INSURANCE TERMS AND CONDITIONS GROUP INSURANCE PLAN TO COVER REIMBURSEMENT OF MEDICAL EXPENSES INFN GROUP AGREEMENT

between

FONDO DI ASSISTENZA SANITARIA POSTE VITA (POSTE VITA HEALTHCARE FUND) (Contracting Party)
VIALE BEETHOVEN, 11 – 00144 ROME
Tax code/VAT No.: 97778630588

ISTITUTO NAZIONALE DI FISICA NUCLEARE (ITALIAN INSTITUTE FOR NUCLEAR PHYSICS) hereinafter referred to as INFN (Associate)
VIA ENRICO FERMI, 54 – 00044 - ROME
Tax code/VAT No.: 84001850589

AND

POSTE ASSICURA (INSURER)
VIALE BEETHOVEN, 11 – 00144 - ROME
Tax code/VAT No.: 07140521001

Effective from 24:00 hours on	**30 June 2020**
Until 24:00 hours on	**30 June 2022**

CONTENTS

In accordance with the Italian Insurance Code (Legislative Decree No. 209 of 7 September 2005) and the implementing provisions, clauses referring to risks and those governing the liabilities and obligations of the Insured and of the Contracting Party, exclusions, limitations, suspension of cover, voidness, forfeitures, rights of recourse and warnings, are highlighted in bold type.

DEFINITIONS

Insurance
The health insurance cover.

Policy
The document which provides proof of the insurance.

Associate
ISTITUTO NAZIONALE DI FISICA NUCLEARE (ITALIAN INSTITUTE FOR NUCLEAR PHYSICS), referred to as INFN

Waiting period
Period during which the cover under the insurance contract is not effective. If the insured event occurs during this period, the Insurer will not cover the cost of the insured service.

Contracting Party
Fondo di Assistenza Sanitaria Poste Vita (Poste Vita Healthcare Fund)

Insured party
The party whose interests are protected under the insurance policy.

Insurer
Poste Assicura S.p.A.

Premium
The consideration payable by the Contracting Party to the Insurer.

Accident
An unexpected violent, external event causing bodily injuries that can be objectively established.

Illness
Any health disorder that is not a malformation or physical defect and not necessarily resulting from an accident.

Malformation
Abnormal structural development of a person's body or parts of the organs thereof due to congenital medical conditions.

Physical defect
Abnormal structural development of a person's body or parts of the organs thereof due to congenital disorders or traumatic injury.

Healthcare Facility
Hospital, clinic or university medical institute, nursing home, duly authorised by the competent authorities, in accordance with legal requirements, to provide hospital care, including on a day-patient basis, excluding spas, convalescent and residential care homes and clinics specialised in aesthetic treatments and nutrition.

Affiliated healthcare facility
Healthcare facility, out-patient clinic, specialist centre with which the Insurer has entered into an agreement for the direct payment of services.

Hospitalisation
Admission to a healthcare facility involving an overnight stay.

Day-patient care
Healthcare services in connection with surgical and medical treatment provided at a healthcare facility on a day-patient basis and documented by medical records and discharge form.

Surgery
Any medical procedure involving an incision with manual or instrumental techniques carried out for therapeutic purposes.

Out-patient surgical procedure
Surgery that, owing to the type of procedure, does not require the patient to be kept under post-operative observation.

Diagnostic test/Assessment
Instrumental medical procedure performed to search for and/or determine the presence and/or course of a disease, including internal and/or invasive procedures.

Claim
The occurrence of the event for which the insurance is provided.

Compensation
The amount due by the Insurer against a claim.

Allowance in lieu of reimbursement
Daily allowance paid by the Insurer if the Insured is admitted to hospital but does not request reimbursement of medical bills for services provided during or in connection with the hospital stay.

Excess
The fixed amount of the insurance claim that the Insured agrees to pay.
If this is stated in days, it refers to the number of days for which the amount covered will not be paid to the Insured.

Deductible
The percentage of the amount to be paid by the Insured.

SECTION I - GENERAL TERMS AND CONDITIONS

Article 1 - Policy term and cover start date
This policy has a term of two years. Cover commences at 24:00 hours on **30 June 2020** and ends at 24:00 hours on **30 June 2022**, during which time the policy may not be cancelled by the Insurer. The insurance cover provided under this policy will cease at the end of that period without any need for formal notification by either party. Tacit renewal is not permitted under any circumstances.

At least six months before the expiry of the insurance period, INFN may propose an extension of the term of this policy from one year to the next and for up to a maximum of 24 additional months. The proposal to renew the policy a second time must be submitted by INFN to the Insurer at least six months before the end of the last insurance year; the Insurer may refuse each such request by notifying INFN of its decision within 30 (thirty) days of receiving the request.

INFN may, at least 60 (sixty) days before the date of expiry of the Agreement, ask the Insurer to extend it for a period of up to 180 (one hundred and eighty) days, to allow completion of all the procedures necessary for awarding the new contract; in that case, the Insurer must extend the insurance, for the requested period and under the same contractual and economic terms and conditions, subject to payment of a premium amounting to the number of twelfths of the annual policy premium corresponding to the number of months of the extension requested by INFN.

In terms of the effectiveness of the insurance cover and the conditions for and validity of inclusion in the plan, this policy operates seamlessly, for all purposes, with the policies previously taken out by INFN through the Poste Vita Healthcare Fund in favour of the Insureds as defined in Article 6 of Section I of the General Terms and Conditions, which expired on 30 June 2020 (policy numbers: 31007048, 31007049, 31007050).

Article 2 - Termination
By way of exception to Article 1898 of the Italian Civil Code, the Insurer waives the right to terminate the insurance contract prior to the expiry thereof.

Article 3 - Subject-matter of the insurance
This policy covers the reimbursement of costs incurred by Insureds for medical and healthcare services necessary as a result of illness, accident or childbirth (and for the purpose of prevention where specifically envisaged) within the terms, to the extent and in accordance with the provisions set forth in this contract (Sections III, IV and V).

Article 4 - 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. Subsequent instalments must be paid within a 30-day grace period after the due date. If the premium is not paid on time or within the aforesaid grace period, the policy will be suspended with effect from 24:00 hours on the thirtieth day after the payment was due and will resume with effect from 24:00 hours on the

date of payment, without affecting subsequent due dates. With reference to the premium for the Insureds referred to in Article 6(a) and (b) hereunder, at the beginning of each insurance year INFN will notify the Insurer of the number of Insureds to be included in the cover. The overall premium, calculated on the basis on that number, will be payable in two six-monthly instalments in accordance with the provisions set forth in the next paragraph. The same premium payment method may also be used for the family members of the Insureds referred to in Article 6(a) and (b) hereunder, when the notification of their inclusion and the respective premium payments are made through INFN.

By way of exception to Article 1901 of the Italian Civil Code, premium payments by INFN (first instalment, adjustments, subsequent instalments) must be made within a 60-day grace period after the due date. If the premium is not paid the policy will be suspended with effect from 24:00 hours on the sixtieth day after the payment was due and will resume with effect from 24:00 hours on the date of payment, without affecting subsequent due dates.

Article 5 - Amendments
Any amendments to the contract made after the policy has been issued must be approved by the Parties in writing.

Article 6 - Insureds
The benefits under this policy are provided under a group plan, with premiums payable by INFN to the benefit of:

a) employees of INFN
b) holders of research grants and scholarships awarded by INFN.

The benefits under this policy are provided on an individual basis, with premiums payable by each individual party concerned, to the benefit of:

c) retired INFN employees
d) associate staff of INFN/staff seconded to INFN

The Insureds referred to in points a) and b) above, and the Insureds referred to in points c) and d) above may extend the insurance cover provided under this policy to other members of their family unit as defined in Article 7 below, on their own initiative and at their own expense.

Article 7 - Family unit
For the purposes of this group insurance plan, family unit means and includes the Insured (employee/research grant or scholarship holder/retired employee/associate/seconded staff), the Insured's spouse/civil or registered cohabiting partner (regardless of gender) and children included in the family status certificate; children up to the age of 26 who are students are also included, even if not cohabiting. The family unit may also include the following cohabiting family members included in the family status certificate: the Insured's parents and grandparents, parents-in-law, siblings, grandchildren and children's spouses.

Article 8 - Premium
The annual premium for the overall services covered under this policy, in respect of each insured and inclusive of tax charges, is defined as follows:

1) **INFN employee/holder of research grant or scholarship awarded by INFN:** see Article 13, Section III, Sub-section A;

1.a) Members of the Insured's family unit as defined in point 1: see Article 13, Section III, Sub-

section A.

2) **Retired INFN employee:** see Article 13, Section III, Sub-section B;

2.a) Members of the Insured's family unit as defined in point 2: see Article 13, Section III, Sub-section B.

3) **Associate staff of INFN /Staff seconded to INFN:** see Article 13, Section III, Sub-section C;

3.a) Members of the Insured's family unit as defined in point 3: see Article 13, Section III, Sub-section C.

Article 9 - Age limit

The insurance policy is effective for all Insureds with no age limit, apart from the 26-year age limit for non-cohabiting children provided they are students (as per Article 7, Section I of these General Terms and Conditions).

Article 10 - Limitation period for inclusion and extensions

- **Group membership**

Within 30 days from the date on which the insurance cover commences, and from the start of each subsequent insurance year, INFN must give the Insurer the names of the Insureds as per the first part of Article 6 - Section I of the General Terms and Conditions, i.e.:

a) employees of INFN
b) holders of research grants and scholarships awarded by INFN.

The insurance cover for the Insureds referred to in points a) and b) will commence on the policy starting date, or from the starting date of subsequent insurance years, subject to payment of the premium in accordance with the provisions set forth herein.

- **Individual membership**

Before the policy starting date, and before the start of each subsequent insurance year, the Insureds referred to in the third paragraph of Article 6 - Section I of the General Terms and Conditions, i.e.:

c) retired INFN employees
d) associate staff of INFN/staff seconded to INFN

may apply to be included in the insurance plan and pay the relative premium. If the aforesaid deadlines have expired, the insurance cover cannot be activated and the party concerned must wait until the start of the next insurance year. The insurance cover for the Insureds referred to in points c) and d) will commence on the policy starting date, or from the starting date of subsequent insurance years for which it has been requested, subject to payment of the premium in accordance with the provisions set forth herein.

- **Inclusion of family members**

The Insureds as per Article 6 of the General Terms and Conditions - Section I may extend the insurance cover to include members of their family unit and pay the relative premium, following the same procedures and according to the same terms applicable to the Insured family head. If the aforesaid deadlines have expired, the insurance cover cannot be activated and the party concerned must wait until the start of the next insurance year. The insurance cover for the family members included in the plan will commence on the policy starting date, or from the starting date of the insurance years for which it has been requested, subject to payment of the

premium in accordance with the provisions set forth herein.

Article 11 - Change of insureds during the year

- **Inclusion of new members during the year.**

If new employees are hired or new research grants or scholarships are awarded, pursuant to Article 6(1)(a) and (b) of the General Terms and Conditions - Section I, and in the event of new staff association or secondment agreements, pursuant to Article 6(2)(d) of the General Terms and Conditions - Section I, the insurance cover under this policy will commence on the date of appointment/award/association/secondment on condition that INFN gives the Insurer the details of the new Insureds within 90 days. If such details are not provided within that term, the insurance cover will not commence until the date of notification to the Insurer.

For all new Insureds included during the insurance year, the premium will be calculated based on the actual period of cover provided, so that the premium paid will be equal to the number of days covered multiplied by the premium per day (annual premium/360). Premiums for new Insureds included during the year must be paid at the time of the premium adjustment.

- **Inclusion of new family members during the year.**

Within 30 days after any changes to the family unit as the result of a marriage/civil partnership, new registered cohabiting partnership or the birth/adoption of children, the head of the family unit may extend the cover provided under this contract.

In other cases resulting in a change to the family unit, or if the 30-day period referred to in the previous paragraph has expired, the cover provided in the current insurance year cannot be extended but may be activated at the start of the next insurance year.

For all new Insureds included during the insurance year, the premium (which will differ for each category insured) will be calculated based on the actual period of cover provided, so that the premium paid will be equal to the number of days covered multiplied by the premium per day (annual premium/360).

- **Departures during the year**

Departures from the plan during the insurance year will not have any effect (no part of the premium will be refunded) until the first annual renewal date.

Article 12 - Personal details

INFN undertakes to send the Insurer the list with details of the Insureds included in the group plan, in record layout, within 30 days from the starting date of the insurance cover, and to send revised details on a monthly basis throughout the year.

Personal details about individual members will be collected by the Insurer, including through the Fund.

Article 13 - Transmission of information about claims

Every three months the Insurer will send INFN statistical information (relating to each insurance period, from the effective date of the cover to the last day of the month considered). This information, which may also be provided in digital files, will be divided by category of Insureds. It must include a summary of direct and indirect claims (with information about services provided under the NHS) settled, allocated and rejected, according to the type of benefit, type of service and type of medical or healthcare sub-service. The report must state

the number of claims for each benefit and the number of each service and sub-service provided, in addition to the amount (for the aforesaid claims, services and sub-services) requested, paid and allocated.

The Insurer undertakes to provide the aforesaid information until 12 months after the end of the contract.

Article 14 - Events covered by the insurance policy and network of affiliated providers

This insurance policy covers the events and the benefits listed in Sections III, IV and V. Insureds have access to the Insurer's network of affiliated medical and healthcare service providers that guarantee reduced rates and the direct payment of eligible treatment as laid down in Article 1(a) of Section IV.

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.

In order to ensure the availability of an adequate nationwide network of affiliated providers, INFN reserves the right to inform the Insurer of additional healthcare professionals and facilities to be included in the network with a view to improving the service. Within not more than four months of receiving such information, the Insurer undertakes to notify INFN of the outcome of the affiliation process and, for facilities that are not approved for inclusion in the network, it must explain the reasons for that decision.

Article 15 - Exclusions

Subject to any specific exceptions applicable to each benefit/insured service, the insurance does not cover claims for:

1. treatment and/or surgery to eliminate or correct any physical defect or malformation that existed prior to the contract being issued;
2. fertility treatment or treatment of any sort relating to artificial insemination;
3. treatment for mental illness and psychiatric disorders in general, including nervous disorders;
4. dental prostheses, treatment of periodontal disease, dental treatment and examinations;
5. medical treatment to alter or improve appearance (except for reconstructive plastic surgery made necessary as the result of an accident or of destructive surgical procedures that took place during the period of cover);
6. hospitalisation, including on a day-patient basis, solely for physical examinations or therapies that, due to their technical nature, can also be performed in an out-patient clinic;
7. hospitalisation when the Insured needs assistance with basic daily living activities and long-term hospital stays. Long-term hospital stays refer to cases in which the Insured's physical condition cannot be cured by medical treatment and requires him or her to remain in a healthcare facility in order to receive assistance or maintenance physiotherapy.
8. treatment of illness resulting from the misuse of alcohol and psychotropic substances, and from the non-therapeutic use of narcotic drugs and hallucinogens;

9. injuries resulting from the practice of air sports, motor-vehicle racing and competitions and related trial sessions;
10. injuries suffered as a result of criminal actions committed by the Insured;
11. the direct or indirect consequences of nuclear transmutation, radiation generated by artificial acceleration of atomic particles and exposure to ionising radiation, with the exception of staff working in the field who are exposed to a Class A radiation hazard, in accordance with Italian Legislative Decree No. 203/95;
12. the consequences of war, insurrections, earthquakes and volcanic eruptions.

Article 16 - Additional exclusions for Insureds included in the plan on an individual basis

In addition to the exclusions set forth in Article 15 above, the following exclusions also apply exclusively to Insureds included in the plan on an individual basis (as per Articles 6 and 7 of the General Terms and Conditions - Section I), i.e.:

- retired INFN employees;
- associate staff of INFN/staff seconded to INFN;
- family members (of all the categories insured referred to in Article 6(a), (b), (c) and (d) of Section I - General Terms and Conditions);

and only in respect of the services referred to in Articles 1 (Hospital Benefit Cover) and 5 (Allowance in lieu of reimbursement) of Section III – Benefits (sub-sections A, B and C):

a) pre-existing illnesses and/or conditions for which tests had been carried out or treatment/therapy had been provided prior to inclusion in/activation of the cover (for the first time);
b) injuries sustained prior to inclusion in/activation of the cover (for the first time).

For the Insureds referred to above, the following expenses are also excluded:

c) childbirth/abortion (specifically Article 1(B) and (D) of Section III - Sub-sections A, B and C - Benefits) and all expenses in connection with problems during pregnancy for all the services referred to in Section III (sub-sections A, B and C) - Benefits, when the Insured became pregnant prior to inclusion in/activation of the cover (for the first time).

The exclusions referred to in points a), b) and c) above do not apply to:

- all Insureds already covered on 30 June 2020 by policies taken out by INFN through the Healthcare Fund and who renewed the cover provided under this contract without any break in the cover provided under the previous policies that have expired;
- Insureds who have taken out the insurance cover as individual members of the plan without any break in the cover enjoyed as an employee of INFN.

For Insureds who do not renew their individual plan membership each year, for the purposes of the exclusions referred to in points (a), (b) and (c) above, cover will commence on the last effective date for inclusion in the plan (thus without considering any previous non-continuous periods of inclusion).

Article 17 - Waiting period

In addition to that set forth in Articles 15 and 16 of the General Terms and Conditions - Section I, for members included in the plan on an individual basis (as referred to in Articles 6 and 7 of the General Terms and Conditions - Section I), i.e.:

- retired INFN employees;
- associate staff of INFN;
- staff seconded to INFN;

- family members (of all the categories insured referred to in Article 6(a), (b), (c) and (d) of Section I - General Terms and Conditions);

the insurance cover will commence after a 30-day waiting period from the date of inclusion in/activation of the cover (for the first time).

The waiting period does not apply to:

- injuries sustained after joining the scheme;
- all Insureds already covered on 30 June 2020 under policies taken out by INFN through the Healthcare Fund and who renewed the cover provided under this contract without any break in the cover provided under the previous policies that have expired;
- insureds who have taken out the insurance cover as individual members of the plan without any break in the cover enjoyed as an employee of INFN.

For Insureds who do not renew their individual plan membership each year, for the purposes of the application of the waiting period referred to above, cover will commence on the last effective date for inclusion in the plan (thus without considering any previous non-continuous periods of inclusion).

SECTION II - RULES COMMON TO ALL BENEFITS

Article 18 - Insurance in the interest and to the benefit of third parties
This insurance policy has been taken out in the interest and to the benefit of third parties to cover the risks described herein; the obligations arising from the contract must be fulfilled by the Associate and, where specified, by the Contracting Party, with the exception of those which, by their very nature, can only be fulfilled by the Insured, as established under Article 1891 of the Italian Civil Code.

Article 19 - Territorial scope
The insurance is valid worldwide.

Article 20 - Medical records
The Insurer will assume the risks without requesting any medical records.

Article 21 - Tax charges
All taxes in connection with the insurance will be charged to the Contracting Party.

Article 22 - Other insurance cover
INFN must notify the Insurer of the existence of any other insurance policies that have been taken out or that will be taken out in the future to cover the same risk insured under this contract. Within 30 (thirty) days of receiving such notification, the Insurer may withdraw from the contract, subject to giving prior notice of at least 30 (thirty) days. The Insured is under no obligation to inform the Insurer of the existence of any other policies he or she has taken out to cover the same risk, except in the event of filing a claim.

Article 23 - Broker clause
INFN represents that it has entrusted the management of this policy to the appointed insurance broker ITAL BROKERS S.p.A., Via Albaro 3 - Genoa – Tax code/VAT No. 08536311007– RUI (Register of insurance, reinsurance and ancillary insurance intermediaries) registration number: B000059359. Therefore, in accordance with the terms and conditions of this policy, the Insurer hereby acknowledges that all notifications sent by the Contracting Party to the Broker will be deemed as sent to the Insurer, and vice versa, and likewise, all notifications sent by the Broker to the Insurer will be deemed as being sent by the Contracting Party.

By way of exception to Article 1901 of the Italian Civil Code and the provisions of Article 11 of the General Terms and Conditions, the Insurer also acknowledges that the premium payments made by INFN will be made through the aforesaid appointed Broker and that such payment will constitute full discharge of liabilities of the Contracting Party. The Broker in question will be remunerated in accordance with usual market practice, that is, by the Insurance Companies, in the amount of a 3.00% commission on premiums collected net of tax.

Article 24 - Notifications
All notifications must be sent by means of registered letter, or by telegram, telefax, e-mail or certified e-mail.

Article 25 - Board of arbitration
Disputes of a medical nature may be referred to a Board of Arbitration made up of three physicians. Each party will appoint one member of the Board of Arbitration and the third will be

appointed by mutual agreement or, should the parties fail to agree, by the Medical Council (Consiglio dell'Ordine dei Medici) with jurisdiction in the place where the Board is to meet. The medical Board will meet in the municipality where the Institute of legal medicine is based closest to the home of the Insured. 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, with each Party liable only for its own expenses.

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 which hereby waive any recourse, except in the case of violence, fraud, mistake or breach of contract. The results of the arbitration process must be recorded in a specific report, to be drawn up in two copies, one for each Party.

The above without prejudice to the right of the Parties to bring action before the competent judicial authority.

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

Article 26 - 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 Court of Rome.

Article 27 – Applicable law

Any matters not otherwise covered herein are governed by the provisions of law.

Article 28 - Confidentiality

The Insurer has a duty to treat data and information which comes into its possession or is made known to it as confidential and must not disclose such data or information in any way whatsoever or use it in any form for purposes other than those strictly necessary for the performance of the Contract. In the event of breach of the duty of confidentiality, INFN will be entitled to terminate the Contract, without prejudice to the obligation of the Insurer to compensate INFN for any damage or loss incurred.

Article 29 - Privacy

The Contracting Party and the Insurer undertake to treat the personal data provided or collected in relation to this contractual relationship and the staff concerned, exclusively for the purposes connected with the performance of this Contract, in full compliance with the measures and obligations imposed by Italian Legislative Decree No. 196/2003 and Regulation (EU) No. 2016/679.

Article 30 – Specific termination clause

Within the meaning of and pursuant to Article 1456 of the Italian Civil Code, this policy will be automatically terminated upon occurrence of any of the events listed below, without prejudice to the right of INFN to claim compensation for any damage or loss incurred:

1. sub-contracting of services provided under this contract without authorisation by INFN;
2. assignment of the contract;
3. after three shortcomings in the performance of the service, contested in writing by means of registered letter with advice of receipt/certified e-mail;
4. legal action taken against the contractor's representatives under current anti-mafia legislation;
5. revocation of the licence to carry on insurance activities;
6. breach of the obligation of confidentiality.

Article 31 – Processing of personal data

The Insurer, in its capacity as the data Controller, has appointed Poste Welfare Servizi S.r.l. ("PWS") as its designated Processor pursuant to Article 28 of Regulation 2016/679/EU ("GDPR"), to provide administrative and operational management services in connection with this contract. Consequently, the Insurer will ensure, under its own responsibility, that all personal details and special categories of personal data (as defined in Article 9 of the GDPR) concerning Insureds are communicated directly by the Contracting Party to PWS to enable the latter to perform its operational activities in a correct and timely manner. To that end, the Contracting Party undertakes to guarantee all ownership rights in respect of the data communicated thereby to PWS and the lawfulness of the processing of such data.

The Parties hereby agree that any requests by the Contracting Party to retrieve data about Insureds, which could come under the definition of the processing of personal data according to the GDPR, must be addressed to the Insurer which, in its capacity as the Controller, may authorise PWS to send such data, subject to verification of the purposes of the processing and, in any case, in full compliance with the provisions of data protection legislation.

Article 32 – Temporary Joint Venture (TJV) and lead insurer

The companies Poste Assicura S.p.A. and Società Reale Mutua di Assicurazioni have entered into a temporary joint venture arrangement to provide the services under this contract, and have appointed the company Poste Assicura S.p.A. as the lead insurer authorised to represent the grouping, in accordance with the applicable legislation.

Società Reale Mutua di Assicurazioni has granted special power of attorney to Poste Assicura S.p.A., pursuant to Italian Legislative Decree No. 50/2016, appointing it as the lead insurer authorised to represent the grouping, so that it can do everything useful and/or necessary, on its own behalf and on behalf of the principal, to carry out the services, including from a procedural standpoint and until all obligations under the contract are satisfied. Poste Assicura S.p.A. and Società Reale Mutua di Assicurazioni hereby assume the obligation towards INFN in respect of the services rendered hereunder, in accordance with the provisions of the applicable legislation.

The shares of the companies in the joint venture are as follows:

- Poste Assicura S.p.A. (lead insurer/representative of the grouping): 60% (sixty per cent)
- Società Reale Mutua di Assicurazioni (principal): 40% (forty per cent).

The mandate and temporary joint venture will automatically end upon termination of the contractual relationship and, in any case, upon satisfaction of all obligations in connection with this contract, or upon occurrence of one of the reasons for termination under the applicable legislation.

SECTION III

BENEFITS SUB-SECTION A

(Employees, Holders of research grants and scholarships awarded by INFN, family members)

FOREWORD.

The benefits referred to in this sub-section III A are available for:

- **employees of INFN** - Article 6(1)(a) of Section I of the General Terms and Conditions
- **holders of research grants and scholarships awarded by INFN:** Article 6(1)(b) of Section I of the General Terms and Conditions
- **family members of the Insureds listed above,** included in the insurance scheme in accordance with the final paragraph of Article 6 of Section I of the General Terms and Conditions.

Article 1 – Hospital Benefit Cover
The Insurer will reimburse expenses incurred as a result of illness or injury occurring during the insurance year:

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) up to a maximum amount of € 350.00 per day.
4. Tests, diagnostic assessments and specialist examinations carried out during the 150-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 150-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. Board and overnight stay at a healthcare facility or in a hotel if no accommodation is

available at the hospital, for a person accompanying the Insured up to a maximum amount of € 150.00 per day and for no longer than the period of hospitalisation, for a maximum of 100 days per insurance year.

8. Transportation of the Insured by ambulance, mobile coronary care unit and air ambulance to and from the healthcare facility, up to a maximum amount of € 1,100.00 per operation or hospital stay.
9. Transportation of the Insured and of the accompanying person, where applicable, to and from a foreign country, by train or commercial airline (excluding private car), up to a maximum amount of € 2,000.00 per operation or hospital stay.
10. In the event of death following surgery abroad, the insurance includes the reimbursement of expenses to repatriate the remains up to a maximum amount of € 1,500.00.

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 € 7,000.00 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) up to a maximum amount of € 350.00 per day.
4. Tests, diagnostic assessments and specialist examinations carried out during the 150-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 150-day period after surgery or discharge from hospital, provided they are directly related to the surgery.
6. Board and overnight stay at a healthcare facility or in a hotel if no accommodation is available at the hospital, for a person accompanying the Insured up to a maximum amount of € 150.00 per day and for no longer than the period of hospitalisation, for a maximum of 100 days per insurance year.
7. Transportation of the Insured by ambulance, mobile coronary care unit and air ambulance to and from the healthcare facility, up to a maximum amount of € 1,100.00 per operation or hospital stay.

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) up to a maximum amount of € 350.00 per day.
3. Tests, diagnostic assessments and specialist examinations carried out during the

150-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 150-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 by ambulance, to and from the healthcare facility, up to a maximum amount of € 1,100.00 per hospital stay.
6. Transportation of the Insured and of the accompanying person, where applicable, to and from a foreign country, by train or commercial airline (excluding private car), up to a maximum amount of € 2,000.00 per operation or hospital stay.

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 € 5,000.00 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) up to a maximum amount of € 350.00 per day.
4. Tests, diagnostic assessments and specialist examinations carried out in the 150-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 150-day period after discharge from hospital, provided they are directly related to the birth.
6. Board and overnight stay at a healthcare facility or in a hotel if no accommodation is available at the hospital, for a person accompanying the Insured up to a maximum amount of € 150.00 per day and for no longer than the period of hospitalisation, for a maximum of 100 days per insurance year.
7. Transportation of the Insured by ambulance, mobile coronary care unit and air ambulance to and from the healthcare facility, up to a maximum amount of € 1,100.00 per operation or hospital stay.

Article 2 - Effectiveness of the insurance cover

The insurance provided under this policy is effective independently of and in addition to the cover provided by the National Health Service.

Article 3 - Benefit limit

The benefit referred to in Article 1 - Hospital Benefit Cover of this Section is for up to a maximum amount of € 500,000.00. The benefit is per insurance year and per Insured (or per family unit where included in the cover), without prejudice to any other applicable sub-limits.

Article 4 - Deductibles and excess
The Insurer will reimburse the expenses referred to in Article 1 - Hospital Benefit Cover of this Section after applying the excess and deductibles specified below, which differ according to the type of service/benefit and the conditions under which they are provided:

1. In-patient and day-patient care as per points A) and C):
Affiliated healthcare facilities: no deductible and/or excess

Non-affiliated healthcare facilities:	20% deductible with a minimum of € 500.00 and a maximum of € 10,000.00 (the minimum amount does not apply for treatment provided on an out-patient basis)
Benefit to supplement the NHS (co-payment only):	reimbursement of the full amount with no deductible or excess.

2. Caesarean section/therapeutic abortion and natural childbirth as per points B) and D)

Affiliated healthcare facilities:	no excess
Non-affiliated healthcare facilities:	10% deductible
Benefit to supplement the NHS (co-payment only):	reimbursement of the full amount with no deductible or excess.

Article 5 - Allowance in lieu of reimbursement
Insureds who do not ask the Insurer to reimburse expenses for in-patient/day-patient treatment or for any other services in connection therewith will be entitled to an allowance of € 180.00 (reduced by 50% for day-patient treatment) per day in hospital for a period of not more than 60 days per hospital stay.

This allowance is also payable when, instead of or in addition to receiving treatment at an NHS healthcare facility, the Insured, as directed by the National Health Service healthcare facility, receives the following forms of healthcare at home:
- Home-based healthcare - arranged and provided by the hospital, which sends medical and nursing staff to the patient's home;
- Protected discharge - when the patient is discharged from hospital early, the hospital specifies the patient's needs and the equipment required and the local health authority supplies such equipment and staff to provide the necessary healthcare.

Article 6 – Out-Patient Benefit Cover.
Article 6.1 - Advanced diagnostics and therapies
The Insurer will pay or reimburse the costs of the services listed below.

To receive the benefit, the Insured must provide a medical prescription indicating the provisional diagnosis or the condition that led to the service being needed. In the case of an accident, the Insured must provide the Emergency Department discharge form or, alternatively, a medical certificate indicating the type of injury sustained and the

date/period of occurrence.

Advanced diagnostics (including digital imaging), computerised tomography and contrast imaging tests:

- Angiography
- Arthrography
- Bronchography
- Cisternography
- Cystography
- Cystourethrography
- Contrast enema
- Intravenous cholangiography
- Per-cutaneous cholangiography (PTC)
- Trans-Kehr cholangiography
- Cholecystography
- Colonoscopy
- Dacryocystography
- Defecography
- Discography
- Fistulography
- Phlebography
- Fluorescein angiography
- Galactography
- Gastroscopy
- Hysterosalpingography
- Lymphography
- Myelography
- Pneumoencephalography
- Retinography
- Oesophageal X-ray with contrast
- Stomach and duodenal X-ray with contrast
- X-ray of the small intestine and colon with contrast
- Chest X-ray
- Rectoscopy
- Sialography
- Splenoportography
- Renal CT scan
- Xerographic tomography
- Chest CT scan
- Computerised tomography (CT) in general
- Urography
- Vesiculo-deferentography
- Video angiography
- Wirsungraphy

Tests
- Amniocentesis and chorionic villus sampling
- Computerised bone densitometry (MOC)
- Echocardiography
- Electroencephalography
- Electromyography
- Mammography or Digital Mammography
- Nuclear magnetic resonance (RMN) (including MR angiography)
- Scintigraphy
- Computerised axial tomography (CAT) (including virtual CAT)

Therapies
- Chemotherapy
- Cobalt therapy
- Dialysis
- Laser therapy for physiotherapy
- Radiotherapy

Article 6.1.1 - Benefit limit
The annual maximum benefit limit for all of the services listed in Article 6.1 - Advanced diagnostics and therapies is € 10,000.00. This is the full amount of the benefit available per insurance year and per Insured (or per family unit where included in the insurance cover).

Article 6.1.2 – Deductibles and excess
For the services listed in Article 6.1 - Advanced diagnostics and therapies, when provided by the Insurer's affiliated healthcare facilities, the costs of the services provided to the Insured will be paid directly by the Insurer to the facility, without applying any deductible or excess.

If, on the other hand, the above services are provided by non-affiliated healthcare facilities, the Insurer will reimburse the Insured after applying a 20% deductible for each service or treatment cycle. For services provided through the National Health Service, the Insurer will reimburse the full amount of the co-payments made by the Insured.

Article 6.2 - Diagnostic and laboratory tests and assessments
The Insurer will pay or reimburse the costs of specialist consultations, examinations and diagnostic and laboratory tests, following an illness or injury, with the exception of routine paediatric check-ups to chart growth and routine dental check-ups.

To receive the benefit, the Insured must provide a medical prescription indicating the provisional diagnosis or the condition that led to the service being needed. In the case of an accident, the Insured must provide the Emergency Department discharge form or, alternatively, a medical certificate indicating the type of injury sustained and the period of occurrence.
Claims for reimbursement of specialist consultations must include supporting expense documentation (bills and/or receipts) attesting to the physician's field of specialisation, which must be consistent with the condition reported in the claim.

Article 6.2.1 - Benefit limit
The annual maximum benefit limit for all of the services listed in Article 6.2 - Diagnostic and laboratory tests and assessments is € 3,000.00. This is the full amount of the benefit available per insurance year and per Insured (or per family unit where included in the insurance cover).

Article 6.2.2 - Deductibles and excess
For the services listed in Article 6.2 - Diagnostic and laboratory tests and assessments, when provided by the Insurer's affiliated healthcare facilities, the costs of the services provided to the Insured will be paid directly by the Insurer to the facility, without applying any deductible or excess.

If, on the other hand, the above services are provided by non-affiliated healthcare facilities, the Insurer will reimburse the Insured after applying a 20% deductible amounting to a minimum of € 40.00 per service or treatment cycle (by that also meaning each specialist consultation or test relating to a single condition, prescribed together by the physician and submitted to the Insurer in a single claim).

For services provided through the National Health Service, the Insurer will reimburse the full amount of the co-payments made by the Insured.

Article 7 - Orthopaedic prostheses and hearing aids
The Insurer will reimburse the costs of orthopaedic prosthetic devices and hearing aids purchased by the Insured, less a deductible of 20%.

To receive the benefit, the Insured must provide a medical certificate indicating the condition or injury that led to the prosthetic device being needed.

The annual maximum benefit limit for all of the services listed in this Article is € 5,000.00. This is the full amount of the benefit available per insurance year and per Insured (or per family unit where included in the insurance cover).

Article 8 - Cancer Treatment
The Insurer will pay or reimburse the costs of specialist consultations, investigations, diagnostic and laboratory tests, therapies and medications for the treatment of cancer.

To receive the benefit, the Insured must provide a medical certificate indicating the condition that led to the service being needed.

The annual maximum benefit limit for all of the services listed in this Article is € 5,000.00. This is the full amount of the benefit available per insurance year and per Insured (or per family unit where included in the insurance cover).

For the services referred to in this Article, when provided by the Insurer's affiliated healthcare facilities, the costs of the services provided to the Insured will be paid directly by the Insurer to the facility, without applying any deductible or excess.

If the above services are provided by non-affiliated healthcare facilities, the Insurer will reimburse the Insured after applying a 20% deductible. For services provided through the National Health Service, the Insurer will reimburse the full amount of the co-payments

made by the Insured.

Article 9 - Dental treatment following injury
By way of partial exception to Article 15 - Exclusions, of Section I of the General Terms and Conditions, the Insurer will reimburse the costs of dental treatment and prostheses made necessary following an accident, up to the maximum limit of € 3,000.00, provided the accident is certified by the Emergency Department or other equivalent hospital facility to which the Insured went to receive emergency treatment. This is the full amount of the benefit available per insurance year and per Insured (or per family unit where included in the insurance cover).

Article 10 - Preventive dental care
By way of partial exception to Article 15 - Exclusions, of Section I of the General Terms and Conditions, the Insurer will pay the costs of one specialist dental examination and one oral hygiene session per year per Insured, performed by an affiliated dentist at an affiliated facility (services paid for directly by the Insured will not be reimbursed).

Article 11 - Physiotherapy and rehabilitation.
The Insurer will pay or reimburse the costs of physiotherapy and rehabilitation services following an accident certified by an Emergency Department discharge form and provided the therapy was prescribed by a physician and is performed by a medical specialist or qualified healthcare professional with an appropriate diploma or degree.

The annual maximum benefit limit for all of the services referred to in this Article is € 1,000.00. This is the full amount of the benefit available per insurance year and per Insured (or per family unit where included in the insurance cover).

For the services referred to in this Article, when provided by the Insurer's affiliated healthcare facilities, the costs of the services provided to the Insured will be paid directly by the Insurer to the facility, without applying any deductible or excess.

If the above services are provided by non-affiliated healthcare facilities, the Insurer will reimburse the Insured after applying an excess of € 100 per invoice or cycle of therapy (meaning all the services provided on the basis of a single medical prescription).

For services provided through the National Health Service, the Insurer will reimburse the full amount of the co-payments made by the Insured.

Article 12 - Dental surgery on an out-patient basis
By way of partial exception to Article 15 - Exclusions, of the General Terms and Conditions, the Insurer will pay or reimburse the costs of surgical procedures made necessary as a consequence of the following conditions, including dental implant surgery also made necessary due to the following:

1. maxillary osteitis
2. bone neoplasms of the mandible and maxilla
3. follicular cysts
4. radicular cysts
5. adamantinoma
6. odontoma

To receive the benefit, the Insured must provide a medical prescription indicating the provisional diagnosis or the condition that led to the service being needed. The medical records listed below must be submitted in order to obtain reimbursement of the expenses incurred:

- X-rays and X-ray medical reports for the conditions as per points 1, 2, 3, 4, 5, 6 above;
- (in addition to the above) results of histological analyses for bone neoplasms of the mandible and maxilla, follicular or radicular cysts.

The annual maximum benefit limit for all of the services referred to in this Article is € 3,000.00. This is the full amount of the benefit available per insurance year and per Insured (or per family unit where included in the insurance cover).

For the services referred to in this Article, when provided by the Insurer's affiliated healthcare facilities, the costs of the services provided to the Insured will be paid directly by the Insurer to the facility, without applying any deductible or excess.

If the above services are provided by non-affiliated healthcare facilities, the Insurer will reimburse the Insured for the full amount of the cost.

For services provided through the National Health Service, the Insurer will reimburse the full amount of the co-payments made by the Insured.

Article 13 - Premium
The annual premium for the cover provided under this policy, for each of the Insureds listed below, inclusive of tax charges, is defined as follows:

1) Employees of INFN/holders of research grants and scholarships awarded by INFN
Article 6(1)(a) and (b) of Section I of the General Terms and Conditions: **€ 378.00**

Members of the family unit of the Insureds specified above, to whom the insurance cover has been extended in accordance with the final paragraph of Article 6 of Section I of the General Terms and Conditions:

1.1) Dependent spouse/civil partner: € 302.40
1.2) Non-dependent spouse/civil partner/registered cohabiting partner: € 340.20
1.3) Child: € 264.40
1.4) Family member: € 567.00

As regards the Insureds listed in points 1.1 and 1.2 above, any changes in the tax burden during the insurance year will not affect the premium (reduction/increase) already determined/paid for the current year, but may be considered in determining the premium for the following year.

SECTION IV - CLAIMS PROCEDURE

Article 1 - Provision of services
The services covered by this contract, specifically those referred to in Section III (Sub-sections A, B and C), may be provided as follows:

a) **Affiliated facilities**: at private or public healthcare facilities that are part of the Insurer's provider network, by 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 deductible or excess applicable to each type of benefit and service, which must be paid directly by the beneficiary of the service to the healthcare facility/professional.

By way of partial exception to the above, for the services listed below referred to in Article 1 - Hospital Benefit Cover of Section III (sub-sections A, B and C), expenses for:

- board and overnight stay for a person accompanying the Insured;
- transportation of the Insured by ambulance, mobile coronary care unit or air ambulance;
- transportation of the Insured and of the accompanying person, where applicable, to and from a foreign country, by train or plane;
- repatriation of remains

will be reimbursed without applying any deductible or excess, subject to the limits laid down herein.

Furthermore, for the hospital services referred to in Article 1 Hospital Benefit Cover of Section III (sub-sections A, B and C), in the case of in-patient/day-patient care provided at affiliated healthcare facilities and by affiliated physicians, the Insurer will pay hospital stay charges (excluding unnecessary expenses) without applying the limit established in the aforesaid Article 1.

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 paid 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).

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 (subject to application of any deductible or excess) in accordance with the procedures established for each type of benefit and service.

By way of partial exception to the above, for the services listed below referred to in Article 1 - Hospital Benefit Cover of Section III (Sub-sections A, B and C), expenses for:

- board and overnight stay for a person accompanying the Insured;
- transportation of the Insured by ambulance, mobile coronary care unit or air ambulance;
- transportation of the Insured and of the accompanying person, where applicable, to and from a foreign country, by train or plane;
- repatriation of remains

will be reimbursed without applying any excess or deductible, subject to the limits laid down herein.

c) Services under the National Health Service

In the case of hospitalisation in a National Health Service facility or a healthcare facility commissioned to provide care under the NHS, with all costs charged to the NHS, the Insurer will fully reimburse the Insured for all costs incurred; alternatively, the Insured may request the "Allowance in lieu of reimbursement" for in-patient/day-patient treatment.

Article 2 - Obligations of the Insured

To obtain reimbursement of out-of-pocket expenses (or recognition of the allowance in lieu of reimbursement), the Insured must file a claim with the Insurer in accordance with the operational procedures agreed upon between the latter and INFN.

When filing a claim, the Insured must include a copy of the relevant medical records, indicating the presumed or proven diagnosis, relating to the service for which the reimbursement is requested, or a copy of the medical report certifying the nature of the illness or injury (in the latter case, the Insured must provide a copy of the Emergency Department discharge form or, alternatively, the relevant medical certificates and/or diagnostic test results from which the cause of the injury sustained and the date of occurrence can be determined).

In the case of hospitalisation, the Insured must provide a copy of the medical records (including in electronic format).

The Insured must provide all the information requested and consent to examinations by physicians appointed by the Insurer and to any assessments or tests deemed necessary. Exclusively for that purpose, the Insured must therefore release the physicians who examined and treated him/her from the duty of professional secrecy.

The above documentation must be submitted in the form of copies, notwithstanding the right of the Insurer to ask, at any time (either prior to or after payment), for the original documents or true copies thereof if the documents received are completely or partially illegible, incomplete or have been written in different ways, or for the purpose of statistical checks.

The Insurer will examine the claim and notify the Insured of the outcome of its assessment (with details of the amounts to be reimbursed directly and those approved, or the reasons for denial), within 30 days of it being filed.

Article 3 - Direct settlement scheme for services provided through Affiliated Healthcare Facilities

With reference to the provision of services described in Article 1(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, either in full or after applying the deductibles and excess 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 provided, the Insured must provide a valid identity document and medical prescription 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 deductible or excess applicable to each benefit or expenses that have not been authorised or that exceed the maximum benefit limit.

Art. 4 - Advance payment

In the case of hospitalisation - as referred to in Article 1 - Hospital Benefit Cover of Section III (sub-sections A, B and C), at a healthcare facility that is not part of the Insurer's provider network, the Insured may request an advance payment for up to 80% of the estimated cost (70% in the cases of hospitalisation referred to in sub-sections B and C), subject to presentation of the appropriate documentation to the Insurer. The Insurer will usually pay the advance within 5 days from the date of receiving the necessary documentation.

The Insurer will settle the claim and pay the final balance when the treatment has ended and after receiving the original copies of the bills from the Insured.

Should the Insured be able to notify the Insurer of the exact amount to be reimbursed, as quoted by the healthcare facility, the advance payment may be up to 100% of the costs incurred within the limits laid down in the contract.

SECTION V - ASSISTANCE

Foreword: the services referred to in this section are available to all the Insureds listed in Article 6 of Section I of the General Terms and Conditions.

Article 1 - CONSULTANCY SERVICES AND ASSISTANCE

The consultancy services listed below are provided by the Operations Centre, which can be contacted on freephone number **800.186.035** between 8 am and 6 pm from Monday to Friday.

For mobile phones and calls from abroad, the number is **+39 06.89320211**, with the cost charged to the caller. The Insurer generally undertakes to answer calls for consultancy services and assistance within not more than ten minutes.

Article 2 - SERVICES IN ITALY

a) Telephone healthcare information service

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, how to request reimbursements and apply for the direct settlement scheme;
- specialised medical centres for specific diseases in Italy and abroad.

b) Appointment management

The Operations Centre is available to book appointments for the healthcare services covered by the plan under the direct settlement scheme at affiliated healthcare facilities.

The consultancy services and assistance listed below are provided by the Operations Centre on freephone number **800.55.40.84**, which operates 24 hours a day. For calls from abroad the number is **+39.011.74.17.180**.

c) Immediate medical opinion

If the Insured needs to consult a doctor about an injury or illness, physicians at the Operations Centre are on-hand to offer information and advice.

d) Sending a doctor

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) Transfer from hospital emergency department

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.

f) Purchase and delivery of medicines

Insureds may ask the Operations Centre to arrange for medicines listed in the Italian pharmaceutical formulary to be delivered to their home. Acting in compliance with all rules governing the purchase and transportation of medicinal products, the Operations Centre will first send someone to the Insured's home to collect the money and prescription in order to buy the medicine, and then deliver the medicines requested. Once the medicines have been purchased, they will be delivered as quickly as possible.

g) Home blood sampling service

When blood tests have been prescribed by a general practitioner, the Insured may ask the Operations Centre to arrange for the sample to be taken at home. This service must be booked 5 (five) working days in advance.

h) Comparative Diagnosis

The Insured may contact the Operations Centre directly to request to have a diagnosis or therapeutic approach re-examined by specialists with expert knowledge in the field concerned. The Insured will be duly notified of the procedure to be followed in order to obtain the service covered by the plan.
This service is available for Insureds diagnosed with the following serious conditions:

- Alzheimer's disease
- AIDS
- Blindness
- Cancer
- Cardiovascular problems
- Deafness
- Kidney failure
- Loss of speech
- Transplantation of vital organs
- Neuromotor diseases
- Multiple sclerosis
- Paralysis
- Parkinson's disease
- Stroke

To receive the benefit, the Insured must send the Insurer the medical documentation in his or her possession concerning the specific condition for which the comparative diagnosis is requested. The Insurer's physician will specify which records are required. These records will then be forwarded by the Insurer, at its own expense, to the external medical consultants who will decide on the best external specialist to treat the specific disorder.

Article 3 - ADDITIONAL SERVICES, ABROAD

The Insurer also provides the following services, available 24 hours a day for callers from abroad on: **+39.011.74.17.180**

i) Travel of a family member abroad

If the Insured is hospitalised for more than 10 days due to illness or injury, the Operations Centre will, at the Insurer's expense, provide one family member of the Insured with a return airline ticket (economy class) or rail ticket (first class) and will cover the costs of accommodation for up to € 2,000.00 per claim.

j) Urgent delivery of medicines abroad

If, following an accident or due to illness, the Insured requires treatment with special medicinal products that are not available in that country (but which are sold in Italy), the Operations Centre will send them by the fastest means possible, compatibly with local rules on the transportation of medicinal products, with all costs of the service borne by the Insurer. The Insured Party will be required to pay the cost of the medicinal products.

k) Medical repatriation

If the Insured is unexpectedly taken ill or injured while abroad and his or her condition, assessed locally by the physician in attendance in direct contact and/or in contact via other means of telecommunication with doctors at the Operations Centre, warrants transfer to an appropriate hospital in Italy or back to the Insured's home, the Operations Centre will arrange the repatriation, at its own expense, choosing from among the means of transport listed below deemed most suitable based on the Insured's condition:

- air ambulance;
- commercial airline, economy class, with stretcher if necessary;
- rail, first class and in sleeper accommodation if necessary;
- ambulance with no limitation on distance.

Repatriation from non-European countries will always be by commercial airline, in economy class. The Operations Centre will make all arrangements for transportation, including any medical and/or nursing care deemed necessary by the physicians. This service is not available for injuries or illnesses that the physicians consider can be treated locally or would not prevent the Insured from continuing the journey. Following repatriation at the expense of the Operations Centre, the latter may ask the Insured for the unused flight or rail ticket, where already purchased.

False, incorrect or incomplete statements made by the person authorised to provide the information required in order to conclude this contract may affect the right to the service, pursuant to Articles 1892, 1893 and 1894 of the Italian Civil Code.

The Contracting Party_____

Pursuant to Articles 1341 and 1342 of the Italian Civil Code, the Contracting Party hereby specifically agrees to the terms of: Section I, Articles 1, 9, 10, 11 – Section II, Article 19 – Section IV, Article 2 of the Policy Terms and Conditions

The Contracting Party_____

OBLIGATIONS OF THE CONTRACTING PARTY

Where Insureds are responsible for payment of all or part of the premium and thus have an interest in the service directly or through their assigns, the Contracting Party hereby undertakes to provide them with a copy of the Policy Terms and Conditions.

The Contracting Party_____

PRE-CONTRACTUAL INFORMATION

The Contracting Party hereby confirms that it has received and examined the Policy Terms and Conditions. The Contracting Party also hereby confirms that it has examined and received (where required by law) the summary of the main standards of conduct applicable to insurance intermediaries, and has examined and received the document containing general information about the insurance intermediary, in accordance with the applicable legal and regulatory requirements.

The Contracting Party_____ **POSTE ASSICURA S.p.A.**

PLEASE READ THIS PRIVACY POLICY STATEMENT CAREFULLY
Privacy policy statement in accordance with Regulation (EU) 2016/679 - "General Data Protection Regulation"

Poste Assicura S.p.A. (hereinafter the Insurer), which is part of the Poste Vita Insurance Group, a member of the Poste Italiane Group - with registered office in Rome, Viale Beethoven 11, in its capacity as the "controller", has drawn up this statement to provide you with clear and simple information about how your personal data will be processed. If you have any doubts or would like clarifications regarding anything in this statement, please do not hesitate to contact our Data Protection Office at the numbers and addresses provided below.

SOME KEY DEFINITIONS

'**Personal data**' means any information relating to an identified or identifiable natural person ('**data subject**'); an identifiable natural person is one who can be identified, directly or indirectly, in particular by reference to an identifier such as a name, an identification number, location data, an online identifier or to one or more factors specific to the physical, physiological, genetic, mental, economic, cultural or social identity of that natural person.

'**Processing**' means any operation or set of operations performed on personal data, whether or not by automated means, including collection, recording, organisation, structuring, storage, adaptation, alteration, retrieval, consultation, use, disclosure by transmission, dissemination, making available, alignment, combination, restriction, erasure or destruction.

'**Controller**' means the legal person which, alone or jointly with others, determines the purposes and means of the processing of personal data.

'**Joint controller**' means the legal person which, jointly with one or more Controllers, determines the purposes and means of the processing of personal data of the data subject, and the respective responsibilities for compliance with the obligations under the applicable legislation.

'**Processor**' means the natural or legal person which processes personal data on behalf of the Controller.

'**Consent**' of the data subject means a freely given, specific, informed and unambiguous indication of the data subject's wishes by which he or she, by a statement or by a clear affirmative action, signifies agreement to the processing of personal data relating to him or her.

'**Marketing**' means commercial, advertising and promotional activities including, but not limited to the sending of advertising material, direct sales, market research and commercial communications, or promotional activities at events and award ceremonies sponsored by the Insurer.

'**Profiling**' means automated and computer processing of personal data consisting in the use of personal data to evaluate certain personal aspects or aspects concerning that natural person's performance at work, economic situation, personal preferences, interests, reliability in making payments, behaviour, location or movements.

PARTIES AUTHORISED TO PROCESS PERSONAL DATA

The Insurer may process your personal data, in respect of the service requested, jointly with other:

- Controllers, when they each only determine the purposes and means of the processing of personal data for the part within their respective areas of responsibility in providing the service. These subjects must provide their own privacy policy statement for customers;
- Joint controllers, when they, jointly with the Poste Vita Insurance Group, determine the purposes and means of the processing in relation to the provision of a given service. In that case, the privacy policy statement is drawn up by the Joint controller and by the Poste Vita Insurance Group together.

To perform certain activities that are necessary in order to provide the requested service, or to meet legal obligations and ensure compliance with personal data protection legislation, the Insurer may appoint external Processors (third parties which process personal data on behalf of the Insurer).

Please visit the website https://postevita.poste.it/ for detailed information about any other Controllers, Joint Controllers and the main Processors based on the service you have requested.

The people responsible for processing are the Insurer's employees and equivalent workers, specifically authorised by the Controller to process personal data, either directly or indirectly through agents.

CATEGORIES OF RECIPIENTS OF PERSONAL DATA

The Insurer may transfer your personal data to the following categories of recipients without requiring your explicit consent:

- insurance and reinsurance intermediaries and other channels through which insurance contracts are sold; technical experts and other parties that carry out auxiliary activities on behalf of the Insurer, including legal professionals, appraisers and medical experts; affiliated clinics; companies that provide premium payment and receipt services; companies that provide claims management, settlement and payment services; law firms;
- companies that provide IT, telematics and telecommunications services; companies that provide data collection, processing and storage services; companies that provide postal services for correspondence with data subjects; companies (e.g. call centres) for assistance, advertising, promotional activities, market research and customer satisfaction surveys; auditors and companies that certify the Insurer's activities, including in the interests of customers; companies that provide consultancy services and assistance; companies that provide fraud control services; debt collection companies; cheque guarantee companies;
- regulatory and supervisory authorities and any state or private bodies with public functions (e.g., IVASS (the Italian Insurance supervisory authority), CONSOB (the Italian financial markets regulator), COVIP (the Italian pension fund regulatory authority), ANIA (the Italian national association of insurance companies), CIRT (the Italian consortium of impaired risk life insurance companies), CONSAP (the Italian public insurance services agency), Banca d'Italia, UIF (the Italian financial intelligence unit), etc.); organisations that manage national and international systems to protect financial intermediaries against the risk of fraud.
- entities that operate, for example, in the field of electronic systems, assistance,

consultancy, quality, marketing, printing and packaging, financial and insurance services, debt collection, auditing and certification, bulk document processing;

- entities to which data must be transferred in order to comply with the requirements of national and European legislation (for instance, anti-money laundering laws, laws on the prevention of payment card fraud, laws regarding fiscal and tax assessments, investment services) and with provisions issued by supervisory and regulatory bodies.

The Insurer may also transfer your personal data to other companies in the Poste Italiane Group, for administrative and accounting purposes. This type of processing is necessary for carrying out organisational, administrative, financial and accounting activities, whatever the nature of the data processed (in particular: activities related to internal organisation, compliance with contractual and pre-contractual obligations, the correct keeping of accounting records and the application of tax laws and regulations governing social security contributions, health, hygiene and safety at work).

DATA PROTECTION OFFICER

The Data Protection Officer (DPO) is the person responsible for the protection of personal data and is designated by the Controller to fulfil the tasks expressly laid down by the European Regulation on the protection of personal data. The DPO can be contacted at the office of the Data Protection Officer of Poste Italiane, Viale Europa, 175 - 00144 Rome, e-mail: ufficiorpd@posteitaliane.it.

ORIGIN OF PERSONAL DATA

In order to provide the insurance services and/or products requested or envisaged to the benefit of the data subject, the personal data processed by the Insurer will be collected from the data subject at the time of requesting the product or service or during the contractual relationship, and also from other entities in connection with the contractual relationship (e.g., holders of an insurance policy under which the data subject is the insured, the beneficiary, jointly liable, etc.) and/or insurance and reinsurance intermediaries (including Poste Italiane S.p.A. - Patrimonio BancoPosta, persons involved in mediation such as employees, co-workers and other entities appointed by the intermediary to carry out activities under outsourcing arrangements; agents; insurance brokers, etc.).

Personal data may also be collected by telephone through the Contact Centre, by e-mail and through other channels including, for example, websites (social networks, chats, applications, cookies: for information about third-party cookies, please read the policy statements on the providers' websites). Your data may be associated with online identifiers provided by your devices, applications, tools and protocols, such as IP addresses, cookie identifiers or other identifiers. These identifiers may leave traces which, when combined with unique identifiers and other information received by the servers, may be used, with your consent, to create individual profiles.

LEGAL BASIS, PURPOSES OF THE PROCESSING AND PROVISION OF DATA

The Insurer will process your personal data for the purposes of "insurance", when necessary in the context of a contract or for the entering into or performance of a contract or for the fulfilment of pre- and post-contractual requirements (e.g. preparation and taking out of insurance policies; collection of premiums; settlement of claims or payment of other services). Your data may also be processed to meet legal obligations (e.g. to comply with regulations concerning the prevention of the use of the financial system

to recycle the proceeds of criminal activities and the financing of international terrorism). The Insurer may also transfer your personal data to Poste Italiane S.p.A. and/or to other companies in the Poste Italiane Group, for administrative and accounting purposes. This type of processing is necessary for carrying out organisational, administrative, financial and accounting activities, whatever the nature of the data processed (in particular: activities related to internal organisation, compliance with contractual and pre-contractual obligations, the correct keeping of accounting records and the application of tax laws and regulations governing social security contributions, health, hygiene and safety at work).

The provision of personal data for these purposes is necessary; without such data the service you have requested cannot be provided.

The processing of your personal data will also be regarded as lawful where:

- it is necessary for the performance of a task carried out in the public interest;
- it has a basis in Union or Member State law for the exercise of official authority;
- it is necessary to protect an interest which is essential for the life of the data subject or that of another natural person;
- it is performed for purposes other than those for which the personal data were initially collected, where the processing is compatible with the purposes for which the personal data were initially collected;
- it is necessary for the purposes of the legitimate interests pursued by the Controller or by a third party.

Furthermore, the Insurer may process your personal data for the purposes of marketing or profiling if you have given your explicit and voluntary consent. If you give your consent for profiling, the Insurer will use automated means to analyse and process data for the purpose of evaluating your personal preferences in relation to the services offered in order to improve them and align them more closely with your needs, aggregating data to create homogeneous groups and defining personal profiles.

Lastly, in order to supply insurance products and/or services, and particularly for some of the products in the Protection range and in connection with claims management services, the Insurer needs to process **certain categories of personal data**, including personal data that reveal racial or ethnic origin, political opinions, religion or philosophical beliefs, trade union membership, and the processing of genetic data, data concerning health or data concerning a natural person's sex life or sexual orientation, unless otherwise specified by law. You will be asked to give your explicit consent for the processing of such data within the limits of the insurance purposes specified above, using a separate form. The Insurer will only process such data in connection with specific services and transactions requested by customers. These include, for example, the payment of trade union or political party membership fees; the purchase of goods or services using credit/debit cards which involve the processing of such data.

The Insurer may only process personal data regarding criminal convictions and offences in the cases authorised by law or by an official authority.

Lastly, within the meaning of and pursuant to the Prime Minister's Decree of 22 February 2013, the Insurer intends to make an advanced digital signature (ADS) system available for use by customers. The system was developed by Poste Italiane and the service provider is Poste Vita Insurance Group. This solution involves the processing of **biometric data** (writing speed, pressure, angle of the pen, acceleration, number of times the pen is raised from the writing surface) which are described in detail in the policy statement by Poste Italiane on the processing of biometric data. This policy statement - to which reference should be made -

provides a detailed description of the entire ADS management process, including the methods used by handwriting analysis experts to de-encrypt signatures should they be contested, all designed to ensure compliance with the appropriate security measures required by law.

The ADS system guarantees greater legal certainty in relations with customers, especially with reference to the rigorous mechanism used to identify the signatory and uniquely link that person to the signature. Customers who wish to use the aforesaid ADS system must give their explicit consent using the separate form provided by Poste Italiane, after reading the personal data processing policy statement and giving their consent to the processing of biometric data.

METHODS USED TO PROCESS AND STORE DATA

Your personal data will be processed in a manner that ensures an adequate level of security and confidentiality and to prevent unauthorised access to or use of your personal data. Therefore, your personal data will be processed and stored in full compliance with the principles of necessity, data minimisation and storage limitation, using appropriate technical and organisational measures in relation to the level of risk of the processing and for no longer than is necessary for the purposes for which the personal data are processed, and in any case for the period prescribed by law.

RIGHTS OF THE DATA SUBJECT

You have the right to obtain from the Insurer access to the following information: the purposes of the processing, the categories of personal data concerned, the recipients or categories of recipient to whom personal data have been or will be disclosed (including recipients in third countries or international organisations), the envisaged period for which personal data will be stored or, if not possible, the criteria used to determine that period, the source of personal data, the existence of profiling and information about the logic involved.

You also have the right to:

- obtain the rectification of inaccurate personal data;
- have incomplete personal data completed;
- obtain restriction of processing of personal data (in which case, your data will only be processed with your consent, except for the necessary storage of such data);
- object to processing;
- erasure of your data (‘right to be forgotten’);
- data portability, meaning the right to have your personal data transmitted from one controller to another, where technically feasible.

You may exercise your rights by contacting the Insurer’s **Data Protection Office**, through the following channels: e-mail: privacy@postevita.it; postal address: Viale Beethoven, 11, 00144 Rome.

RIGHT TO LODGE COMPLAINTS

Should you consider that the processing of personal data relating to you infringes the provisions of the European General Data Protection Regulation, you have the right to lodge a complaint with the Italian Data Protection Authority in accordance with Article 77 of Regulation 2016/679/EU.

TRANSFERS OF PERSONAL DATA TO A THIRD COUNTRY

Transfers of personal data from EU Member States to “third” non-EU countries are not allowed, in principle, unless the Controller or the Processor can guarantee an “adequate” level of protection. Personal data will not be transferred to third countries, except in the case of services expressly requested by the customer or in specific cases in which the Insurer adopts adequate guarantees and informs the data subject.

(Privacy policy statement to be signed and dated when filing a claim)

PLEASE READ THIS PRIVACY POLICY STATEMENT CAREFULLY
Privacy policy statement in accordance with Regulation (EU) 2016/679 – "General Data Protection Regulation"

With reference to the Privacy Policy Statement pursuant to Regulation (EU) 2016/679 (GDPR), received at the time of signing the policy through the Contracting Party and available on the website www.poste-assicura.it, please note that, in connection with claims management and settlement services, Poste Assicura S.p.A (hereinafter the Insurer), in its capacity as the Controller, uses the services of other entities to which it may disclose your data. These entities specifically include insurance and reinsurance intermediaries (e.g., brokers, agents), technical experts and other entities that carry out auxiliary activities on behalf of the Insurer, including legal professionals, appraisers and medical experts; affiliated clinics; companies that provide premium payment and receipt services; companies that provide claims management, settlement and payment services. Such entities operate in their capacity as independent Controllers or Processors.

To receive the complete list of these entities, please contact the Insurer's Data Protection Office through the following channels: e-mail: privacy@postevita.it, postal address: Viale Beethoven, 11, 00144 Rome.

In consideration of the foregoing, I consent to the processing of personal data concerning my health and for the purposes of claims management and settlement services.

Where insurance cover has been extended to include members of your family unit, only insofar as minor children are concerned, you personally assume all liability in respect of all personal data relating to the health of such family members given to the Insurer for the purposes of claims management and settlement services.

Place and date, .../...../.....

Signature of the Insured (or of the person acting on the Insured's behalf)

.....

Please note that your consent to the processing of personal data concerning your health is necessary. Without such consent we cannot start the settlement procedure.