded the administrative, medical and insurance checks on the request made, the authorisation for direct services shall be sent to the Insured **via e-mail or text message** and simultaneously also to the identified affiliated facility. The Insured shall indicate at the time of requesting the medical service whether the authorisation is to be received by text message or e-mail. If the Insured does not have a smartphone, in order to access the healthcare facility, s/he must choose e-mail as the means of receiving the authorisation and, if necessary, print it from any PC.

The text message or email will have a short web link (so-called "tiny link") that will allow the authorisation to be displayed on the device's screen.

The Company will make direct payment of the expenses eligible for compensation under the policy according to the terms of the agreement concluded with the affiliated nursing homes, professionals and clinical centres.

If the Insured are interested in a healthcare facility that is not currently part of the Network made available to them, they may indicate such an entity in order to assess the possibility of affiliation; to this end, it will be sufficient to propose the facility to the Company, sending the request to the following e-mail address: ufficio.convenzioni@intesasanpaolorbmsalute.it

Subject to the minimum notice period of 2 working days (48 hours), the Operations Centre guarantees the response (authorisation/denial) on the outcome of the assessment of the direct care request:

- if the request is received at least 7 working days before the date of the event, the Operations Centre guarantees a response within 2 working days of the Insured's request
- if the request is received between 6 and 4 working days before the date of the event, the Operations Centre guarantees a response within 2 working days before the date of the event

- if the request is received between 3 and 2 working days before the date of the event, the Operations Centre guarantees a response within 1 working day before the date of the event.

This does not affect the Insured's right to give at least 2 working days' (48 hours) advance notice; however, in this case, this minimum advance notice could result in the Operations Centre notifying the Insured, should the authorisation be denied, close to the time scheduled for the use of the service.

In any case, it should be noted that during the start-up phase of the Health Plans, it may not be possible to comply with the aforementioned service levels until the process of acquiring personal data is completed. To this end, all the Insured who intend to make use of a direct care service are invited to contact the Operations Centre as soon as possible.

During access to the affiliated Healthcare Facility, the Insured, in order to receive the authorised service, shall present the authorisation received from the Operations Centre and submit the medical prescription.

The Insured must notify the Operations Centre in advance of any changes and/or additions to the authorised service, so that the new authorisation can be issued, once the necessary administrative and technical/medical checks have been successfully completed.

The waiver of the need to request prior authorisation from the Operations Centre to activate the direct care scheme and in any case for access to affiliated healthcare facilities is provided only for the emergency cases referred to in paragraph b) below.

Any sums not recognised by these terms and conditions of insurance (e.g. deductibles and coinsurance) shall be borne by the Insured..

b) Failure to activate the Operations Centre

If the Insured gains access to affiliated Health facilities without complying with the obligations of prior activation of the Operations Centre, the service cannot be paid under Direct Care or Reimbursement.

c) After the service

Once the service has been rendered, the Insured must countersign the invoice issued by the affiliated facility, which shall indicate the amount to be paid by the Insured (for any services not covered by the Terms and Conditions of Insurance).

Direct payment of expenses, within the terms set out in the Terms and Conditions of Insurance, shall be made upon receipt by the healthcare facility of the invoice and the medical documentation requested from the Insured and/or the healthcare facility (e.g., medical record).

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20.3 Procedure to access services - Payment scheme

a) Hardcopy claim application

In order to obtain compensation as soon as the complete medical documentation is available, the Insured may complete the **Claim Form** (www.intesasanpaolorbmsalute.com, section Group Health Policies – Forms). In the event that this form is not used, the Company will accept the claim application only if all the information on the form is provided in full (including the "Consent to the personal data processing pursuant to the relevant legislation in force", to be signed with a specific signature in addition to that placed at the bottom of the claim application). In any case, the Insured must attach copies of the following documents to the claim application:

1. **receipted expense documentation** (invoices, bills, receipts), issued by a healthcare facility or medical centre. Invoices issued by medical practices or specialists must clearly and legibly indicate the professional's specialisation, which must be consistent with the diagnosis. **All documentation must be fiscally compliant with current legislation. For the payment of expenses incurred for healthcare services under the Italian National Health Service, the invoice or receipt issued at the time of payment by the Local Health Unit or healthcare facility accredited with the Italian National Health Service is required, or the payment receipt issued by Punto Giallo with the booking sheet issued by the Local Health Unit at the time of booking or when the service was provided. The provider will check that the service (which can be found in the appropriate code contained in the aforementioned documents) is one of those provided for by the Health Plan (e.g., expenses incurred for prevention and/or control services are excluded). In order to be able to consider the services as performed under the Italian National Health System co-payment scheme, with the application of the relevant settlement conditions, it is necessary that the expenditure document unequivocally indicates the payment scheme.**
2. **complete medical records and hospital discharge form (HDS), in the event of hospitalisation, including Same-Day Treatment. Please note that a stay in the Emergency Room is not considered a hospitalisation or Same-Day Treatment;**
3. **valid medical prescription** (including electronic) in accordance with the regional regulations in force at the time, stating the nature of the pathology and the services provided, in the case of non-hospital benefits;
4. **detailed medical report stating the nature of the pathology and the services carried out, in the case of outpatient procedure, with a histological report, if any;**
5. **the following document must also be submitted in the event of an Accident:**
   - **emergency room report within 48 hours of the event**, as the accident must be objectively documented. If there are no Emergency Rooms in the place where the accident occurred, the Insured may submit a certificate issued by a substitute public medical facility (drawn up within 48 hours of the event).

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For this insurance cover to be operative, the circumstance that the Emergency Room report contains the term "accident" does not in itself determine the eligibility of the claim to be paid under the policy; In order to determine whether there is an accident or not according to the policy it is necessary to examine what is written in the Emergency Room certificate and in the supplementary medical documentation, if any. Situations in which fortuitous, violent, and external illnesses and events coexist must be evaluated on a case-by-case basis in light of the medical documentation submitted.

The Company may request further documents if there are particular situations that make it necessary to carry out in-depth assessments and evaluations before settling the claim, for particular investigative requirements or to comply with specific legal provisions.

The form and its annexes should be sent to the following address:

PREVIMEDICAL C/O CSU – BOLOGNA (INTERNAL MAIL)

or

Ufficio Liquidazioni UNI.C.A. - PREVIMEDICAL

Casella Postale n. 142

31021 Mogliano Veneto (TV)

The documentation must be in the name of the Insured and the payment will be made to the covered Insured.

For the purposes of the due payment, all insured services must be prescribed by a doctor other than the doctor who will - directly or indirectly - provide the said services.

If the prescribing doctor is also - directly or indirectly - the doctor providing the insured services, the latter must be certified by sending the relevant report.

The services must be provided by specialised personnel (doctor, nurse), accompanied by the relevant diagnosis (indication of the pathology or suspected pathology), and invoiced by a healthcare facility or medical centre. Invoices issued by medical practices or specialists must clearly and legibly indicate the professional's specialisation, which must be consistent with the diagnosis.

For the purposes of a correct evaluation of the claim or to verify the truthfulness of the documentation produced in copy, the Company shall always have the right to request the production of the originals of the aforementioned documentation.

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b) Online payment claim

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

Documentation will be submitted using an optical scanning system, which the Company considers legally equivalent to the original for the purposes of applying this cover. The Company reserves the right to carry out all the necessary checks with doctors and healthcare facilities in order to prevent possible abuse of this channel.

For those who do not have access to the Internet, payment claims may be made through the traditional channel (hardcopy), as described in the previous paragraph.

The Policyholder expressly approves the provisions of articles[6]:

Article 6 - Declarations on circumstances concerning risk - Health Questionnaire
Article 7 - Commencement of Insurance – Tacit Renewal – Right to withdraw
Article 8 - Underwriting of Cover – Change of the Insured
Article 14 - Jurisdiction
Article 18 - Exclusions
Article 19 - Non-insurable Persons
Article 20 - Charges in the event of a claim and procedures to access services

Intesa Sanpaolo RBM Salute S.p.A.
Marco Vecchietti
CEO and General Manager

[Illegible signature]

[6] Article 1341 "General Terms and Conditions of Contract" of the Italian Civil Code.

Annex 1: Summary Sheet

The following are the ceilings/sums insured, coinsurance and deductibles for the various options. Unless otherwise indicated, the ceilings are per Year/Family Unit and the coinsurance/deductibles are per event.

HOSPITALISATION	
Ceiling A and B	€20,000.00 per event/family unit, increased to €40,000.00 for MS
A) Indemnity in lieu for surgical/non-surgical hospitalisation with the Italian National Health System.	
Ceiling	30 days per person/event
Surgical/non-surgical hospitalisation	€80 a day
MS	€160 a day
Pre/Post-op	100% - 90 days/90 days increased to 120 days in case of MS
B) Post-hospitalisation as private service in a public facility	90 days/90 days increased to 120 days in case of MS
Conditions	100% only direct services

ATTACHMENT 2: POLICY IN RESPECT OF NATURAL PERSONS PURSUANT TO ARTICLES 13 AND 14 OF REGULATION (EU) 679/2016 OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL OF 27 APRIL 2016 (HEREINAFTER THE "POLICY") AND CONSENT TO DATA PROCESSING

The Regulation on the "protection of natural persons with regard to the processing of personal data and on the free movement of such data" (hereinafter the "Regulation") contains a series of provisions aimed at ensuring that the processing of personal data is carried out in compliance with the fundamental rights and freedoms of persons. This Policy incorporates the provisions thereof.

SECTION 1 – IDENTITY AND CONTACT DETAILS OF THE DATA CONTROLLER

Intesa Sanpaolo RBM Salute S.p.A., with registered office in Via A. Lazzari n.5, 30174 Venice – Mestre (VE), as the Data Controller (hereinafter also the "Company" or the "Data Controller") processes your personal data (hereinafter the "Personal Data") for the purposes set out in Section 3. For more information please visit the website Intesa Sanpaolo RBM Salute www.intesasanpaolorbmsalute.com and, in particular, the "Privacy" section with all the information regarding the use and processing of Personal Data.

SECTION 2 – CONTACT DETAILS OF THE DATA PROTECTION OFFICER

Intesa Sanpaolo RBM Salute has appointed a "data protection officer" as provided for by the Regulation (also *DPO*). For all matters relating to the processing of your Personal Data and/or to exercise your rights under the Regulation, as listed in Section 7 of this Policy, you may contact the DPO at the following email address: privacy@intesasanpaolorbmsalute.com

SECTION 3 – CATEGORIES OF PERSONAL DATA, PURPOSE AND LEGAL BASIS OF PROCESSING

Categories of Personal Data
The Personal Data that the Company processes are personal data, contact data, data relating to the family unit, policy data, data relating to any claims that concern you, bank data for the settlement of claims, other personal data provided by you, as well as data classified by Article 9.1 of the Regulation as "special categories", such as:

a) Data on health status;
b) data contained in prescriptions and medical reports, invoices from specialists, receipts for the purchase of drugs and medical devices;
c) data relating to insurance services rendered in favour of other Insured Persons, where provided for by the insurance contract.

In addition, within the management of any complaints and disputes, multimedia data (e.g., recordings of telephone calls) may be processed.

Purposes and legal basis for processing:
The Personal Data concerning you, communicated by you to the Company or collected by third parties[1] (in the latter case subject to a check of compliance with the conditions of lawfulness by the third parties), are processed by the Company as part of its activities for the following purposes:

[1] For example, insurance brokers, policyholders of group or individual policies in which you are insured, any jointly obliged parties, other insurance operators (such as agents, insurance brokers, insurance companies, etc.); parties from whom we require information or are required to provide information in order to fulfil your requests (e.g., for issuance or renewal of insurance cover, settlement of a claim, transfer of benefit position, etc.); associations and consortia in the insurance sector; Judiciary, Law Enforcement and other public entities

a) Provision of insurance services and/or products requested by you or available for you
As part of the above, your data will be processed in order to provide you with the services and/or products included under any insurance contracts to which you are a party or by pre-contractual measures taken at your request (including the processing of claims for services rendered, administrative checks and health controls, and the settlement of indirect and direct healthcare cases).

In relation to this purpose, the processing of data may be carried out without your consent, as necessary for the execution of the insurance contract to which you are party or pre-contractual measures taken at your request (article 6.1, letter b, of the Regulation).
In relation to this purpose, the processing of particular data (including data suitable for detecting your health conditions and data relating to the health service received) may be carried out only with your consent, the refusal of which may make it impossible for the Company to fulfil the request (article 6.1, letter a of the Regulation).

b) Service communications relating to the relationship between the Data Subject and the Data Controller and notices
Within the scope of this purpose, your data will be processed to facilitate the possible sending of notices and communications between you and the Data Controller, always within the scope of the execution of any insurance contracts. The provision of such data (e.g., e-mail address or telephone number) will be optional.

In relation to this purpose, the processing of data may be carried out without your consent, as necessary for the execution of the insurance contract to which you are party or pre-contractual measures taken at your request (article 6.1, letter b, of the Regulation).

c) Provision of services online or directly via App
As part of this purpose, your data will be processed to allow you to register in the "Reserved Area" of the Data Controller's website and/or access directly through the Apps for mobile devices (FeelUp and Citrus). These data will be used to identify you as our insured, to provide you with the services provided by your policy, to send you the communications necessary for the management of the guaranteed services (also through push notifications, if activated, you may be sent information on the status of your bookings, reminders or appointment confirmations, feedback on the settlement of claims, statements of claims).

In relation to this purpose, data processing may be carried out without your consent, as necessary to allow you to obtain online services through the Reserved Area or App on your smartphone as part of the execution of the insurance contract to which you are party or pre-contractual measures taken at your request (article 6.1, letter b of the Regulation).

d) Fulfilment of legal obligations related to the execution of insurance contracts
As part of this purpose, your data will be processed in order to comply with legal obligations related to the execution of insurance contracts to which you are party, including anti-terrorism, tax, anti-corruption, insurance fraud prevention requirements, to comply with provisions or requests from supervisory and regulatory authorities (e.g., IVASS regulations and the European Insurance Distribution Directive (IDD) require the assessment of the adequacy of the contract offered for the entire life of the contract) or, finally, to verify the company's compliance with national and supranational laws and regulations of your requests (e.g., to issue or renew insurance cover, to settle a claim, to transfer a pension position, etc.) we may request information from you or you may be required to provide information to us; associations and consortia in the insurance sector; Judiciary, Law Enforcement and other public entities

Your data may also be processed for the management of any complaints (receipt of the complaint, processing, recording in the appropriate register, preparation of the response and sending it).

In relation to this purpose, data processing may be carried out without your consent, as necessary to comply with legal obligations.

e) Extension of the insurance policy in favour of other Insured persons

Within the scope of this purpose, your data and those of your family members will be processed in order to extend the insurance cover to other Insured persons, if provided for by the contract.

In this context, you may be required to provide special categories of data (data disclosing health status, medical reports, etc..) relating to you or your family. This provision of data is necessary to provide you with insurance services, but such data provided may only be processed with your express consent or that of any other Insured concerned, where required by the insurance contract.
For the purpose of extending insurance cover to other Insured Persons, if so provided for in the insurance contract, certain data, including data falling within the category of special data, relating to insurance services rendered in their favour, shall be made known to you, where necessary, for the management of the existing policy, as well as for the verification of the relative cover and the limits guaranteed.

f) Business development and insurance risk management of the Company

As part of this purpose, your data will be processed to develop the Company's business and manage risk. Your data may also be transmitted within the Business Group for administrative purposes. In addition, the processing of your Personal Data is necessary in order to:

- manage any disputes;
- pursue any further legitimate interests, including the verification of complaints on a statistical basis and the recording of telephone calls with you. In the latter case, the Company may process your Personal Data only after having informed you and ascertained that the pursuit of its own legitimate interests or those of third parties does not compromise your rights and fundamental freedoms.

In relation to this purpose, data processing is carried out based on the legitimate interest of the Data Controller (article 6.1, letter f) of the Regulation.

SECTION 4 – CATEGORIES OF RECIPIENTS TO WHOM YOUR PERSONAL DATA MAY BE COMMUNICATED

In order to pursue the above purposes, it may be necessary for the Company to disclose your Personal Data to the following categories of recipients:

a) **Companies belonging to the Intesa Sanpaolo Group.**
b) **Third Parties** (companies, freelance professionals, etc.), e.g.:
   - Previmedical S.p.A.;
   - Mutual Aid Societies;
   - Insurance Companies and Brokers;
   - Companies that perform audit and certification services;
   - Legal departments, in the case of handling complaints and disputes;
   - Health funds;
   - Healthcare facilities and other affiliated healthcare service providers;

- Companies that perform filing, mail printing, and mail handling services;
- Companies entrusted with the management, settlement and payment of claims;
- Companies providing computer, telematic, financial, administrative or other technical/organisational services);
- Banks

c) **Authorities** (e.g., judicial, administrative, etc.) and public information systems established within public administrations, as well as other entities, such as: IVASS (Istituto per la Vigilanza sulle Assicurazioni - Italian Insurance Oversight Agency); ANIA (National Association of Insurance Undertakings); CONSAP (Concessionaria Servizi Assicurativi Pubblici - Italian Public Insurance Service Concessionaire); FIU (Financial Information Unit); Central Accident Records; CONSOB (Italian National Commission for Companies and the Stock Exchange); COVIP (Commissione di vigilanza sui fondi pensione - Italian Pension Funds Oversight Authority); the Bank of Italy; SIA, CRIF, Ministries; Mandatory social insurance agencies, such as INPS, INPDAI, INPGI, etc. Internal Revenue Service and Tax Registry; Judiciary; Law Enforcement; Equitalia Giustizia, Conciliation bodies pursuant to Legislative Decree no. 28 of 4 March 2010.

The Companies and third parties to whom your Personal Data may be disclosed act as: 1) Data Controllers, i.e., entities that determine the purposes and means of the processing of Personal Data; 2) Data Processors, i.e., entities who process Personal Data on behalf of the Data Controller or 3) Joint Data Processors who jointly determine the purposes and means thereof with the Company or 4) appointed by the Data Controller as authorised entities to process such data.
The Data Controller undertakes to rely solely on entities that provide adequate guarantees regarding data protection, and will appoint them as Data Processors pursuant to article 28 of the Regulation.

SECTION 5 – TRANSFER OF PERSONAL DATA TO A THIRD COUNTRY OR INTERNATIONAL ORGANISATION OUTSIDE THE EUROPEAN UNION

Your Personal Data are processed by the Company within the territory of the European Union and are not disseminated.
If necessary, for technical or operational reasons, the Company reserves the right to transfer your Personal Data to countries outside the European Union for which there are "adequacy" decisions of the European Commission, or based on the adequate safeguards or specific derogations provided for by the Regulation.

SECTION 6 – METHODS OF PROCESSING AND STORING PERSONAL DATA

The processing of your Personal Data is carried out using manual and computerised means and in such a way as to ensure the security and confidentiality of the data.
Your Personal Data is kept for a period of time not exceeding that necessary to achieve the purposes for which they are processed, without prejudice to the retention periods provided for by law. In particular, your Personal Data is generally stored for a period of 10 years from the termination of the contractual relationship to which you are a party; or for 12 months from the issue of the requested quotation in the event that this is not followed by the conclusion of the definitive insurance contract. Personal Data may also be processed for a longer period if an act interrupting and/or suspending the statute of limitations justifies the extension of data storage.

SECTION 7 – RIGHTS OF THE DATA SUBJECT
As a data subject you may exercise, at any time, vis-à-vis the Data Controller the rights provided for by the Regulation listed below, by sending a specific request in writing to the following email address privacy@intesasanpaolorbmsalute.com. You may withdraw at any time the consents expressed with this information in the same way.

Any notices and actions taken by the Company, upon exercise of the rights listed below, will be made free of charge. However, if your requests are manifestly unfounded or excessive, in particular because they are repetitive, the Company may charge you a fee, taking into account the administrative costs incurred, or refuse to meet your requests.

1. Right to access

You may obtain confirmation from the Company as to whether or not any processing of your Personal Data is taking place and, if so, obtain access to the Personal Data and information required by Article 15 of the Regulations, including, without limitation: the purposes of the processing, the categories of Personal Data processed, etc.

If Personal Data is transferred to a third country or international organization, you are entitled to be informed of the existence of adequate safeguards relating to the transfer. If requested, the Company may provide you with a copy of the Personal Data being processed. For any additional copies, the Company may charge you a reasonable fee based on administrative costs. If this request is made by electronic means, and unless otherwise specified, the information will be provided to you by the Company in a commonly used electronic format.

2. Right to rectification

You may obtain from the Company the rectification of your Personal Data which are inaccurate as well as, taking into account the purposes of the processing, the integration thereof, if they are incomplete, by providing a supplementary declaration.

3. Right to erasure

You may obtain from the Data Controller the erasure of your Personal Data, if one of the reasons set forth in article 17 of the Regulation exists, including, by way of example, if the Personal Data is no longer necessary in relation to the purposes for which it was collected or otherwise processed or if you have withdrawn the consent on which the processing of your Personal Data is based and there is no other legal basis for processing.

We inform you that the Company cannot proceed with the erasure of your Personal Data: if their processing is necessary, for example, for the fulfilment of a legal obligation, for reasons of public interest, for the establishment, exercise or defence of legal claims.

4. Right to restriction of processing

You may obtain the restriction of the processing of your Personal Data if one of the cases provided for by article 18 of the Regulation applies, including, for example: if you dispute the accuracy of your Personal Data being processed or if your Personal Data is necessary for the establishment, exercise or defence of legal claims, although the Company no longer needs it for processing purposes.

5. Right to data portability

If the processing of your Personal Data is based on consent or is necessary for the performance of a contract or pre-contractual measures and the processing is carried out by automated means, you may:

- request to receive the Personal Data you provide in a structured, commonly used and machine-readable format (e.g.: computer e/o tablet);
- transmit your Personal Data received to another Data Controller without hindrance from the Company.

You may also request that your Personal Data be transmitted by the Company directly to another data controller designated by you, if this is technically feasible for the Company. In this case, it will be your responsibility to provide us with the exact details of the new data controller to which you intend to transfer your Personal Data, and to provide us with a written authorisation to do so.

6. Right to object

You may object at any time to the processing of your Personal Data if the processing is carried out for the performance of an activity in the public interest or in pursuit of a legitimate interest of the Data Controller (including profiling activity).
Should you decide to exercise the right to object described herein, the Company will refrain from further processing your personal data, unless there are legitimate grounds for processing (grounds overriding the interests, rights and freedoms of the data subject), or the processing is necessary for the establishment, exercise or defence of legal claims.

7. Right to lodge a complaint with the Italian Personal Data Protection Authority
Without prejudice to your right to take action in any other administrative or jurisdictional court, if you believe that the processing of your Personal Data by the Data Controller is in breach of the Regulation and/or the applicable legislation, you may lodge a complaint with the competent Data Protection Authority.

SECTION 8 – PROCESSING OF SPECIAL CATEGORIES OF PERSONAL DATA

In relation to the processing of special categories of personal data (including data relating to the health status and the health service received), used exclusively for the insurance and settlement activities that concern you (e.g., processing claims for reimbursement of health checks carried out), an express manifestation of consent is required, without prejudice to the specific cases provided for by the Regulations which allow the processing of such Personal Data even in the absence of consent.

[i] Last updated on 22 January 2021

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Share Capital €160,000,000 fully paid-in - Chamber of Commerce of Treviso TIN and entry in the Companies Register of Treviso-Belluno 05796440963, VAT reg. no. 11991500015, Company registered under no. 1.00161 in the Italian Register of Insurance Companies, authorised to carry out insurance business by ISVAP Order no. 2556 of 17/10/2007 (OJ no. 255 02/11/2007).