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

UNICA FUND – RBM TuttoSalute! Product Uni.C.A.

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

What kind of insurance is it?

The cover supplements the collective BASE Health Plan and provides for the reimbursement of expenses incurred, following injury or illness, for hospital services (hospitalisations, etc.) and hospital services.

What is covered by the insurance?

The Company shall pay the following expenses:

- ✓ Disability and Non-Self-Sufficiency
- ✓ Care Services;
- ✓ Medicinal Products;
- ✓ Co-pay in healthcare expenses for the purchase of medicinal products;
- ✓ Eyewear;
- ✓ Lenses and optical materials;
- ✓ Alternative medicine;
- ✓ Aesthetic medicine;
- ✓ Coinsurance and deductibles under the Base health plan remaining payable by the Insured following the primary cover.

The cover provides for a maximum annual limit (ceiling) of the indemnities recognised by the single benefits.

What is not covered by the insurance?

- × Persons with alcoholism, drug addiction and HIV seropositivity are not insurable.
- × Injuries prior to the signing of the policy.
- × New insured who have already reached the age of 85 on 31 December 2021 are not permitted to join the policy.
- × There are also a number of cases in which insurance cover does not operate. For example, accidents resulting from the practice of certain sports (including air sports and car races) and from participation in professional competitions and related training are excluded, as well as 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 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 also excluded. This description of excluded risks is merely a summary and does not include all the cases of exclusion provided for by 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.
- ! The policy provides for waiting periods, i.e., periods during which insurance cover is not active and therefore expenses incurred cannot be reimbursed and/or authorised.

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 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.
- In the event of an accident, if the damaging event is attributable to the responsibility of a third party, the Insured is obliged to notify the Company of the name and address of the third party responsible, as well as to forward the report from the Emergency Room.
- In the event of a road accident - at the same time as the first claim or first request for direct healthcare, regarding medical services that have become necessary as a result of the accident - the Insured is required to send the Company the accident report drawn up by the police or the CID Form (amicable accident report).
- In order to obtain the settlement of claims, it is necessary to submit the medical in the name of the Insured.

When and how should I pay?

The premium shall be paid in monthly instalments in advance.

When does cover begin and when does it end?

- The insurance contract has a duration of 2 years from midnight on the day of the date of signing the insurance contract and paying the premium; expires at midnight of the two-year membership period (2022-2023)
- 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.

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: TUTTOSALUTE! 2.0

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 Company.

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 extent of the Company's commitment is related to the limits and sums insured agreed with the policyholder.

What is NOT covered by the insurance?

Excluded risks	The following expenses are excluded from payment: 1. procedures to correct or eliminate myopia, except as provided for by the BASE Health Plan; 2. dental prostheses, paradontopathies, dental treatments and dental examinations, except as provided for by the BASE Health Plan; 3. medical services for aesthetic purposes, with the exception of reconstructive plastic surgery required as a result of an accident or demolitive procedures or cancer surgery (limited to the anatomical site of injury) and those involving children under the age of three; 4. 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; 5. hospitalisation caused by the need for the Insured to receive care from third parties in order to carry out the elementary activities of daily living, 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; 6. intoxications and injuries resulting from: - alcohol abuse; - use of hallucinogens; - non-therapeutic use of psychotropic drugs and narcotics; 7. voluntary non-therapeutic abortion; 8. the correction or elimination of malformations or physical defects, unless they result from a pathology or are the consequence of an accident, and without prejudice to what is provided in the BASE Health Plan; 9. all procedures and interventions for the purpose of assisted reproduction, except as provided for by the BASE Health Plan. In any case, the daily indemnity in lieu is not recognised for this type of procedure; 10. 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; 11. clinical check-ups; 12. acupuncture, except as provided for by the BASE Health Plan; 13. 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; 14. psychotherapy, except as provided for by the BASE Health Plan; 15. 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; 16. the consequences of war, insurrections, earthquakes and volcanic eruptions; 17. accidents resulting from the practice of air sports in general or any sport practised professionally; 18. 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; 19. injuries sustained and illnesses occurring during the performance of military service or service in lieu thereof, voluntary enlistment, recall for mobilisation or for exceptional reasons; 20. expenses incurred as a result of the following mental illnesses: psychosis, neurotic personality disorders and other non-psychotic mental disorders, mental retardation and in any case all illnesses included in chapter 5 (MENTAL DISORDERS) of the 9th revision of the International Classification of Diseases (ICD9-CM) of the World Health Organisation and/or the taking of psychotropic drugs for therapeutic purposes; 21. 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 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 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/Person and the coinsurance/deductibles are per event.

MODULE NO. 1 – NON-SELF-SUFFICIENCY AND CARE SERVICES		
	HIGH PROTECTION	**TOTAL PROTECTION**
a) DISABILITY AND NON-SELF-SUFFICIENCY	**indemnity of €7,000**	**indemnity of €10,000**
Conditions	**4 ADLs out of 6**	**4 ADLs out of 6**
Waiting period	**no waiting period**	**no waiting period**

b) CARE SERVICES	**In Network only**	**In Network only**
In Network	**- Medical Consultation - Permanent Emergency Medical Service - Second opinion - Tutoring - Medical Transport (Ceiling €1,500) - Repatriation of Body (Ceiling €2,000) - Medical Repatriation (Ceiling €700)**	**- Medical Consultation - Permanent Emergency Medical Service - Second opinion - Tutoring - Medical Transport (Ceiling €1,500) - Repatriation of Body (Ceiling €2,000) - Medical Repatriation (Ceiling €700)**
Waiting period	**no waiting period**	**no waiting period**
MODULE 2 – MEDICINAL PRODUCTS		
	HIGH PROTECTION	**TOTAL PROTECTION**
a) GENERICS		
Ceiling	**€350**	**€500**
Conditions	**25% coinsurance**	**25% coinsurance**
Waiting period	**45 days (no waiting period in case of injury)**	**90 days (no waiting period in case of injury)**
b) CO-PAY		
Ceiling	**€350**	**€500**
Conditions	**reimbursement of 75% of co-pay**	**reimbursement of 75% of co-pay**
Waiting period	**45 days (no waiting period in case of injury)**	**45 days (no waiting period in case of injury)**
MODULE 3 – EYEWEAR		
	HIGH PROTECTION	**TOTAL PROTECTION**
a) EYEGLASSES	**1 pair per year, following change in visual acuity**	**1 pair per year, following change in visual acuity**
Ceiling	**€ 130**	**€ 150**
Conditions:		
In Network	**deductible €15**	**deductible €15**
Out of Network	**deductible €30**	**deductible €30**
Waiting period	**45 days**	**45 days**
b) OTHER ITEMS	**In Network only - as per list**	**In Network only - as per list**
Ceiling	**unlimited**	**unlimited**
Conditions	**differentiated deductible for each service**	**differentiated deductible for each service**
Out of Network	**not included**	**not included**
Waiting period	**no waiting period**	**no waiting period**
MODULE 4 – ALTERNATIVE MEDICINE		
	HIGH PROTECTION	**TOTAL PROTECTION**
	ALTERNATIVE OR COMPLEMENTARY MEDICINE SERVICES: - acupuncture performed by physician - osteopathic treatments - chiropractic treatments	**ALTERNATIVE OR COMPLEMENTARY MEDICINE SERVICES: - acupuncture performed by physician - osteopathic treatments - chiropractic treatments**
Ceiling	**€350**	**€ 550**
Conditions:		
In Network	**reimbursement €35 per session**	**reimbursement €35 per session**
Out of Network	**reimbursement €35 per session**	**reimbursement €35 per session**

Waiting period	**45 days (no waiting period in case of injury)**	**45 days (no waiting period in case of injury)**
MODULE 5 – AESTHETIC MEDICINE		
	HIGH PROTECTION	**TOTAL PROTECTION**
	OUTPATIENT SURGICAL PROCEDURES	**OUTPATIENT SURGICAL PROCEDURES**
	In Network only - as per list	**As per Module 12 list**
Ceiling	**€ 3,500**	**€ 5,000**
Conditions:		
In Network	**€350 deductible per event**	**€350 deductible per event**
Out of Network	**25% coinsurance non indemnifiable minimum of €1,000**	**25% coinsurance non indemnifiable minimum of €1,000**
Pre	**30 days**	**30 days**
Post	**60 days**	**45 days**
Waiting period	**45 days (no waiting period in case of injury)**	**45 days (no waiting period in case of injury)**
MODULE 6 - COINSURANCE AND DEDUCTIBLES		
OPTIONS AND ANNUAL CEILINGS PER PERSON		
	Option	**Annual ceiling per person**
	Option A	€250.00
	Option B	€ 500.00
	Option C	€750.00
	Option D	€ 1,000.00

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

What to do in case of a claim?	**Reporting a claim:** The claim must be reported by the Insured or his/her assignees to the Company as soon as they have the opportunity, communicating it to the Company 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 has the right to access, through prior activation by the Operations Centre, some health services provided by the facilities belonging to the Network made available by the Company.
	Processing by other companies: not included.
	Limitation: pursuant to Article 2952 of the Italian Civil Code, the right to pay the premium instalments shall lapse one year after the individual due dates. Other rights deriving from the insurance contract lapse in two years from the day on which the event on which the right is based occurred.
Incorrect or reticent statements	Incorrect or reticent statements by the Policyholder relating to the circumstances that influence the risk assessment may result in the total or partial loss of the indemnity, as well as the termination of the effects of the insurance, pursuant to Articles 1892, 1893 and 1894 of the Italian Civil Code. The Insured must notify the Company in writing of any worsening of or reduction in risk.
Company obligations	The Company shall: **a) Direct care scheme** - issue a Health Voucher within 7 calendar days of receipt of the complete authorisation request for which the technical, medical, and investigation has had a positive outcome. The Insured, subject to prior booking, may receive the service at the facility indicated on the Voucher within 30 days of the issue of the latter. The performance of the service within 30 days is guaranteed solely at the facilities proposed by the Operations Centre. **b) Payment scheme** - make payment to the Insured within 20 calendar days of receipt of the request for payment complete with all the necessary medical and expense documentation.

When and how should I pay?

Premium	The premium is always determined for insurance periods of one year. The premium shall be paid in monthly instalments (in advance) for each month with the last day of the month preceding the month in question (e.g., for April, the premium must be paid by 31 March). However, solely with regard to the first instalment of January and the second instalment of February, the payment shall be made together with the next instalment of March due on February 28th. The premium shall be paid by the Policyholder to the Company by bank transfer.
Reimbursement	Not included.

When does cover begin and when does it end?

Duration	The insurance contract shall take effect from midnight 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 following payment and shall expire at midnight, on 01/01/2024. The policy has waiting periods (during which cover is not active).
Suspension	Not included.

How can I cancel my policy?

Change of mind after underwriting	Not included.
Termination	There are no cases, other than those provided for by law, in which the Policyholder has the right to terminate the contract.

Who is this product for?

The insurance product is intended for personnel in service under an Italian contract with the UniCredit Group, who intend to obtain 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 n. 5, 30174 Venezia – 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 n. 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 INSURED (CALLED *INSURANCE HOME*), SO AFTER SIGNING YOU CAN CONSULT THIS AREA AND USE IT TO MANAGE THE CONTRACT ELECTRONICALLY.

INTESA SANPAOLO
RBM SALUTE

Insurance Contract covering
medical expenses for illness and accident
drawn up in accordance with the Guidelines issued by ANIA (Italian Insurance Company Association) following the outcome of the “Simple and Clear Contracts” Working Table (6 February 2018)

RBM TUTTOSALUTE! UNICA

Insurance Contract
for reimbursement of healthcare costs

Patto Chiaro Salute - Policy verified by Adiconsum

FORM FI0070
Version 01/01/2022

Please read the Terms and Conditions of Insurance carefully before taking out the policy

Intesa Sanpaolo RBM Salute S.p.A. Sede Legale e Direzione Generale: Via A. Lazzari 5, 30174 Venezia-Mestre (VE) Uffici amministrativi: Viale Stelvio 55/57, 20159 Milano comunicazioni@pec.intesasanpaolorbmsalute.com Capitale Sociale Euro 160.000.000 Codice fiscale e n. Iscrizione Registro Imprese di Venezia Rovigo 05796440963 Società partecipante al Gruppo IVA “Intesa Sanpaolo” - Partita IVA 11991500015 (IT11991500015) e soggetta all’attività di direzione e coordinamento di Intesa Sanpaolo Vita S.p.A. Iscritta all’Albo delle imprese di assicurazione e riassicurazione al n. 1.00161 Appartenente al Gruppo Assicurativo Intesa Sanpaolo Vita, iscritto all’Albo dei Gruppi Assicurativi al n. 28.

Società del gruppo INTESA SANPAOLO

CONTENTS

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 in "underlined and bold" font.

Section I

GLOSSARY

Insured: person whose interest is covered by the insurance.

Insurance: the contract whereby the Company undertakes to indemnify the Insured, within the agreed limits, for the damage caused to the Insured by an event.

Nursing care: care provided by a health professional with a specific qualification (nursing diploma). Any person who does not meet this qualification is excluded.

Waiting period: the period of time between the effective date of insurance and the commencement of cover.

Fund: Uni.C.A Cassa Assistenza, with registered office in Via San Protaso no. 1, postcode 20121 - MILAN TIN 97450030156, a welfare entity qualified by law also pursuant to Article 51 of Presidential Decree no. 917/1986, to receive contributions and to undertake the contracting of the health programme for tax and contribution purposes.

TCIs: Terms and Conditions of Insurance.

Operations Centre: it is the Previmedical structure that provides, with costs borne by the Company, the services attributed to it by the policy. Previmedical – Servizi per Sanità Integrativa S.p.A. provides administrative and liquidation services to the Company's clients; Previmedical is based in Italy, via Forlanini 24 – 31022 Borgo Verde, Preganziol, Treviso.

Medical centre: A facility with hospital health management that is 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).
It may also not be used for hospitalisation, and it must not be for the treatment of cosmetic issues.

Certificate of Insurance: the document issued by the Company which contains the key elements of the insurance (commencement and expiry of the policy, the premium, the details of the Policyholder, the insured parties, etc.).

Bariatric Surgery: Also known as "obesity surgery". Surgical procedures aimed at reducing food intake by decreasing the stomach's capacity (restrictive surgery) or the capacity of the intestine to absorb food (malabsorptive procedures).

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

Policyholder: Uni.C.A Cassa Assistenza, with registered office in Via San Protaso no. 1, postal code 20121 – MILAN TIN 97450030156, the entity that stipulates the insurance contract in its own interest or in the interest of the person to whom it belongs and who is responsible for the payment of the premium.

Physical defect: organic alteration that is clinically static and stabilised and is either acquired, the result of previous morbid process or traumatic lesion, or derives from a congenital anomaly.

Event/Date of Event:

- **Hospital Services -** the individual hospitalisation, also for Same-Day treatments, or individual outpatient surgery. The date of the event shall be the date of admission to hospital, or if there was no admission to hospital, the date of the outpatient surgical procedure.
- **Out-of-Hospital Services –** the date of the claim is the date the service was provided; for Form no. 1 "Non-self-sufficiency and Care Services" the time of occurrence of the claim is to be understood as the supervening state of non-self-sufficiency

Deductible: the part of the expenses incurred, determined in a fixed manner, which remains the responsibility of the Insured. Unless otherwise specified, it applies per event.

Indemnity: the sum due by the Company in the event of a claim.

Accident: an event due to a fortuitous, sudden, violent and external cause whose direct and exclusive consequence is objectively ascertainable and documentable physical injury.

Outpatient surgical procedure: surgical procedure performed without inpatient hospitalisation.

Healthcare Facility: Hospital, university clinic, university facility or private clinic regularly authorised, according to law and by the competent authorities, to provide hospital care.
Spa establishments, convalescent and residential homes, health camps and nursing homes for dietary and aesthetic purposes or long-term care facilities are not considered "healthcare facilities".

IVASS: Istituto per la Vigilanza sulle Assicurazioni, name assumed by ISVAP from 1 January 2013.

LTC - Long Term Care: Care to provide protection and assistance for non-self-sufficient persons.

Long-term hospitalisation: hospitalisation in which the physical conditions of the Insured are such that recovery cannot be achieved with medical treatment and the stay in a healthcare facility is made necessary by health care or physical therapy measures mainly for maintenance purposes.

Illness: any progressive alteration in health that is not due to an accident. Pregnancy is not considered an illness.

Mental Illness: all mental disorders (such as psychosis, neurosis, depressive syndromes, disorders of psychological development, anorexia, bulimia, etc.) included in Chapter 5 (MENTAL DISORDERS) of the 9th revision of the International Classification of Diseases (ICD9-CM of the WHO).

Ceiling: the maximum reimbursable expense up to which, for each insurance year, the Company provides cover.

Alternative or Complementary Medicine: "Unconventional" medical practices defined by the Italian National Federation of Medical and Dental Boards: acupuncture; phytotherapy; ayurvedic medicine; anthroposophic medicine; homeopathic medicine; Chinese traditional medicine; homotoxicology; osteopathy; chiropractic.

Module: one or more of the insurance covers provided by the Policy.

Non-self-sufficiency: The inability, tending to be permanent and in any case lasting for at least 90 days, to independently carry out elementary activities of daily living related to mobility, nutrition and personal hygiene in at least 4 of the 6 primary activities of daily living (ADL).

Family Unit: the entire household as defined in the article "Insurable persons" of the BASE Health Plan for the employees of the UniCredit Group with contracts under Italian law.

Basic Health Plan: the illness/accident policy underwritten by the Policyholder in favour of the Insured for staff in service: Nuova Plus, Extra, Extra4, Extra5

Policy: The documents that describe and prove the insurance.

Premium: The amount due by the Policyholder to the Company.

Complaint: a statement of dissatisfaction in writing with the Company or an intermediary relating to an insurance contract or service; requests for clarification or information, claims for compensation for damages or fulfilment of contract, are not considered complaints.

Direct care scheme: access, through prior activation of the Operations Centre, to health services provided by the affiliated facilities belonging to the Network, with direct payment to the affiliated facilities of the amount due for the service received by the Insured, net of any sums that remain at his/her expense, within the limits and conditions established by the TCIs.

Reimbursement scheme: the reimbursement of expenses incurred for services received from freely chosen healthcare facilities that are not part of the Network, within the limits and at the conditions established by the TCIs.

Coinsurance: the part of the expenses incurred, determined on a percentage basis, which remains the responsibility of the Insured. Unless otherwise specified, it applies per event.

Accident: the occurrence of the harmful event for which the insurance is stipulated.

Professional Sports: activities carried out by athletes who practice a sport for remuneration, on a continuous basis or as a main activity with respect to other professional activities.

Healthcare facility: any nursing home, institute, or hospital in Italy or abroad, duly authorised in accordance with legal requirements and by the competent authorities, to provide hospital healthcare**.**

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.

Durable support: any instrument which enables the Policyholder to store information directed personally to him/her in such a way that it can be easily retrieved during a period of time adequate for the purposes for which the information is intended, and which permits the unaltered reproduction of the information stored.

CHAPTER 1 – GENERAL INFORMATION

Art. 1. General information on the insurance company

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[1].
Website: www.intesasanpaolorbmsalute.com
Email: info@intesasanpaolorbmsalute.com
CERTIFIED E-MAIL: comunicazioni@pec.intesasanpaolorbmsalute.com

Art. 2. Contractual waiting periods

The policy provides for waiting periods, i.e., periods during which insurance cover is not active and therefore expenses incurred cannot be authorised (see Modules nos. 1-6).
A waiting period is the period of time during which no compensation is paid even though the insurance cover has been activated.
The Terms and Conditions of Insurance indicate the waiting periods, differentiated by type of event; Therefore, depending on the services rendered, the waiting period may vary in duration.
If the policy has been issued in substitution, without interruption (and therefore without a day of lack of insurance cover), of another policy, taken out with the Company for the same risk and concerning the same Insured and the same covers, the following waiting terms shall apply:

- from the day on which the substituted policy took effect, for the benefits and the ceilings set out by the latter;
- from the day on which this insurance takes effect, limited to the greater sums and different benefits provided for by it.

This also applies in the case of variations occurring during the course of the same contract.
In the event of non-payment of a premium instalment, the waiting period provided for in the policy in the "Waiting period" paragraph of the various covers shall be applied again.

Example:
a) Let's assume that the insurance contract is effective from 01/08/2022.
An Insured who, on 15/08/2022, purchased 1 pair of eyeglasses (Module 3) will not be entitled to reimbursement as there is a 45-day waiting period.
b) Let's assume that the insurance contract is effective from 01/08/2019.
An Insured who, on 25/09/2022, purchased 1 pair of eyeglasses (Module 3) will be entitled to reimbursement under the terms of the policy.

Art. 3. Adjustment of premium and insured amounts

The sums insured and premiums are not indexed; therefore, there is no automatic adjustment of the amounts with respect to reference indices, such as the ISTAT index.

Art. 4. Right to withdraw - change of mind

The Policyholder's right to withdraw is provided.

Art. 5. Limitation and forfeiture of rights under the contract

Pursuant to Article 2952 of the Italian Civil Code, the right to pay the premium instalments shall lapse one year after the individual due dates. Other rights deriving from the insurance contract lapse in two years from the day on which the event on which the right is based occurred.

Art. 6. 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.

[1] OJ 255 of 2 November 2007

CHAPTER 2 – GENERAL RULES GOVERNING THE AGREEMENT

Art. 7. Subject-matter of the agreement
The subject-matter of this agreement is the reimbursement of medical expenses incurred by the Insured as a result of injury or illness, as defined in the attached Modules, up to the ceilings and/or sums insured and with the limits indicated in the individual Modules.

Art. 8.Participation/Persons insurable
Participation in the plans by the entitled persons admitted to the agreement is absolutely free and is completed on a voluntary basis by means of a "Policy Certificate" issued by the Company for each individual entitled person.
The certificates shall have the same expiry date as that of the agreement and the starting date defined by Uni.C.A. as set out in article 17 below, "Commencement of Insurance".
Free choice of the 6 Modules present in the agreement is provided for solely at the time of the activation of this insurance cover, through access to the subscribers' area of the portal dedicated to health assistance for the UniCredit Group.
Therefore, it will not be possible to change the choice made of the freely activated Module(s) at a date following to the activation of this insurance cover.

9.1 - Insurable Persons
The insurance is valid for employees in service with contracts under Italian law of the UniCredit Group and their family units, as identified in the definition of family unit, provided that they are registered with Uni.C.A. and on condition that they are all already insured under the BASE Health Plan, subject to payment, by the entitled person, of the premium corresponding to the freely activated Module(s).
Voluntary participation for all entitled persons of this insurance cover provides for the obligation to activate the cover for the entire family unit already insured under the BASE Health Plan.
In the event that the family unit does not participate in the BASE Health Plan, voluntary participation in this insurance cover is understood to be valid only for the entitled person.

Art. 9.Change of Insured – Premium adjustment
Dismissals or hirings which will occur during the insurance annum must be communicated by the associated companies, by electronic means, to Uni.C.A. and sent by the latter to the Company.

10.1 - Inclusion of new entitled persons during the year
The Insurance shall take effect from midnight on the date of the employee's hiring and provided that the Company is notified within 90 days of the aforesaid date, by means of written communication to be forwarded to the Company. Failure to provide such notice within 90 days of the date of hire shall result in the employee being ineligible for this insurance cover.
For inclusions made during the period of insurance, the premium shall be calculated at the rate of:

- 100% of the annual premium, if inclusion takes place in the first six months of insurance;
- 60% of the annual premium if inclusion takes place in the second six months of insurance.

The ceilings for the following Modules nos. 1 to 6 are in any case to be understood as 100%.
Without prejudice to the terms of the waiting period provided for in the paragraph "Waiting Period" of Modules Nos. 1 to 6 below (where applicable), the covers are active from midnight on the date of the employee's hiring and participation in this insurance cover.

10.2 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 the policy 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 midnight 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. Failure to provide such notice within 90 days of the date of hire shall result in the employee being ineligible for this insurance cover.
For inclusions made during the period of insurance, the premium shall be calculated at the rate of:

- 100% of the annual premium, if inclusion takes place in the first six months of insurance;
- 60% of the annual premium if inclusion takes place in the second six months of insurance.

The ceilings for the following Modules nos. 1 to 6 are in any case to be understood as 100%.

10.3 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) reaching of the age of 85, subject to the possibility of maintaining cover under the terms of Article 30 “Non-insurable Persons";
g) exclusion of the employee resolved on in accordance with the Articles of Association and the Regulations by the Board of Directors of the Policyholder;
h) termination of the BASE Health Plan.

In the aforementioned cases, the insurance shall cease 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 cases of exclusion of the employee resolved in accordance with the Articles of Association and Regulations by the Board of Directors of the Policyholder, dismissals for just cause and subjective just reason or terminations with the establishment of an employment relationship with a company outside the UniCredit Group in which cases the employee and any insured family members shall immediately cease to be covered with the occurrence of the event.

Article 11 Changes

No changes to the covers and conditions under this insurance may be introduced and/or imposed by the Company except by specific agreement.

Art. 12. Jurisdiction

Without prejudice to the right of the Parties to resort to conciliation systems where existing, for the resolution of disputes deriving from this Contract, the Judicial Authority having jurisdiction is identified for any dispute between the Company and Uni.C.A.; the Judicial Authority where the Company has its headquarters has jurisdiction.

CHAPTER 3 - TERMS AND CONDITIONS OF INSURANCE

Art. 13. Subject-matter of Insurance

The Company ensures, in addition to the provisions of the BASE Health Plan for employees of the UniCredit Group, the reimbursement of expenses incurred by the Insured during the validity of this contract and made necessary as a result of illness or injury, as defined in the attached Modules.
These expenses are reimbursedup to the ceilings and/or sums insured and with the limits indicated in the individual attached Modules.

NB: If the policy has been issued in substitution, without interruption (and therefore without a day of lack of insurance cover), of another policy, taken out with the Company for the same risk and concerning the same Insured and the same covers, the following waiting terms indicated in the individual attached Modules shall apply:

- from the day on which the substituted policy took effect, for the benefits and the ceilings set out by the latter;
- from the day on which this insurance takes effect, limited to the greater sums and different benefits provided for by it.

This also applies in the case of variations occurring during the course of the same contract.

Art. 14. Presence of multiple insurance coverage

This insurance cover is active:

- as secondary cover, in addition to the covers provided by the BASE Health Plan, and in relation to the portion remaining for the Insured following payment for primary cover;
- as primary cover, in the case of covers that are not present in the BASE Health Plan.

In both cases, the deductibles and coinsurance provided for in this insurance cover shall apply.

Art. 15. Declarations on circumstances concerning risk - Health Questionnaire

If the Policyholder and/or the Insured provide incomplete and/or false information which may influence the evaluation of the risk, they may lose or have their right to indemnity limited, as well as determine the termination of the effects of the insurance in accordance with Articles 1892, 1893 and 1894 of the Italian Civil Code.
NB: If the Policyholder and/or Insured do not provide the appropriate information, the contract may not be appropriate for their needs.
The Insured must notify the company in writing of any worsening of or reduction in risk. For example, in the event of a change of residence there may be an aggravation of risk that must be reported.
There is no requirement to complete and sign the Health Questionnaire.

Art. 16. Other insurance/coverage

The 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 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 also applies in the event that the same risk is covered by contracts stipulated by the Insured with Entities, Funds, or Supplementary Health Funds.
This is without prejudice to the Company's right of recourse and, therefore, to the Company's right to recover any sum paid by way of payment of damages.
The right of recourse shall mean that the Company may demand return of the amount paid to cover the damages.

Art. 17. Commencement of Insurance
The insurance shall take effect from midnight 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 following payment and shall expire at midnight, on 01/01/2024.

Art. 18. Tacit renewal
This contract shall run for 2 (two) years from the date on which it takes effect; it shall in any event be deemed to have expired on its natural date of expiry without any obligation to give notice.

Art. 19. Territorial Validity
The insurance is valid for the entire world, with the understanding that the indemnity shall be paid in Euros.
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 (European Central Bank) quotation.

Art. 20. Obligations to submit documents
Before taking out the insurance, the following documents must be delivered to the Policyholder and the Insured:
a) PID;
b) Additional PID;
c) Terms and Conditions of Insurance;
d) Privacy Policy (consent to personal data processing).

Art. 21. Extraordinary corporate transactions
In cases of:
- amendments to the articles of association concerning a change of company name or transfer of the registered office,
- transfer, even in part, of the portfolio, merger or demerger of the portfolio,

the Company shall, within a period of ten days from the effective date of the transaction, provide the Policyholder and/or Policyholder with detailed information.

Art. 22. Tax regime
Premiums are subject to tax of 2.50%.
Indemnities are not subject to taxation.
Taxes and other expenses established by the law, present and future, related to the premium and to the accessories of the policy and of the acts dependent on it are at the expense of the Policyholder..

Art. 23. Insurance on behalf of others
The obligations of the policy must be borne by the Policyholder even when the latter stipulates the contract on behalf of others, except for those which by their nature can only be fulfilled by the Insured, as provided for by Article 1891 of the Italian Civil Code.

Art. 24. Jurisdiction
Any dispute between the Company and Policyholder shall be referred to the judicial authorities at the place of residence or domicile of the Policyholder.

Art. 25. Disputes: conciliation
For disputes related to the 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 competent2.
An attempt at conciliation is a condition for admissibility of court proceedings.
If the dispute is not settled by conciliation, the Parties are free to resort to judicial authorities.

Art. 26. Law applicable to the Contract – Reference to the provisions of the Law
The contract shall be governed by Italian law.
Italian rules shall apply to whatever is not regulated otherwise.

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

Section II

CHAPTER 1 - LIMITS AND EXCLUSIONS OF INSURANCE

Art. 27. Prior pathologies
The insurance covers illnesses (including chronic and relapsing conditions), malformations and pathological states, which have given rise to treatment, exams, or diagnoses, prior to the effective date of the policy.

Art. 28. Exclusions
The following expenses are excluded from payment:
1. procedures to correct or eliminate myopia, except as provided for by the BASE Health Plan;
2. dental prostheses, paradontopathies, dental treatments and dental examinations, except as provided for by the BASE Health Plan;
3. medical services for aesthetic purposes, with the exception of reconstructive plastic surgery required as a result of an accident or demolitive procedures or cancer surgery (limited to the anatomical site of injury) and those involving children under the age of three;
4. 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;
5. hospitalisation caused by the need for the Insured to receive care from third parties in order to carry out the elementary activities of daily living, 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;
6. intoxications and injuries resulting from:
   - alcohol abuse;
   - use of hallucinogens;
   - non-therapeutic use of psychotropic drugs and narcotics;
7. voluntary non-therapeutic abortion;
8. the correction or elimination of malformations or physical defects, unless they result from a pathology or are the consequence of an accident, and without prejudice to what is provided in the various BASE Health Plans;
9. all procedures and interventions for the purpose of assisted reproduction, except as provided for by the BASE Health Plan. In any case, the daily indemnity in lieu is not recognised for this type of procedure;
10. 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;
11. clinical check-ups;
12. acupuncture, except as provided for by the BASE Health Plan;
13. 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;
14. psychotherapy, except as provided for by the BASE Health Plan;
15. 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;
16. the consequences of war, insurrections, earthquakes and volcanic eruptions;
17. accidents resulting from the practice of air sports in general or any sport practised professionally;
18. 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;

19. injuries sustained and illnesses occurring during the performance of military service or service in lieu thereof, voluntary enlistment, recall for mobilisation or for exceptional reasons;
20. expenses incurred as a result of the following mental illnesses: psychosis, neurotic personality disorders and other non-psychotic mental disorders, mental retardation and in any case all illnesses included in chapter 5 (MENTAL DISORDERS) of the 9th revision of the International Classification of Diseases (ICD9-CM) of the World Health Organisation and/or the taking of psychotropic drugs for therapeutic purposes[3]
21. 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.

Art. 29. Non-insurable Persons

New insured who have already reached the age of 85 on 1 January 2022 are not permitted to join the policy.

However, individuals who were already covered under the previous health plan and who turn 85 during the term of the contract may continue to be insured until 31 December 2023.

Up to the age limit for this cover, mentally handicapped persons or persons taking psychotropic medications for therapeutic purposes will also be eligible for cover, as provided for by the exclusions".

However, the Insured who turn 85 during the term of the contract may continue to be insured until 31 December 2023, subject to a 25% premium increase from the year following their 85th birthday.

CHAPTER 2 - PAYMENT OF INDEMNITY

Art. 30. Charges in the event of a 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.

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

[3] The clarifications introduced regarding the exclusion in question are the result of the indications given to companies by IVASS (formerly ISVAP) following Italy's implementation of the UN Convention on the Rights of Persons with Disabilities by Law no. 18 of 3 March 2009. These indications required companies to specify - on the subject of mental disorders - which healthcare services were eligible for payment as a result of permanent mental illnesses that existed prior to inclusion in the cover.

- 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
- service provided in an affiliated facility
- 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:
  - details of the will
  - declaration if the will is the last valid and has not been challenged
  - 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:
  - the Insured died without leaving a will,
  - the personal details, age and capacity to act of the legitimate heirs,
  - 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.

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).

Operational Procedure - Direct Care Scheme

a) Before the service

The Insured shall:

- collect all the documentation required, if requested by these TCI, 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. A prescription is not required for preventive services (health and dental).**
  A prescription from a primary care physician is required for the following services: high specialization, diagnostic tests and specialist visits.
  For services other than those indicated, 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 case of accident:**
  - ⇨ **emergency room report**, 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);
  - ⇨ **if the damaging event is attributable to the responsibility of a third party, also the name and address of the third party responsible. In the event of a road accident** - at the same time as the first request for direct healthcare, regarding medical services that have become necessary as a result of the accident **- the Insured is required to also send the Company the accident report drawn up by the police or the CID Form** (amicable accident report).

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 health 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:

For hospital services:

- 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.

For out-of-hospital services:

- if the request is received at least 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

In the event that the Insured gains access to affiliated healthcare facilities without complying with the obligations of prior activation of the Operations Centre, the service cannot be paid directly or submitted for 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).

d) ***Exception: cases of medical urgency (for hospitalisation only)***

If it is absolutely impossible to contact the Operations Centre in advance, limited to pathologies/illnesses in an acute phase or in the case of objectively ascertainable physical injuries produced by an event due to a fortuitous, violent and external cause,

- the Insured or other authorised person may request authorisation within 5 days of the start of hospitalisation and in any case before being discharged from the affiliated facility, if less days have passed
- the Insured or other authorised person contacts the Operations Centre which sends a form to be filled out by the health facility where the Insured is hospitalised
- **the form, once completed, is to be returned to the Operations Centre** (by replying to the email received from the Operations Centre or by fax **0422.17.44.523**) **attaching** the report of the doctor

who ordered emergency hospitalisation or, in case of accident, the report of the Emergency Room, drawn up within 24 hours of the event.

The final assessment of whether or not the case is actually serious is carried out by the Operations Centre; the activation of the urgency procedure is subject to this assessment.
The urgency procedure cannot be activated for hospitalisations under direct care abroad, for which the Insured must always receive prior authorisation from the Operations Centre.

Operating Procedure - 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 Individual 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).**
2) **complete medical records and hospital discharge form (HDS), in the event of hospitalisation, including Same-Day Treatment (if provided for by the activated Module). 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. A prescription from a primary care physician is required for the following services: high specialization, diagnostic tests and specialist visits (if provided for by the activated Module);**
4) **detailed medical report stating the nature of the pathology and the services carried out, in the case of outpatient procedure (if provided for by the activated Module);**
5) **certificate issued by a duly qualified ophthalmologist or optometrist, certifying the change in visual acuity, in the case of the purchase of eyewear (if covered by the selected option), excluding disposable lenses. Please note that it should be specified whether this is a prescription for first lenses; please also note that it is necessary to submit the certificate of conformity issued by the optician, as per Italian Legislative Decree no. 46 of 24/02/97.**
Contact lens claims must be submitted together by the end of the year (if provided for by the activated Module);
6) **medical report on the causes of the loss of self-sufficiency, drawn up on the appropriate form supplied by the Company, and other clinical documentation (hospitalisations, specialist visits, instrumental tests), as well as the results of a diagnostic assessment including the result of a**

test evaluating cognitive functions (for example, Folstein's M.M.S. exam), in the case of loss of self-sufficiency (if provided for by the activated Module);

7) **medical prescription (bearing the cost of the individual products with the stamp of the pharmacy) and invoice (or nominative receipt) with the specification of the medicines purchased and adhesive labels, in the case of purchase of medicines (if provided for by the activated Module);**
8) **whatever else may be necessary for the proper settlement of claims.**

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.

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.

c) Return of amounts unduly paid

In the event of hospitalisation in a direct care facility, if, either during or after hospitalisation, it is ascertained that the policy is not valid or that there are conditions or elements that determine the inoperability of the benefit or the ineffectiveness of the insurance cover, the Company shall notify the

Insured in writing, who shall return to the Company all sums unduly paid by the latter to the medical facility, if already paid by the Company to the affiliated facility and/or doctors, or shall pay both the affiliated facility and doctors directly.

d) ONLINE CONSULTATION - HOME INSURANCE
If the Insured has access to the Internet, s/he may use the following function.

"EasyUnica" mobile app
The Insured may access "EasyUnica" to access the following features:
- display and modification of personal and contact data;
- display of details to contact the Operations Centre;
- search for affiliated Network facilities;
- display of the status and details of cases;
- pre-activation of 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).

For the purposes of Article 1341 of the Italian Civil Code, Uni.C.A. declares that s/he expressly approves the provisions of the following articles:

TERMS AND CONDITIONS OF INSURANCE
Article 9 Participation/Persons insurable
Article 10 Change of Insured
Article 15 Declarations on circumstances concerning risk - Health Questionnaire
Article 16 Other insurance/coverage
Article 17 Commencement of Insurance
Article 18 Tacit renewal
Article 28 Prior pathologies
Article 29 Exclusions
Article 30 Non-insurable Persons
Article 31 Charges in the event of a claim

Intesa Sanpaolo RBM Salute S.p.A.
Marco Vecchietti
Amministratore Delegato e Direttore Generale

MODULE No. 1 – NON-SELF-SUFFICIENCY AND CARE SERVICES (FOR FAMILY MEMBERS ONLY)

HIGH Level of Protection

A) DISABILITY AND NON-SELF-SUFFICIENCY

The cover operates for cases of non-self-sufficiency in the performance of primary activities (as described in "*Criteria for ascertaining loss of self-sufficiency*") deriving from injury or illness/surgery (all called "cause"), which determine, based on the calculation rules provided for the present cover, a score equal to 10 points in at least 4 of the 6 primary activities of daily living (ADLs), tending to be permanent and in any case lasting for at least 90 days ("event").

The eligibility to the cover starts upon completion of the event, i.e., after 90 days from the onset of a state of non-self-sufficiency eligible for benefits based on the above rules, caused by accident or illness/surgery.

The cover shall operate with reference to the cases of non-self-sufficiency identified above that occur during the period of validity of the cover.

The Company shall cover the expenses of care mentioned below only if incurred for services rendered during the period of validity of the policy, and subject to verification by the Company of the documentation necessary to attest the state of non-self-sufficiency of the Insured, as described in the paragraph "Criteria for ascertaining loss of self-sufficiency" below.

Said verification shall be carried out in the shortest possible time and shall be completed within 15 days of the date of receipt by the Company of the said complete documentation. Once the verification has been completed, the Company shall notify the Insured of the outcome, which may consist in notification of recognition of the cover and of the approved score for the state of non-self-sufficiency (10 points in at least 4 of the 6 primary activities of daily living, or ADL), rejection of cover or suspension of the assessment if it is necessary to supplement the submitted documentation.

Said communication must take place by the deadline indicated above by sms or e-mail; otherwise, the Company shall send the letter containing the result of the verification by the indicated term.

To this end, 12 months after the completion of the event and annually for each year of cover, the Company may request the Insured to send within 30 (thirty) days the documentation necessary to verify the persisting state of non-self-sufficiency in coverage, a necessary condition for the cover to continue to operate.

Alternatively, the Company may send, with prior notice, its own medical representative to carry out the aforesaid exam on site. At the time of the annual verification, based on the documentation collected or the visit made, Company shall confirm the score assigned in the previous year to the state of non-self-sufficiency of the Insured, or shall re-evaluate it in the event of any changes that may have occurred.

The terms and procedures for carrying out the annual verification of the persisting state of non-self-sufficiency and for communicating the results to the Insured are the same as those established for the verification of eligibility for the cover.

Insured Sum

In the event that the Insured is in the conditions indicated in the section "*Criteria for ascertaining loss of self-sufficiency*", the Company shall cover the expenses for care services to the Insured against appropriate proof of expenditure (such as notices, invoices, etc.) within the annual limit of €7,000 and for as long as this insurance cover is operative, provided that the Insured's state of non-self-sufficiency persists during this period of time.

Criteria for assessing loss of self-sufficiency (ADL – Activities of Daily Living)
In order to ascertain the state of non-self-sufficiency, the situation of the Insured shall be evaluated with respect to his/her capacity to independently carry out the activities of daily living: Bathing, dressing and undressing, grooming, mobility, toileting and eating.
The evaluation shall be made based on the following table, applied by the attending physician and accompanied by a medical report drawn up by said physician on the causes of the loss of self-sufficiency, drawn up using the appropriate form provided by the Company, and by clinical documentation (hospitalisations, specialist visits, instrumental exams) attesting to the reasons that have led to the diagnosis of the pathology causing the loss of self-sufficiency.

Bathing:
1st degree: the Insured is able to bathe and/or shower completely by him/herself: score 0
2nd degree: the Insured Person requires help getting into and/or out of the bathtub: score 5
3rd degree: the Insured Person requires help getting into and/or out of the bathtub and during bathing: score 10

Ability to dress and undress:
1st degree: the Insured is able to dress and undress completely by him/herself: score 0
2nd degree: the Insured requires help dressing and/or undressing either the upper or lower part of the body: score 5
3rd degree: the Insured requires help dressing and/or undressing both the upper and lower part of the body: score 10

Ability to groom:
1st degree: the Insured is capable of performing the following sets of activities identified as (1), (2) and (3) independently and without help from third parties:
(1) go to the bathroom
(2) wash, brush teeth, comb, dry, shave
(3) take care of personal hygiene after going to the bathroom:
score 0
2nd degree: the Insured requires help for at least one and no more than two of the above sets of activities (1), (2) and (3): score 5
3rd degree: the Insured requires help for all of the above sets of activities (1), (2) and (3): score 10

Ability to ensure one's own mobility:
1st degree: the Insured is able to get up independently from the chair and bed and to move around without help from third parties: score 0
2nd degree: the Insured requires help getting around, possibly including technical aids such as a wheelchair, crutches. S/he is, however, able to get up independently from his/her chair and bed: score 5
3rd degree: the Insured requires help getting up from a chair and bed and moving around: score 10

Toileting:
1st degree: the Insured is completely continent: score 0
2nd degree: the Insured has urine or faecal incontinence at most once a day: score 5
3rd degree: the Insured is completely incontinent and technical aids such as a catheter or colostomy are used: score 10
Ability to eat and drink:
1st degree: the Insured is fully and independently capable of consuming beverages and prepared and served food: score 0
2nd degree: the Insured requires help with one or more of the following preparatory activities:
- chop/cut food
- peel fruit

- open a container/box
- pour beverages into a glass
score 5
3rd degree: the Insured is unable to independently drink from a glass and eat from a plate. Artificial feeding is part of this category: score 10.

In any case, the Company reserves the right to have the Insured medically examined by its own fiduciary in order to evaluate the Insured's actual condition.
The Company reserves the right to request the sending of any document it deems necessary to evaluate the Insured's state of health.

TERMS AND CONDITIONS OF LIQUIDATION
Waiting period
There shall be no Waiting period for benefits under this cover.

B) CARE SERVICES
The following care services are also included in the cover:

- **Specialist medical telephone consultation**

When the Insured requires a medical specialist telephone consultation, the Operations Centre can make available **24 hours a day, every day, including Saturdays, Sundays and holidays** a team of specialists with whom to speak directly to receive information of first necessity.
The service does not provide diagnosis or prescriptions.

- **Permanent emergency medical service**

When the Insured, following an accident or illness, needs to receive feedback as part of general and specialised medical advice (in particular, cardiology, gynaecology, orthopaedics, geriatrics, neurology and paediatrics), s/he can contact the Operations Centre **24 hours a day, every day, including Saturdays, Sundays and holidays**. The unit dedicated to the service deals directly with both telephone contacts with the patients and with the doctors/paramedics, allowing the patients to receive constant feedback through a continuous medical presence.
There is no charge to the Insured for the call.
The costs for the any procedures and/or house calls shall be charged to the Insured, applying however the agreed rates.

- **Second opinion**

The Insured, after having provided the Operations Centre with the clinical documentation in his/her possession, can receive a second medical opinion from the best specialised facilities and centres of excellence in Italy and abroad, complementary to a previous medical evaluation. The service is available **24 hours a day, every day, including Saturdays, Sundays and holidays.**

- **Tutoring**

The Insured may have access to constant and professionally qualified support to identify the most appropriate therapeutic paths, to organise personalised prevention programmes and to manage his/her own care needs. The service is provided through the coordination of professionals and means made available within the care network and through the interaction and constant support with the medical consulting unit.
There is no charge to the Insured for this service from a landline telephone.

- **Medical transport, medical transfer and medical repatriation**

If the Insured, following hospitalisation for injury or illness, needs to be transported from his/her home to a healthcare facility or hospital or vice versa or from one healthcare facility or hospital to another,

s/he may request that the transport be carried out directly, with management thereof by the Operations Centre.
In this case, the Company covers the payment of transport costs up to a maximum of 300 km of total distance (round trip) with a maximum of €1,500 per event.
In case of injury or sudden illness, the cover is also valid for the simple return to home, if the Insured is at least 50 km from it with a maximum of €700 per event.
Benefits are not payable for transportation for ongoing treatment.

- **Repatriation of body**

In the event of death abroad during hospitalisation (as a result of surgery eligible for payment under this insurance cover), the Company shall provide for the payment of expenses for the return of the body with a maximum limit of €2,000 per event.

TERMS AND CONDITIONS OF LIQUIDATION
Waiting period
There shall be no Waiting period for benefits under this cover.

TOTAL Level of Protection

A) DISABILITY AND NON-SELF-SUFFICIENCY

The cover operates for cases of non-self-sufficiency in the performance of primary activities (as described in "*Criteria for ascertaining loss of self-sufficiency*") deriving from injury or illness/surgery (all called "cause"), which determine, based on the calculation rules provided for the present cover, a score equal to 10 points in at least 4 of the 6 primary activities of daily living (ADLs), tending to be permanent and in any case lasting for at least 90 days ("event").
The eligibility to the cover starts upon completion of the event, i.e., after 90 days from the onset of a state of non-self-sufficiency eligible for benefits based on the above rules, caused by accident or illness/surgery.
The cover shall operate with reference to the cases of non-self-sufficiency identified above that occur during the period of validity of the cover.
The Company shall cover the expenses of care mentioned below only if incurred for services rendered during the period of validity of the policy, and subject to verification by the Company of the documentation necessary to attest the state of non-self-sufficiency of the Insured, as described in the paragraph "Criteria for ascertaining loss of self-sufficiency" below.
Said verification shall be carried out in the shortest possible time and shall be completed within 15 days of the date of receipt by the Company of the said complete documentation. Once the verification has been completed, the Company shall notify the Insured of the outcome, which may consist in notification of recognition of the cover and of the approved score for the state of non-self-sufficiency (10 points in at least 4 of the 6 primary activities of daily living, or ADL), rejection of cover or suspension of the assessment if it is necessary to supplement the submitted documentation.
Said communication must take place by the deadline indicated above by sms or e-mail; otherwise, the Company shall send the letter containing the result of the verification by the indicated term.
To this end, 12 months after the completion of the event and annually for each year of cover, the Company may request the Insured to send within 30 (thirty) days the documentation necessary to verify the persisting state of non-self-sufficiency in coverage, a necessary condition for the cover to continue to operate.
Alternatively, the Company may send, with prior notice, its own medical representative to carry out the aforesaid exam on site. At the time of the annual verification, based on the documentation collected or

the visit made, Company shall confirm the score assigned in the previous year to the state of non-self-sufficiency of the Insured, or shall re-evaluate it in the event of any changes that may have occurred.
The terms and procedures for carrying out the annual verification of the persisting state of non-self-sufficiency and for communicating the results to the Insured are the same as those established for the verification of eligibility for the cover.

Insured Sum
In the event that the Insured is in the conditions indicated in the section "*Criteria for ascertaining loss of self-sufficiency*", the Company shall cover the expenses for care services to the Insured against appropriate proof of expenditure (such as notices, invoices, etc.) within the annual limit of €10,000 and for as long as this insurance cover is operative, provided that the Insured's state of non-self-sufficiency persists during this period of time.

Criteria for assessing loss of self-sufficiency (ADL – Activities of Daily Living)
In order to ascertain the state of non-self-sufficiency, the situation of the Insured shall be evaluated with respect to his/her capacity to independently carry out the activities of daily living: Bathing, dressing and undressing, grooming, mobility, toileting and eating.
The evaluation shall be made based on the following table, applied by the attending physician and accompanied by a medical report drawn up by said physician on the causes of the loss of self-sufficiency, drawn up using the appropriate form provided by the Company, and by clinical documentation (hospitalisations, specialist visits, instrumental exams) attesting to the reasons that have led to the diagnosis of the pathology causing the loss of self-sufficiency.

Bathing:
1st degree: the Insured is able to bathe and/or shower completely by him/herself: score 0
2nd degree: the Insured Person requires help getting into and/or out of the bathtub: score 5
3rd degree: the Insured Person requires help getting into and/or out of the bathtub and during bathing: score 10

Ability to dress and undress:
1st degree: the Insured is able to dress and undress completely by him/herself: score 0
2nd degree: the Insured requires help dressing and/or undressing either the upper or lower part of the body: score 5
3rd degree: the Insured requires help dressing and/or undressing both the upper and lower part of the body: score 10

Ability to groom:
1st degree: the Insured is capable of performing the following sets of activities identified as (1), (2) and (3) independently and without help from third parties:
(1) go to the bathroom
(2) wash, brush teeth, comb, dry, shave
(3) take care of personal hygiene after going to the bathroom:
score 0
2nd degree: the Insured requires help for at least one and no more than two of the above sets of activities (1), (2) and (3): score 5
3rd degree: the Insured requires help for all of the above sets of activities (1), (2) and (3): score 10

Ability to ensure one's own mobility:
1st degree: the Insured is able to get up independently from the chair and bed and to move around without help from third parties: score 0
2nd degree: the Insured requires help getting around, possibly including technical aids such as a wheelchair, crutches. S/he is, however, able to get up independently from his/her chair and bed: score 5
3rd degree: the Insured requires help getting up from a chair and bed and moving around: score 10

Toileting:
1st degree: the Insured is completely continent: score 0
2nd degree: the Insured has urine or faecal incontinence at most once a day: score 5
3rd degree: the Insured is completely incontinent and technical aids such as a catheter or colostomy are used: score 10

Ability to eat and drink:
1st degree: the Insured is fully and independently capable of consuming beverages and prepared and served food: score 0
2nd degree: the Insured requires help with one or more of the following preparatory activities:
- chop/cut food
- peel fruit
- open a container/box
- pour beverages into a glass
score 5
3rd degree: the Insured is unable to independently drink from a glass and eat from a plate. Artificial feeding is part of this category: score 10.

In any case, the Company reserves the right to have the Insured medically examined by its own fiduciary in order to evaluate the Insured's actual condition.
The Company reserves the right to request the sending of any document it deems necessary to evaluate the Insured's state of health.

TERMS AND CONDITIONS OF LIQUIDATION
Waiting period
There shall be no Waiting period for benefits under this cover.

B) CARE SERVICES

The following care services are also included in the cover:

- **Specialist medical telephone consultation**

When the Insured requires a medical specialist telephone consultation, the Operations Centre can make available **24 hours a day, every day, including Saturdays, Sundays and holidays** a team of specialists with whom to speak directly to receive information of first necessity.
The service does not provide diagnosis or prescriptions.

- **Permanent emergency medical service**

When the Insured, following an accident or illness, needs to receive feedback as part of general and specialised medical advice (in particular, cardiology, gynaecology, orthopaedics, geriatrics, neurology and paediatrics), s/he can contact the Operations Centre **24 hours a day, every day, including Saturdays, Sundays and holidays**. The unit dedicated to the service deals directly with both telephone contacts with the patients and with the doctors/paramedics, allowing the patients to receive constant feedback through a continuous medical presence.
There is no charge to the Insured for the call.
The costs for the any procedures and/or house calls shall be charged to the Insured, applying however the agreed rates.

- **Second opinion**

The Insured, after having provided the Operations Centre with the clinical documentation in his/her possession, can receive a second medical opinion from the best specialised facilities and centres of excellence in Italy and abroad, complementary to a previous medical evaluation. The service is available **24 hours a day, every day, including Saturdays, Sundays and holidays.**

- **Tutoring**

The Insured may have access to constant and professionally qualified support to identify the most appropriate therapeutic paths, to organise personalised prevention programmes and to manage his/her own care needs. The service is provided through the coordination of professionals and means made available within the care network and through the interaction and constant support with the medical consulting unit.
There is no charge to the Insured for this service from a landline telephone.

- **Medical transport, medical transfer and medical repatriation**

If the Insured, following hospitalisation for injury or illness, needs to be transported from his/her home to a healthcare facility or hospital or vice versa or from one healthcare facility or hospital to another, s/he may request that the transport be carried out directly, with management thereof by the Operations Centre.
In this case, the Company covers the payment of transport costs up to a maximum of 300 km of total distance (round trip) with a maximum of €1,500 per event.
In case of injury or sudden illness, the cover is also valid for the simple return to home, if the Insured is at least 50 km from it with a maximum of €700 per event.
Benefits are not payable for transportation for ongoing treatment.

- **Repatriation of body**

In the event of death abroad during hospitalisation (as a result of surgery eligible for payment under this insurance cover), the Company shall provide for the payment of expenses for the return of the body with a maximum limit of €2,000 per event.

TERMS AND CONDITIONS OF LIQUIDATION

Waiting period

There shall be no Waiting period for benefits under this cover.

MODULE No. 2 – MEDICINAL PRODUCTS

HIGH Level of Protection

A) DRUGS

The cover provides for the payment of expenses for the purchase of medicinal products including "equivalents" (or generics), i.e., containing the same quantity of active ingredient and having the same bioavailability as another branded medicine with an expired patent, which are included in the "medicinal products" category of the Informatore Farmaceutico published by Codifa, available in all pharmacies, (therefore excluding homeopathic medicines, galenic medicines and parapharmaceuticals), prescribed by the attending physician or specialist.
The Insured must submit the medical prescription in copy and the regular invoice (or nominative receipt) in his/her name with the specification of the products purchased and the adhesive labels; the indication on the prescription, by the pharmacist, of the cost of the single products with the stamp of the pharmacy together with the receipt issued by it for the total amount will be valid for the purposes of compensation.

TERMS AND CONDITIONS OF LIQUIDATION/PAYMENT

Waiting period

There is a 45-day waiting period.
There is no waiting period in case of injury.

Ceiling

The ceiling per year and per person provided for this module is as follows:

- €350

Deductible/Coinsurance

Payment scheme

Coinsurance of 25% shall be applied to the expense incurred.

B) CO-PAY IN HEALTHCARE EXPENSES FOR THE PURCHASE OF MEDICINAL PRODUCTS

The cover provides for the reimbursement of the co-pay of healthcare expenses incurred by the Insured for the purchase of medicinal products, included in the "medicinal products" category of the Informatore Farmaceutico published by Codifa, available in all pharmacies (therefore excluding parapharmaceuticals as well as homeopathic and galenic medicines), prescribed by the attending physician or specialist.
The Insured shall submit a copy of the medical prescription (red Italian National Health System prescription) and the regular invoice (or a nominative receipt with the medicine adhesive labels) in his name, specifying the products purchased; the indication on the prescription, by the pharmacist, of the cost of the single products with the stamp of the pharmacy together with the receipt issued by it for the total amount will be valid for the purposes of compensation.

TERMS AND CONDITIONS OF LIQUIDATION/PAYMENT
Waiting period
There is a 45-day waiting period.
There is no waiting period in case of injury.

Ceiling
The ceiling per year and per person provided for this module is as follows:

- €350

Deductible/Coinsurance
Payment scheme
Coinsurance of 25% on the share of co-pay shall be applied.

Example:
Payment scheme
Ceiling €350.00
Claim €100.00
25% coinsurance
Indemnity €75.00 (€100.00 – 25%)

TOTAL Level of Protection

A) DRUGS

The cover provides for the payment of expenses for the purchase of medicinal products including "equivalents" (or generics), i.e., containing the same quantity of active ingredient and having the same bioavailability as another branded medicine with an expired patent, which are included in the "medicinal products" category of the Informatore Farmaceutico published by Codifa, available in all pharmacies, (therefore excluding homeopathic medicines, galenic medicines and parapharmaceuticals), prescribed by the attending physician or specialist.
The Insured must submit the medical prescription in copy and the regular invoice (or nominative receipt) in his/her name with the specification of the products purchased and the adhesive labels; the indication on the prescription, by the pharmacist, of the cost of the single products with the stamp of the pharmacy together with the receipt issued by it for the total amount will be valid for the purposes of compensation.

TERMS AND CONDITIONS OF LIQUIDATION/PAYMENT
Waiting period
There is a 45-day waiting period.
There is no waiting period in case of injury.

Ceiling
The ceiling per year and per person provided for this module is as follows:

- €500

Deductible/Coinsurance
Payment scheme
Coinsurance of 25% shall be applied to the expense incurred.

B) CO-PAY IN HEALTHCARE EXPENSES FOR THE PURCHASE OF MEDICINAL PRODUCTS

The cover provides for the reimbursement of the co-pay of healthcare expenses incurred by the Insured for the purchase of medicinal products, included in the "medicinal products" category of the Informatore Farmaceutico published by Codifa, available in all pharmacies (therefore excluding parapharmaceuticals as well as homeopathic and galenic medicines), prescribed by the attending physician or specialist.
The Insured shall submit a copy of the medical prescription (red Italian National Health System prescription) and the regular invoice (or a nominative receipt with the medicine adhesive labels) in his name, specifying the products purchased; the indication on the prescription, by the pharmacist, of the cost of the single products with the stamp of the pharmacy together with the receipt issued by it for the total amount will be valid for the purposes of compensation.

TERMS AND CONDITIONS OF LIQUIDATION/PAYMENT

Waiting period

There is a 45-day waiting period.
There is no waiting period in case of injury.

Ceiling

The ceiling per year and per person provided for this module is as follows:

- €500

Deductible/Coinsurance

Payment scheme

Coinsurance of 25% on the share of co-pay shall be applied.

Example:
Payment scheme
Ceiling €500.00
Claim €100.00
25% coinsurance
Indemnity €75.00 (€100.00 – 25%)

MODULE NO. 3 – EYEWEAR

HIGH Level of Protection

A) EYEGLASSES

The cover provides for the payment of expenses incurred by each Insured for the purchase of 1 pair of eyeglasses (lenses and frames) correcting vision per year following a change in visual acuity certified by a duly authorised ophthalmologist or optometrist.

TERMS AND CONDITIONS OF PAYMENT
There is a 45-day waiting period.

Ceiling
The Company shall provide for the payment of the expenses of this cover up to a maximum of €130.00 per year and per person.

Deductible/Coinsurance
At affiliated opticians
A deductible of €15 per pair of eyeglasses shall be applied.

At non-affiliated opticians
A deductible of €30 per pair of eyeglasses shall be applied.

B) OTHER ITEMS

The cover provides for the payment of expenses incurred by each Insured for the purchase of eyeglasses (lenses and frames) or contact lenses correcting vision per year following a change in visual acuity certified by a duly authorised ophthalmologist or optometrist.
This cover is provided **solely in the event that the Insured makes use of affiliated opticians**.

TERMS AND CONDITIONS OF PAYMENT
Waiting period
There shall be no Waiting period for benefits under this cover.

Ceiling
This cover provides for an **unlimited ceiling** for the Insured.

Deductible/Coinsurance
The expenses for the services provided to the Insured shall be settled in full directly by the Company to the affiliated optician, leaving the Insured with only a fixed deductible for each service, as indicated in the following table.

Description of service	
LENSES AND OPTICAL MATERIALS	
	Deductible
Daily 30 lenses	€15.90
Daily 90 lenses	€42.08
Daily 30 toric lenses	€21.51
Daily 90 toric lenses	€56.10
Weekly 6 lenses	€17.77
Monthly 1 lens	€5.61
Monthly 3 lenses	€14.03
Monthly 6 lenses	€25.25
Monthly 3 toric lenses	€32.73
Monthly 6 toric lenses	€65.45
Annual soft lenses (per pair)	€70.13
Annual soft toric lenses (per pair)	€168.30
Rigid lenses (per pair)	€187.00
Gas permeable contact lenses	€117.81
Monthly cosmetic lenses (per pair)	€20.57
Saline solution	€1.87
Peroxide	€0.39
Single solution	€4.68
Detergent	€6.55
Eyewash	€6.55
Enzymes	€9.35
Blank organic lenses	€19.64
Anti-glare organic lenses	€49.56
Organic lenses, 1.67, anti-glare	€75.74
Organic lenses, 1.74, anti-glare	€145.86
Organic lenses, anti-glare	€107.53
Progressive lenses	€140.25
Ophthalmic lens, unbreakable material	€18.70
Ophthalmic lens, unbreakable material, anti-scratch coating	€23.38
Ophthalmic lens, unbreakable material, anti-glare coating	€39.27
Bifocal lens, unbreakable mat., Disc 28, anti-scratch coating	€65.45
Bifocal lens, unbreakable mat., Disc 28, anti-glare coating	€93.50
Bifocal lens, unbreakable mat., Disc 28, anti-glare coating, latest generation	€98.18
Transitions VI 1.5, anti-scratch	€65.45
Transitions VI 1.5, anti-glare	€88.83
Transitions VI 1.6, anti-scratch	€88.83

Transitions VI 1.6, anti-glare	€116.88
Transitions VI 1.6, AsF, anti-scratch	€102.85
Transitions VI 1.6, AsF, anti-glare	€135.58
Uncoated glass single vision lens	€18.70
Glass single vision lens, anti-glare coating	€37.40
Uncoated photochromic glass single vision lens	€32.73
Photochromic glass single vision lens, anti-glare coating	€46.75
Uncoated 1.6 glass single vision lens	€ 28.05
1.6 glass single vision lens, anti-glare coating	€46.75
Uncoated 1.6 photochromic glass single vision lens	€46.75
1.6 photochromic glass single vision lens, anti-glare coating	€65.45
Uncoated 1.7 titanium glass single vision lens	€42.08
1.7 titanium glass single vision lens, anti-glare coating	€ 60.78
1.8 lanthanum glass single vision lens, anti-glare coating	€140.25
1.9 lanthanum glass single vision lens, anti-glare coating	€187.00
Celluloid and/or metal frame	€84.15
Rimless frame (a day)	€ 121.55

Example:
Direct care scheme
Unlimited ceiling
Cost of progressive eyeglasses €400.00
Deductible €140.25
Authorised benefit €400.00, of which €259.75 borne by the Company and €140.25 by the Insured

TOTAL Level of Protection

A) EYEGLASSES

The cover provides for the payment of expenses incurred by each Insured for the purchase of 1 pair of eyeglasses (lenses and frames) correcting vision per year following a change in visual acuity certified by a duly authorised ophthalmologist or optometrist.

TERMS AND CONDITIONS OF PAYMENT
There is a 45-day waiting period.

Ceiling
The Company shall provide for the payment of the expenses of this cover up to a maximum of €150.00 per year and per person.

Deductible/Coinsurance
At affiliated opticians

A deductible of €15 per pair of eyeglasses shall be applied.

At non-affiliated opticians
A deductible of €30 per pair of eyeglasses shall be applied.

Example:
Direct care scheme
Ceiling €150.00
Claim eyeglasses €220.00
Deductible €15.00
Authorised benefit €220.00, of which €150.00 borne by the Company and €70.00 by the Insured

Payment scheme
Ceiling €150.00
Claim eyeglasses €220.00
Deductible €30.00
Indemnity €150.00

B) OTHER ITEMS

The cover provides for the payment of expenses incurred by each Insured for the purchase of eyeglasses (lenses and frames) or contact lenses correcting vision per year following a change in visual acuity certified by a duly authorised ophthalmologist or optometrist.
This cover is provided **solely in the event that the Insured makes use of affiliated opticians**.

TERMS AND CONDITIONS OF PAYMENT

Waiting period

There shall be no Waiting period for benefits under this cover.

Ceiling

This cover provides for an **unlimited ceiling** for the Insured.

Deductible/Coinsurance

The expenses for the services provided to the Insured shall be settled in full directly by the Company to the affiliated optician, leaving the Insured with only a fixed deductible for each service, as indicated in the following table.

Description of service	
LENSES AND OPTICAL MATERIALS	
	Deductible
Daily 30 lenses	€ 14.45
Daily 90 lenses	€ 38.25
Daily 30 toric lenses	€ 19.55
Daily 90 toric lenses	€ 51.00
Weekly 6 lenses	€ 16.15
Monthly 1 lens	€ 5.10
Monthly 3 lenses	€ 12.75
Monthly 6 lenses	€ 22.95
Monthly 3 toric lenses	€ 29.75
Monthly 6 toric lenses	€ 59.50

Annual soft lenses (per pair)	€ 63.75
Annual soft toric lenses (per pair)	€ 153.00
Rigid lenses (per pair)	€ 170.00
Gas permeable contact lenses	€ 107.10
Monthly cosmetic lenses (per pair)	€18.70
Saline solution	€ 1.70
Peroxide	€ 0.35
Single solution	€ 4.25
Detergent	€ 5.95
Eyewash	€ 5.95
Enzymes	€ 8.50
Blank organic lenses	€ 17.85
Anti-glare organic lenses	€ 45.05
Organic lenses, 1.67, anti-glare	€ 68.85
Organic lenses, 1.74, anti-glare	€ 132.60
Organic lenses, anti-glare	€ 97.75
Progressive lenses	€ 127.50
Ophthalmic lens, unbreakable material	€ 17.00
Ophthalmic lens, unbreakable material, anti-scratch coating	€ 21.25
Ophthalmic lens, unbreakable material, anti-glare coating	€ 35.70
Bifocal lens, unbreakable mat., Disc 28, anti-scratch coating	€ 59.50
Bifocal lens, unbreakable mat., Disc 28, anti-glare coating	€ 85.00
Bifocal lens, unbreakable mat., Disc 28, anti-glare coating, latest generation	€ 89.25
Transitions VI 1.5, anti-scratch	€ 59.50
Transitions VI 1.5, anti-glare	€ 80.75
Transitions VI 1.6, anti-scratch	€ 80.75
Transitions VI 1.6, anti-glare	€ 106.25
Transitions VI 1.6, AsF, anti-scratch	€93.50
Transitions VI 1.6, AsF, anti-glare	€ 123.25
Uncoated glass single vision lens	€ 17.00
Glass single vision lens, anti-glare coating	€ 34.00
Uncoated photochromic glass single vision lens	€ 29.75
Photochromic glass single vision lens, anti-glare coating	€ 42.50
Uncoated 1.6 glass single vision lens	€ 25.50
1.6 glass single vision lens, anti-glare coating	€ 42.50
Uncoated 1.6 photochromic glass single vision lens	€ 42.50
1.6 photochromic glass single vision lens, anti-glare coating	€ 59.50
Uncoated 1.7 titanium glass single vision lens	€ 38.25
1.7 titanium glass single vision lens, anti-glare coating	€ 55.25
1.8 lanthanum glass single vision lens, anti-glare coating	€ 127.50

1.9 lanthanum glass single vision lens, anti-glare coating	€ 170.00
Celluloid and/or metal frame	€ 76.50
Rimless frame (a day)	€ 110.50

Example:
Direct care scheme
Unlimited ceiling
Cost of progressive eyeglasses €400.00
Deductible €127.50
Authorised benefit €400.00, of which €272.50 borne by the Company and €127.50 by the Insured

MODULE NO. 4 – ALTERNATIVE MEDICINE

HIGH Level of Protection

Alternative or Complementary Medicine Services:
Expenses for "unconventional" medical practices defined by the Italian National Federation of Boards of Physicians and Dentists, such as exams and treatments of:

- Acupuncture performed by physician;
- osteopathy;
- chiropractic;

provided that they are accompanied by a medical report with the description of the pathology and the indication for consequent treatment and are carried out by a physician or at a Medical Centre, or by personnel with a diploma qualifying to exercise.
The cover does not include services provided in gyms, gymnastic sports clubs, beauty studios, health hotels, medical hotels, wellness centres even if they have a medical centre.

TERMS AND CONDITIONS OF LIQUIDATION/PAYMENT

Waiting period
There is a 45-day waiting period.
There is no waiting period in case of injury.

Ceiling
The ceiling per year and per person provided for this cover is as follows:

- €350

Deductible/Coinsurance
In facilities affiliated with the Company
In the case of use of facilities affiliated with the Company, the expenses for the services provided are paid directly by the Company to the facilities up to a maximum of €35 per session.

In facilities not affiliated with the Company
In the case of use of facilities not affiliated with the Company, the expenses for the services provided are paid to the Insured up a maximum of €35 per session.

Example:
Direct care scheme
Ceiling €350.00
Cost of acupuncture service €98.00
Max. €35.00 per session
Authorised benefit €98.00, of which €35.00 borne by the Company and €63.00 by the Insured
Payment scheme
Ceiling €350.00
Claim for acupuncture €98.00
Max. €35.00 per session
Indemnity €35.00

TOTAL Level of Protection

Alternative or Complementary Medicine Services:
Expenses for "unconventional" medical practices defined by the Italian National Federation of Boards of Physicians and Dentists, such as exams and treatments of:

- Acupuncture performed by physician;
- osteopathy;
- chiropractic;

provided that they are accompanied by a medical report with the description of the pathology and the indication for consequent treatment and are carried out by a physician or at a Medical Centre, or by personnel with a diploma qualifying to exercise.
The cover does not include services provided in gyms, gymnastic sports clubs, beauty studios, health hotels, medical hotels, wellness centres even if they have a medical centre.

TERMS AND CONDITIONS OF LIQUIDATION/PAYMENT
Waiting period
There is a 45-day waiting period.
There is no waiting period in case of injury.

Ceiling
The ceiling per year and per person provided for this cover is as follows:

- € 550

Deductible/Coinsurance
In facilities affiliated with the Company
In the case of use of facilities affiliated with the Company, the expenses for the services provided are paid directly by the Company to the facilities up to a maximum of €35 per session.

In facilities not affiliated with the Company
In the case of use of facilities not affiliated with the Company, the expenses for the services provided are paid to the Insured up a maximum of €35 per session.

Example:
Direct care scheme
Ceiling €550.00
Cost of acupuncture service €98.00
Max. €35.00 per session
Authorised benefit €98.00, of which €35.00 borne by the Company and €63.00 by the Insured
Payment scheme
Ceiling €550.00
Claim for acupuncture €98.00
Max. €35.00 per session
Indemnity €35.00

MODULE NO. 5 – AESTHETIC MEDICINE

HIGH Level of Protection

OUTPATIENT SURGICAL PROCEDURES

The Company shall pay the following expenses for minor outpatient surgery for aesthetic purposes as listed below.

Before hospitalisation

- diagnostic tests, laboratory exams, and specialist visits carried out within 30 days prior to outpatient surgery, provided that they are pertinent to the clinical condition that made the surgery necessary.

During hospitalisation

- The fees of the surgeon, assistant, anaesthesiologist, and any other individuals involved in the surgery;
- operating room fees, surgical materials;
- medical and nursing care, treatments, medicinal products, exams.

After hospitalisation

- diagnostic tests, laboratory exams, specialist visits, the purchase of medicinal products, medical, surgical and nursing services, carried out within 60 days of surgery and provided that they are relevant to the clinical condition that made surgery necessary.

Service
AESTHETIC MEDICINE
Telangiectasias
Xanthelasma removal
Localised adiposity
Blepharoplasty (2 eyelids)
Blepharoplasty (4 eyelids)
Inverted nipple
Surgical scar correction > 5 cm
Acne scars
Surgical scar correction < 5 cm
Dermabrasion
Dermoepidermal graft
Earlobe reconstruction
Otoplasty <Prominent Ears>
Scar Revision

TERMS AND CONDITIONS OF LIQUIDATION/PAYMENT

Waiting period
There is a 45-day waiting period.
There is no waiting period in case of injury.

Ceiling
The ceiling per year and per person provided for this cover is as follows:

- € 3,500

Deductible/Coinsurance
In facilities affiliated with the Company
A deductible of €350 per event shall be applied.

In facilities not affiliated with the Company
25% coinsurance shall be applied, with a minimum not eligible for payment of €1,000 per event.

Example:
Direct care scheme
Ceiling €3,500.00
Cost of Blepharoplasty (2 eyelids) €5,600.00
Fixed Deductible €350.00
Authorised benefit €5,600.00, of which €3,500.00 borne by the Company and €2,100.00 by the Insured
Payment scheme
Ceiling €3,500.00
Claim for Blepharoplasty (2 eyelids) €5,600.00
25% coinsurance minimum €1,000.00
Indemnity €3,500.00 (€5,600.00 – 25% which is greater than the minimum not eligible for indemnity, remaining at the expense of the Insured €2,100.00).

TOTAL Level of Protection

OUTPATIENT SURGICAL PROCEDURES
The Company shall pay the following expenses for minor outpatient surgery for aesthetic purposes as listed below.

Before hospitalisation

- diagnostic tests, laboratory exams, and specialist visits carried out within 30 days prior to outpatient surgery, provided that they are pertinent to the clinical condition that made the surgery necessary.

During hospitalisation

- The fees of the surgeon, assistant, anaesthesiologist, and any other individuals involved in the surgery;
- operating room fees, surgical materials;
- medical and nursing care, treatments, medicinal products, exams.

After hospitalisation

- diagnostic tests, laboratory exams, specialist visits, the purchase of medicinal products, medical, surgical and nursing services, carried out within 45 days of surgery and provided that they are relevant to the clinical condition that made surgery necessary.

Service
AESTHETIC MEDICINE
Telangiectasias
Xanthelasma removal
Localised adiposity
Blepharoplasty (2 eyelids)
Blepharoplasty (4 eyelids)
Inverted nipple
Surgical scar correction > 5 cm
Acne scars
Surgical scar correction < 5 cm
Dermabrasion
Dermoepidermal graft
Earlobe reconstruction
Otoplasty <Prominent Ears>
Scar Revision

TERMS AND CONDITIONS OF LIQUIDATION/PAYMENT

Waiting period

There is a 45-day waiting period.
There is no waiting period in case of injury.

Ceiling

The ceiling per year and per person provided for this cover is as follows:

- € 5,000

Deductible/Coinsurance

In facilities affiliated with the Company

A deductible of €350 per event shall be applied.

In facilities not affiliated with the Company

25% coinsurance shall be applied, with a minimum not eligible for payment of €1,000 per event.

Example:
Direct care scheme
Ceiling €5,000.00
Cost of Blepharoplasty (2 eyelids) €5,600.00
Fixed Deductible €350.00
Authorised benefit €5,600.00, of which €5,000.00 borne by the Company and €600.00 by the Insured
Payment scheme
Ceiling €5,000.00
Claim for Blepharoplasty (2 eyelids) €5,600.00
25% coinsurance minimum €1,000.00
Indemnity €4,200.00 (€5,600.00 – 25% which is greater than the minimum not eligible for indemnity, remaining at the expense of the Insured €1,400.00).

MODULE No. 6 - COINSURANCE AND DEDUCTIBLES

The Company provides for payment within the limits listed below of the coinsurance and deductibles established in the respective articles of the BASE Health Plan of employees working under Italian contracts of the UniCredit Group, excluding:

- expenses not reimbursed due to exceeding the ceilings provided for by the individual covers or due to exceeding the indemnity limits, in the case of application of the ceiling, where provided for;
- services that are not reimbursable under this insurance;
- coinsurance and deductibles for services carried out in facilities affiliated *with the Company*, including those indicated in the "TOP Clinics List", without activating the direct scheme, when possible.

Description of packages	
OPTIONS AND ANNUAL CEILINGS PER PERSON	
Option	**Annual ceiling per person**
Option A	€250.00
Option B	€ 500.00
Option C	€750.00
Option D	€ 1,000.00

TERMS AND CONDITIONS OF LIQUIDATION/PAYMENT

Waiting period

There is a 45-day waiting period.

There is no waiting period in case of injury.

Example Option D:
Direct care scheme
Ceiling €1,000.00
Cost of a specialist visit €120.00
Deductible to be borne by the Insured after liquidation of the BASE Health Plan €60.00
Indemnity €60.00

ANNEX No. 1
PRIVACY POLICY PROVIDED TO THE DATA SUBJECT IN ACCORDANCE WITH EU REGULATION 2016/679

RBM Assicurazione Salute S.p.A., in accordance with Article 13 of EU Regulation 2016/679 (GDPR), as data controller, informs you about the use of your personal data and the rights you may exercise (pursuant to Chapter III of the GDPR).

1 Purpose of processing

a) Processing of personal data for insurance purposes

In compliance with current legislation on the protection of personal data, we inform you that our company intends to acquire or already holds personal data about you, including sensitive data (1), in order to provide the services and/or insurance products you have requested or in your favour. Without your data - some of which must be provided by you or by third parties as required by law **(2**) - we will not be able to provide you, in whole or in part, with our insurance services and/or products; therefore, your consent for this purpose is mandatory.

b) Processing of personal data for advertising purposes

In the event of your express consent, your data may be used for the purpose of carrying out promotional activities for our own services and/or products or those of third parties. Please note that consent is, in this case, entirely optional and that your refusal will not have any effect on the provision of services and/or insurance products indicated in this statement.

2 Processing and retention methods

The data, provided by you or by other subjects(3), are only those strictly necessary for the achievement of the aforementioned purposes. The data are processed, including with the aid of electronic and automated tools, in such a way as to guarantee an adequate level of security, using methods and procedures strictly necessary for the purposes described in this policy, even when they are communicated to other subjects connected with the insurance and reinsurance sector.

Your data is processed in Italy; where necessary, it may be communicated, for the provision of the services requested, in countries of the European Union or even outside the European Union, to parties that are part of the so-called insurance chain(4).

Your data may be disclosed to our employees who are specifically authorised to process them, in their capacity as Persons in Charge, for the pursuit of the aforementioned purposes.

Personal data are kept for the time strictly necessary to achieve the purposes for which they were collected and processed.

With reference to the purposes referred to in paragraph 1 a), personal data will be kept for as long as the contractual relationship is in force and in any case in accordance with the applicable legislation.

With regard to the purposes referred to in paragraph 1 b), personal data will be kept in accordance with applicable law or until the data subject has exercised his or her right to object or withdraw his or her consent.

Recording phone calls

We inform you that your calls to the Call Centre may be recorded for security reasons and for the purpose of improving the Customer Care service.

Therefore, the continuation of calls after the caller has listened to the privacy policy implies that the caller has given his consent to the processing of personal and sensitive data that will be provided to the operator.

Telephone calls will be recorded using an automated system. The recordings will be retained with restricted access and may only be listened to by expressly authorised personnel.

Cookies

No personal user data is acquired by the Company's website. We do not use cookies to transmit information of a personal nature, nor do we use so-called persistent cookies of any kind, i.e., systems for tracing users. The use of so-called session cookies (which are not permanently stored on a user's computer and disappear when the browser is closed) is strictly limited to the transmission of session identifiers

(consisting of random numbers generated by the server) necessary to enable exploring the site. The so-called session cookies used in this site do not allow the acquisition of personal data identifying the user.

3 Communication of personal data

Your data may be communicated to other subjects with functions of a technical, organisational and operational nature that are part of the so-called insurance chain(4), possibly, where necessary for the provision of the services requested, also in countries of the European Union, or even outside the European Union. These parties will process your data within the scope of their respective functions and in accordance with the instructions received, in their capacity as Data Processors or Persons in Charge or as independent Data Controllers.

Your data is not subject to dissemination.

4 Rights of the Data Subject

The Data Controller is RBM Assicurazione Salute S.p.A.

Pursuant to and within the limits of Chapter III of the GDPR, you may exercise the following rights:

a. access to personal data;
b. correction of your personal data (we will, upon your request, correct your incorrect data, even if they have become incorrect because they are out of date);
c. withdrawal of consent;
d. erasure of data (right to be forgotten) (e.g. in case of withdrawal of consent, if there is no other legal basis for processing);
e. limitation of processing;
f. opposition to processing for legitimate reasons;
g. data portability (at your request, the data will be transmitted to the party you have indicated in a format that makes it easy to consult and use);
h. lodging a complaint with the supervisory authority (Garante Privacy).

In order to exercise your rights under Chapter III of the GDPR and for detailed information on the subjects or categories of subjects to whom the data is communicated or who become aware of it in their capacity as Data Processors or Persons in Charge, you may contact the Data Protection Officer (DPO) by sending an email to privacy@rbmsalute.it, or alternatively by writing to the Ufficio Privacy at the offices of RBM Assicurazione Salute S.p.A. Via Forlanini, 24 – 31022 Preganziol (TV).

5 Data Controller and Data Protection Officer

RBM Assicurazione Salute S.p.A., with registered office in Via Forlanini n. 24 - 31022 Loc. Borgo Verde di Preganziol (TV), is the data controller to whom you may apply to assert your rights as provided for by Chapter III of the GDPR by writing to privacy@rbmsalute.it / rbmsalutespa@pec.rbmsalute.it

The Data Protection Officer (RDP-DPO) can be contacted at privacy@rbmsalute.it.

Notes

1) “Sensitive data" means personal data revealing racial or ethnic origin, religious, philosophical or other beliefs, political opinions, membership of parties, trade unions, associations or organisations of a religious, philosophical, political or trade-union nature, as well as data concerning a person's health, sex life or sexual orientation, which the GDPR indicates in Article 9 as "special categories of personal data".

2) E.g. for provisions of IVASS, Privacy Authority, tax assessments.

3) For example: policyholders of collective or individual policies that qualify you as an insured, beneficiary or injured party; jointly obliged parties; other insurance operators (agents, insurance brokers, insurers, etc.); parties that provide information to satisfy your requests (such as insurance cover, claim settlement, etc.); associations and consortia in the insurance sector; other public bodies.

4) These are, in particular, the parties making up the so-called '*insurance chain*': agents, sub-agents, agency producers, insurance brokers, banks, stock brokerage firms and other channels for the acquisition of insurance contracts; insurers, co-insurers and reinsurers; lawyers; healthcare facilities and other conventional service providers; companies in the Group to which our company belongs and other service companies, including companies entrusted with the management, settlement and payment of claims, IT, telematics, financial, administrative, filing, printing, and postal services, auditing and certification of financial statements or other services of a technical/organisational nature. There are also associations (ANIA) and consortia belonging to the insurance sector for which the communication of data is instrumental to provide the services indicated above or to protect the rights of the insurance industry; other institutional bodies such as IVASS, the Italian Ministry of Economy and Finance, the Italian Ministry of Labour and Social Security, CONSAP, UCI, compulsory social insurance providers, the Tax Registry, Law Enforcement, the Judiciary and other databases to which the communication of data is compulsory (e.g., the Financial Information Unit at the Bank of Italy, the Central Accident Records Office).

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INTESA SANPAOLO RBM SALUTE S.p.A.
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).