ISTITUTO NAZIONALE DI FISICA NUCLEARE AWARD OF CONTRACT
FOR INSURANCE SERVICES

LOT NO. 4 TECHNICAL SPECIFICATIONS REIMBURSEMENT OF MEDICAL EXPENSES FOR FOREIGN VISITORS

CIG 81988110E0

SUMMARY POLICY DESCRIPTION

1.	**Contracting party**: Istituto Nazionale di Fisica Nucleare (Italian Institute for Nuclear Physics)
2.	**Subject-matter of the insurance:** Reimbursement of Medical Expenses
3.	**Insureds:** Foreign visitors (nationals of non-EU countries) and, where applicable, accompanying family members (pursuant to Article 27-*ter* of Italian Legislative Decree No. 286/98)
4.	**Maximum benefit limit:** € 100,000.00 per insurance year per insured and any accompanying family members
5.	**Main services:** - Hospitalisation with or without surgery - Caesarean section, therapeutic abortion, natural childbirth - Out-patient surgical procedure - Day-patient care
6.	**Per capita gross monthly premium: € 1.37**
7.	**Term of the Contract:** from 24:00 hours on 30 September 2020 until 24:00 hours on 30 September 2023
8.	**Premium instalments:** Annual

DEFINITIONS

The following terms in this Contract have the meanings set out below:

INSURED: the party whose interests are protected under the insurance policy;

INSURANCE: the insurance contract;

CONTRACTING PARTY: Istituto Nazionale di Fisica Nucleare (Italian Institute for Nuclear Physics);

POLICY: the document which provides proof of the insurance;

INSURER: the company that issues the contract;

PREMIUM: the consideration payable by the Contracting Party to the Insurer;

COMPENSATION: the amount due by the Insurer against a claim;

ACCIDENT: any unexpected violent, external event causing bodily injuries that can be objectively established;

HEALTHCARE FACILITY: public healthcare facility or private nursing home duly authorised to provide hospital care, in accordance with the law or other regulations in force in the country where the facility is located;

ILLNESS: any health disorder not resulting from an accident;

HOSPITALISATION: admission to hospital (public or private), involving an overnight stay;

CLAIM: the occurrence of the event for which the insurance is provided;

MEDICAL DISORDER: any health disorder resulting from an accident or illness;

DAY-PATIENT CARE: healthcare services provided at a hospital or nursing home on a day-patient basis;

BROKER: Ital Brokers S.p.A.

PART I - GENERAL RULES GOVERNING THE INSURANCE CONTRACT

Article 1 Declarations of risk

Incorrect and incomplete statements made by the Contracting Party concerning circumstances that could affect the assessment of the risk may result in the full or partial loss of the right to compensation and termination of the insurance pursuant to Articles 1892, 1893 and 1894 of the Italian Civil Code.

Article 2 Increase of risk

The Contracting Party must notify the Insurer in writing of any increase of risk. Any increase of risk about which the Insurer is unaware or to which it does not agree may result in the full or partial loss of the right to compensation and termination of the insurance (Article 1898 of the Italian Civil Code).

Article 3 Decrease of risk

Upon receipt of notification by the Insured of a decrease of risk, the Insurer must reduce the next premium or premium instalments due (Article 1897 of the Italian Civil Code).

Article 4 Changes to legislation

Should there be any changes to legislation or any novel and/or different case-law in the field, or interpretations and/or opinions in relation thereto that, in the sole opinion of the Contracting Party, are such as to render this contract totally or even partially incompatible therewith, the Parties agree as from now to immediately redraft and/or revise the contractual clauses, subject to any other legal provisions and without prejudice to their reciprocal rights under this contract.

Article 5 Good faith

Failure by the Contracting Party/Insured to disclose any circumstances that result in an increase of risk, and providing incorrect or incomplete information when taking out the policy and/or during the term thereof, will not affect the right to full compensation, provided such omissions or incorrect information do not constitute wilful misrepresentation.

Once the Insurer becomes aware of the increased risk, it will have the right to increase the premium in relation to the greater risk from the moment the circumstance that resulted in the increase of risk occurred.

Article 6 Interpretation of the contract

The Parties hereby agree that should there be any doubt as to the meaning of the clauses of this contract, they must be interpreted in the broadest sense and with the meaning that is most favourable to the Contracting Party/Insured.

Article 7 Term of the policy and extension of the insurance period

The insurance cover commences at 24:00 hours on 30 September 2020 and ends at 24:00 hours on 30 September 2023. The insurance cover will automatically cease at the end of that period without any need for formal notification by either party. Tacit renewal is not permitted under any circumstances. Either party may withdraw from the contract at the end of each insurance year, by sending the other party notice, by means of registered letter, at least 180 days before the end of the insurance year.

The Contracting Party reserves the right to renew the contract, under the same terms and conditions, for a maximum term of THREE years, in accordance with the applicable legislation; to exercise said right, the Contracting Party must notify the Insurer by means of certified e-mail at least 60 days before the original contract expiry date.

Upon expiry of the contract, the Contracting Party may request an extension of the contract period, under the same contractual and economic conditions, to allow completion of all the procedures necessary for awarding the new policy contract and, in any case, for a maximum of 180 days. The request must be made in writing to the Insurer.

Article 8 Payment and effect of the insurance cover

The insurance cover will be effective from 24:00 hours on the date specified in the policy, provided the premium or the first premium instalment has been paid; otherwise, it will be effective from 24:00 hours on the date of payment.

By way of partial exception to Article 1901 of the Italian Civil Code, the Contracting Party must pay the first premium instalment not later than 60 days after the starting date of the policy, without prejudice to the effect of the insurance cover.

If the Contracting Party does not pay the subsequent premiums, the policy will be suspended with effect from 24:00 hours on the 60th day after the payment was due and will resume with effect from 24:00 hours on the date of payment, without affecting the right of the Insurer to receive payment of the overdue premiums pursuant to Article 1901 of the Italian Civil Code.

Premiums must be paid to the Agency to which the policy has been assigned or to the Insurer or Broker.

Article 9 Other insurance cover

The Contracting Party is not under obligation to disclose information about any other insurance policies already held by individual insureds or taken out by the latter with other insurers at a later date.

In the event of a claim, the Insured must notify all the Insurers, and give each one the names of the others (Article 1910 of the Italian Civil Code).

Article 10 Changes to the insurance cover

Any changes to the insurance must be approved in writing.

Article 11 Form of notifications by the Contracting Party to the Insurer

All notifications, which the Contracting Party is required to provide by law, must be made in writing and sent by means of e-mail, registered letter and/or fax and/or telex and/or telegram addressed to the Broker. The same applies to notifications by the Insurer to the Contracting Party.

Article 12 Duties and taxes

Present and future duties, taxes and all other fees imposed by law, in connection with the premium, the contract and other related instruments will be charged to the Contracting Party, even when paid in advance by the Insurer.

Article 13 Applicable law and interpretation of the contract

Any matters not otherwise provided for herein are governed by the provisions of Italian law.

Article 14 Place of jurisdiction

For any disputes in connection with the application and execution of this policy, the Parties may apply jointly, or the Party concerned may apply separately, to a Mediation Board authorised by the Italian Ministry of Justice and duly established in accordance with the law. The Mediation Board will invite the other party to join and to take part in the mediation session in order to attempt a settlement pursuant to the provisions of Italian Legislative Decree 28/2010, in accordance with the Regulations on conciliation adopted thereby. Said Board, at the discretion of the Contracting Party or of the Insured, must have its registered office in the province in which either of the aforesaid Parties resides.

Should there be several applications concerning the same dispute, the criterion of chronological order will be applied, so that the mediation is conducted by the Board to which the first request for mediation was submitted.

Should the mediation be unsuccessful or not be carried out, the party concerned may take the matter to court, in which case the exclusive place of jurisdiction will be the place of residence of the Contracting Party or, alternatively, of the Insured.

Article 15 Co-insurance with lead insurer

Only applicable to co-insurance as per Article 1911 of the Italian Civil Code and not to TJV arrangements When the Insurance envisages sharing of the risk among Co-insurers, they will each pay a percentage of the claim, settled in accordance with the Policy Terms and Conditions, in proportion to their share of the risk insured, with each liable only for their own share of the loss.

The Contracting Party represents that it has entrusted the management of this contract to the appointed Broker and the Insurers have agreed to delegate authority to the Lead Insurer named herein; therefore, all contractual relations in connection with this Insurance will be managed on behalf of the Contracting Party by the appointed Broker, which will have dealings with the Lead Insurer.

In particular, all notifications in connection with the Contract, including those regarding withdrawal or termination of the contract and the management of claims, will be deemed as sent or received by the Lead Insurer on behalf and on account of all the Co-insurers.

The Co-insurers acknowledge that all policy management activities undertaken by the Lead Insurer on their common behalf will be valid and effective, with the sole exception of the collection of policy premiums, which will be paid to each Insurer.

The undersigned Lead Insurer hereby represents that it has been authorised by the Co-insurers named in the aforementioned documents (policy and annexes) to sign them also on their behalf and on their account.

Therefore, the signature placed by the representative of the Lead Insurer on the Insurance Documents also renders them effective for all purposes in respect of the shares of the Co-insurers.

The breakdown of each Co-insurer's share of the capital insured, premiums, accessories and taxes is provided in the specific schedule attached hereto.

Article 16 Broker clause

The Contracting Party represents that it has entrusted the management of the policy to Ital Brokers S.p.A., an insurance broker in accordance with Italian Legislative Decree 209/2005, as amended.

Therefore, in accordance with the terms and conditions of this policy, the Insurers hereby acknowledge that all notifications sent by the Contracting Party to the Broker will be deemed as sent to the aforesaid Insurers, and vice versa, and all notifications sent by the Broker to the Insurers will be deemed as being sent by the Contracting Party.

Furthermore, the Insurers acknowledge that premium payments made through the aforesaid Broker will constitute full discharge of liabilities of the Contracting Party.

The Insurer acknowledges that it will be responsible for payment of the commission due to the Broker. Before transferring the premiums to the Insurer, the Broker will withhold the brokerage commission due, in the amount of 3.00% (three per cent) of the taxable premium.

Should the contract between the Contracting Party and the aforesaid Broker for said brokerage service be terminated during the term of this policy, the Contracting Party will notify the Insurer of the name of the new broker to be appointed and the conditions laid down by the latter for any remaining years of the contract.

Likewise, the replacement Broker will become entitled to the commission payable by the Insurer from the first policy expiry date following the date on which the new Broker formally takes over, with neither the Insurer nor the outgoing Broker being allowed to raise any objection in that respect.

Article 17 Obligations relating to the tracking of financial flows and specific termination clause

A. The Insurer is required to assume all obligations regarding the traceability of financial flows as established by Italian Law No. 136/2010, as amended.
B. The Insurer undertakes to inform the Contracting Party and the prefecture/local government office of the province where the Contracting Party has its registered office if it becomes aware, in any contracts signed with sub-contractors in the supply chain of companies in any way involved in the services provided under this contract, of any breaches by said sub-contractors in relation to the traceability obligations set forth in Article 3 of Italian Law No. 136/2010.

C. Whenever payments are made to the Insurer, the Contracting Party may apply additional control measures to ensure that the Insurer fulfils all of its obligations in relation to the tracking of financial flows. The Insurer undertakes to provide all the necessary documentary evidence of its fulfilment of the obligations to ensure the traceability of financial flows pursuant to Law No. 136/2010.

D. In accordance with Article 3(9-*bis*) of Law No. 136/2010, if it is found that any financial transactions referring to payments made by the Insurer have not been made through bank or postal accounts or other systems that enable complete tracking of transactions, this contract will be automatically terminated pursuant to Article 1456 of the Italian Civil Code. This contract will end when the party concerned notifies the other that it intends to apply this termination clause. In accordance with Article 1458 of the Italian Civil Code, termination of the contract does not affect the obligations of the Insurer in connection with claims arising prior to the termination of the contract.

Article 18 OBBLIGATION OF THE INSURER TO PROVIDE INFORMATION ABOUT RISK TRENDS

Every three months the Insurer undertakes to provide the Contracting Party with a detailed list of claims, with the following information:

- Insurer's claim number;
- date of event;
- type of loss;
- access to services (affiliated facilities, non-affiliated facilities, network, NHS)
- claim status ("being processed", "settled" and "closed without follow-up");
- amount paid and date of settlement;
- amount allocated;
- for rejected claims, reasons in writing.

The above obligation does not affect the right of the Contracting Party to ask for and have the above information updated at intervals other than those specified herein.

PART II - RULES GOVERNING THE INSURANCE CONTRACT FOR REIMBURSEMENT OF MEDICAL EXPENSES

Article 19 Subject-matter of the insurance

The insurance covers the costs incurred for the services described in Article 32 "Services", up to the maximum annual benefit specified in the policy and provided such services are relevant to the illness, injury, childbirth or therapeutic abortion referred to in the claim.

Insureds have access to the Insurer's network of affiliated medical and healthcare service providers that guarantee reduced rates and the direct settlement of eligible treatment as laid down in Article 35 "Direct settlement scheme for services provided through Affiliated Healthcare Facilities".

The Insurer undertakes to ensure that the network of affiliated providers in Italy includes:

1) at least 200 nursing homes and/or hospitals, authorised to provide in-patient and day-patient care;
2) at least 400 diagnostic clinics;
3) at least 500 dental clinics.

Article 20 Territorial scope

The insurance is valid worldwide.

Article 21 Age limit

There is no age limit.

Article 22 Non-insurable persons

The insurance cover is not available for persons with an alcohol or drug addiction or with the following mental illnesses: schizophrenia, manic depression or paranoia, other mental disorders characterised by organic brain disease, regardless of their actual state of health.

The insurance cover will cease when any such disorders arise.

However, should the disorder set in after the effective date of the policy, claims in connection with the mental illnesses listed above will be covered but only for the first hospital stay.

The insurance cover is also available for persons with a mental disability, or who take psychotropic drugs for therapeutic use, subject to the exclusions laid down in this policy.

Article 23 Exclusions

The insurance does not cover claims for:

A. the elimination or correction of any physical defect or malformation that existed prior to the signing of the contract or any amendments thereto, or medical disorders in connection therewith, except for any congenital malformation the existence of which the Insured is unaware;
B. mental illness and psychiatric disorders in general, including nervous disorders, except when surgery is required, in which case the insurance will only cover the reimbursement of expenses relating to the actual surgery;
C. injuries suffered as a result of criminal actions committed by the Insured (injuries resulting from acts of gross negligence are covered);
D. injury or intoxication due to excessive alcohol consumption, or the non-therapeutic use of psychotropic substances or narcotic drugs;
E. voluntary, non-therapeutic abortion;
F. cellular-tissue treatments, physiotherapy, mineral water treatments and spa treatments in general (without prejudice to the provisions of Article 32 "Services"), and treatment to alter or improve appearance (except for reconstructive plastic or dental surgery made necessary as the result of an accident or of destructive surgical procedures provided that such surgery was performed after the Insured had been included in the insurance plan);

G. dental care and treatment of periodontal disease;
H. purchase, servicing or repair of prosthetic devices and medical aids, except expenditure relating to the purchase of such devices and aids when applied following a surgical operation;
I. the direct or indirect consequences of nuclear radiation and contamination, occurring naturally or induced, and of the acceleration of atomic particles (nuclear fission and fusion, radio-isotopes, accelerators, X-rays, etc.);
J. the consequences of war, insurrections, earthquakes and volcanic eruptions;
K. hospital stays on a day-patient basis solely for the purpose of specialist examinations and/or preventive diagnostic tests and/or health checks;
L. hospital stays for chronic conditions in long-term care facilities (hospices, care homes, etc.), including those classified as clinics or nursing homes;
M. fertility treatment or treatment of any sort relating to artificial insemination.

Article 24 Obligations for filing claims

In the event of a claim, the Insured must notify the Insurer as soon as possible.
When filing a claim, the Insured must include the relevant medical certificate. The Insured must consent to any medical examinations or tests ordered by the Insurer, provide any additional information requested thereby and a complete copy of the medical records.

Article 25 Settlement criteria

The Insurer will reimburse the amount due when the treatment has ended, upon receipt of the original copies of the bills, notes and receipts, with proof of payment, and a copy of the medical documentation certifying the medical disorder (presumed or diagnosed), the injury (or childbirth) for which the services were necessary; in the case of hospitalisation or services provided on a day-patient basis, the Insured must provide a complete copy of the medical records.
Where the Insured has provided or must provide the original bills, notes or receipts to welfare institutions in order to obtain reimbursement, the Insurer will pay the amount due on the basis of documentary proof of the expenditure actually incurred, net of any amounts already paid by the aforesaid institutions. The Insurer will settle the claim and pay the amount due within 30 working days after receiving the request (complete with all the necessary documentation), after which the bills, notes, invoices and receipts relating to the costs incurred by the Insured will be returned thereto.

Article 26 Disputes

The compensation must be settled with the agreement of the parties. In the event of disagreement, the parties undertake to delegate the decision on whether and to what extent compensation is due, subject to the policy limits and conditions, to a Board of three physicians, one appointed by each party and the third by mutual agreement or, failing agreement, by the Medical Council (Consiglio dell'Ordine dei Medici) with jurisdiction in the place where the Board is to meet. Said mandate must be drawn up in writing.
The Insurer has decided that the medical Board will meet at the Insurer's registered office.
Each party will pay its own expenses and the fee of the physician appointed thereby, in addition to half of the expenses and fee of the third physician.
Decisions by the medical Board will be taken by majority vote, without the need for any legal formalities, and will be binding on the parties, including if one of the physicians refuses to sign the arbitration report.

Art. 27 Benefit limit

The benefits guaranteed by this policy operate in the interests of insureds up to the maximum limit of € 100,000.00 per insurance year and per family unit, subject to the specific sub-limits described in Article 32 "Services". The total amount of compensation paid for all of the guaranteed benefits may not exceed the maximum insured benefit limit in any one insurance year.

Article 28 Insurable persons

The benefits guaranteed by this policy operate in the interests of foreign visitors (nationals of non-EU countries) hosted by the Contracting Party and any accompanying family members under the Hosting Agreements entered into by the Institute (Article 27-*ter* of Italian Legislative Decree 286/98).

Accompanying family members include: the spouse (including same-sex spouse), registered cohabiting partner (including same-sex partner) and children.

Article 29 Premium

The premium will be calculated at the beginning of each insurance year according to the presumed number of months insured, on the understanding that fractions of a month will be counted as a full month. Therefore, 75% of the estimated premium will be paid at the start of the insurance year, as set out in Article 31 below.

Article 30 New entries and departures during the year

The Contracting Party undertakes to provide notification (by electronic means) of:

- new insureds included in the plan after this policy was issued, on the understanding that the cover will take effect from 24:00 hours on the day of the notification sent by the various INFN laboratories to the central office.
- insureds leaving the plan after this policy was issued, on the understanding that the cover will cease from 24:00 hours on the day of the notification sent by the various INFN laboratories to the central office.

The premium for new entries and departures during the year will be determined in twelfths, according to the actual number of months for which the cover is provided, on the understanding that the premium will be calculated on the basis of each calendar month even if only partially enjoyed.

Article 31 Premium adjustment

Having established that the premium must be paid in advance in the amount of 75% of the estimated premium due, the premium will be adjusted on the basis of the notifications received, within 180 days after the end of each insurance year; any increase in the premium due to the Insurer as the result of said adjustment must be paid by the Contracting Party not more than 60 days after receiving the specific payment note.

Should the Contracting Party fail to comply with this requirement, the insurance will be suspended pursuant to Article 1901 of the Italian Civil Code until the day after the date of payment, without prejudice to the Insurer's right to take legal action or to terminate the contract, by means of registered letter.

Article 32 Services

The Insurer will reimburse expenses incurred as a result of illness, injury or childbirth during the insurance year, in the following cases:

A) in the case of surgery, performed in hospital on an in-patient, day-patient or out-patient basis, the Insurer will reimburse the following expenses:

1. Surgical team fees, operating theatre fees, surgical equipment, including endoprostheses applied during the operation.

2. Medical and nursing care, treatment, physiotherapy and rehabilitation, medicines, diagnostic tests and assessments, while hospitalised or performed on a day-patient or out-patient basis for the surgical procedure.
3. Hospital stay charges (excluding unnecessary expenses).
4. Tests, diagnostic assessments and specialist examinations carried out during the 60-day period prior to surgery or hospitalisation, provided they are directly related to the illness or injury that led to the need for the medical services.
5. Tests and specialist examinations, medicines, medical and nursing care, purchase and/or rental of prosthetic devices and medical equipment including wheelchairs, physiotherapy or rehabilitation, spa treatments (excluding all hotel expenses), during the 60-day period after surgery or discharge from hospital, provided they are directly related to the illness or injury that led to the need for the medical services.
6. Complete or partial organ explantation; hospitalisation of the donor and diagnostic tests, medical and nursing care, explantation surgery, treatment, medicines and hospital stay charges.
7. Transportation of the Insured to the healthcare facility, transfer from one healthcare facility to another, transfer back home by means of any medically-equipped means of transport, including abroad.

B) In the case of caesarean section and/or therapeutic abortion, the Insurer will reimburse the following expenses, including for the newborn baby, up to a maximum amount of € 8,000.00 per insurance year:

1. Surgical team fees, operating theatre fees, surgical equipment.
2. Medical and nursing care, treatment, physiotherapy and rehabilitation, medicines, diagnostic tests and assessments, during the period of hospitalisation, including for the newborn baby.
3. Hospital stay charges (excluding unnecessary expenses).
4. Tests, diagnostic assessments and specialist examinations carried out during the 60-day period prior to surgery or hospitalisation, provided they are directly related to the operation.
5. Tests and specialist examinations, medicines, medical and nursing care, purchase and/or rental of prosthetic devices and medical equipment including wheelchairs, physiotherapy and rehabilitation, spa treatments (excluding all hotel expenses), during the 60-day period after surgery or discharge from hospital, provided they are directly related to the surgery.
6. Transportation of the Insured to the healthcare facility, transfer from one healthcare facility to another, transfer back home by means of any medically-equipped means of transport, including abroad.

C) In the case of hospitalisation or day-patient treatment without surgery, the Insurer will reimburse the following expenses:

1. Medical and nursing care, treatment, physiotherapy and rehabilitation, medicines, diagnostic tests and assessments, during the period of hospitalisation or day-patient treatment.
2. Hospital stay charges (excluding unnecessary expenses).
3. Tests, diagnostic assessments and specialist examinations carried out during the 60-day period prior to hospitalisation, provided they are directly related to the illness or injury that led to the need for the medical services.
4. Tests and specialist examinations, medicines, medical and nursing care, purchase and/or rental of prosthetic devices and medical equipment including wheelchairs, physiotherapy and rehabilitation, spa treatments (excluding all hotel expenses), during the 60-day period after discharge from hospital, provided they are directly related to the illness or injury that led to the need for the medical services.
5. Transportation of the Insured to the healthcare facility, transfer from one healthcare facility to another, transfer back home by means of any medically-equipped means of transport,

including abroad.

D) In the case of childbirth where caesarean section is not performed, the Insurer will reimburse the following expenses, including for the newborn baby, up to a maximum amount of € 6,000.00 per insurance year:

1. Medical team fees, operating theatre fees and surgical equipment.
2. Medical and nursing care, treatment, physiotherapy and rehabilitation, medicines, diagnostic tests and assessments, during the period of hospitalisation, including for the newborn baby.
3. Hospital stay charges (excluding unnecessary expenses).
4. Tests, diagnostic assessments and specialist examinations carried out in the 60-day period prior to hospitalisation, provided they are directly related to the birth.
5. Tests and specialist examinations, medicines, medical and nursing care, purchase and/or rental of prosthetic devices and medical equipment including wheelchairs, physiotherapy and rehabilitation, spa treatments (excluding all hotel expenses), during the 60-day period after discharge from hospital, provided they are directly related to the birth.
6. Transportation of the Insured to the healthcare facility, transfer from one healthcare facility to another, transfer back home by means of any medically-equipped means of transport, including abroad.

Article 33 Allowance in lieu of reimbursement

Insureds who do not ask the Insurer to reimburse expenses for in-patient/day-patient treatment (including childbirth and abortion) or for any other services in connection therewith will be entitled to an allowance of **€ 100.00** (reduced by 50% for day-patient treatment) per day in hospital for a period of not more than 30 days per hospital stay.

Article 34 Provision of services

The services covered by this contract, specifically those referred to in Article 32 "Services", may be provided as follows:

a) **Affiliated facilities**: at private or public healthcare facilities that are part of the Insurer's provider network and affiliated physicians.
In this case, the costs of the services provided will be paid directly by the Insurer to the affiliated healthcare facility, less the excess or deductible applicable to each type of benefit and service, which must be paid directly by the beneficiary of the service to the healthcare facility/professional.
In-patient/day-patient/out-patient treatment provided at the Insurer's affiliated private/public healthcare facilities but by non-affiliated physicians will not be settled directly by the Insurer; in that case, the Insured must pay the amount due for the treatment and then request reimbursement of the expenses incurred following the procedure described in point b).

Non-affiliated facilities: at private or public healthcare facilities that are not part of the Insurer's provider network, by non-affiliated physicians.
In this case, the expenses incurred by the Insured will be reimbursed by the Insurer according to the procedures described in Article 25 "Settlement criteria".

Article 35 Direct settlement scheme for services provided through Affiliated Healthcare Facilities

With reference to the provision of services described in Article 34(a) of this Section, the costs of the services provided will be paid directly by the Insurer to the affiliated healthcare facilities and affiliated physicians, in full (or after applying the excess and deductible
for each type of benefit and service, which must be paid directly by the Insured to the healthcare facility/professional).
To benefit from the direct settlement scheme, the Insured must first be authorised by the Insurer. To obtain such authorisation, the Insured must contact the Insurer's specific Operations Centre, which undertakes to process the request and notify the Insured of the outcome within three days.

Upon arrival at the affiliated healthcare facility where the service is to be performed, the Insured must provide a valid identity document and medical certificate indicating the nature of the illness (presumed or diagnosed) or injury sustained as a result of which the services are needed.

The healthcare facility may not charge the Insured directly or bring any action for compensation against the latter, except in connection with expenses incurred for services not included in the policy benefits, any excess or deductible applicable to each benefit or expenses that have not been authorised or that exceed the maximum benefit limit.

Article 36 Consultancy services and assistance

The consultancy services listed below are provided (in Italian and English) by the Insurer's Operations Centre, which can be contacted on freephone number **800.010.300** between 8 am and 6 pm from Monday to Friday.

For calls from abroad, the number is **(+39) 02.303.500.003**.

a) <u>Telephone healthcare information service</u>

The Operations Centre provides a healthcare information service in relation to:

- public and private healthcare facilities: location and specialist areas;
- affiliated healthcare facilities and physicians;
- information about how to use the policy;
- specialised medical centres for specific diseases in Italy and abroad.

b) <u>Appointment management</u>

The Operations Centre is available to book appointments for the healthcare services covered at its affiliated healthcare facilities, whether for services that are reimbursable under the terms of this policy (under the direct payment or reimbursement scheme) or for services not covered by Article 32 "Services".

c) <u>Immediate medical opinion</u>

Physicians at the Operations Centre are on-hand to offer information and advice for Insured who need to consult a doctor about an injury or illness.

d) <u>Sending a doctor</u>

If, following an accident or due to an illness, the Insured, in Italy, needs to see a doctor between 8 pm and 8 am on weekdays or at any time of the day or night on holidays but is unable to contact one, the Operations Centre, having established the need for the service, will send one of its affiliated physicians, at its own expense. If no affiliated physician is available to attend in person, the Operations Centre will arrange, at its own expense, for the transfer of the Insured by ambulance to the nearest suitable medical centre.

e) <u>Return from hospital emergency department</u>

If, following an accident or due to an illness, the Insured needs to be transferred by ambulance from a hospital emergency department, the Operations Centre will send an ambulance directly, bearing all costs of the service up to an amount required to cover a distance of 500 km per event.