The following guidelines are intended to help foreign visitor to understand the insurance details. INFN assumes no responsibility for any inaccuracies, omissions, or, more generally, for any errors contained in the following document.
For the original policy please refer to: RSM OSPITI STRANIERI http://www.ac.infn.it/personale/coperture_assicurative_2020.php

GUIDELINES
POLIZZA RSMO 114011779 – ISTITUTO NAZIONALE DI FISICA

Guaranteed benefits: reimbursement of medical health expenses incurred during the validity of the insurance coverage.

Policyholders:
- Foreign Visitors (nationals of non-EU countries) of the National Institute of Nuclear Physics (INFN);
- any family members reunited under the "Convenzione di Accoglienza" stipulated by the Institute (art. 27-ter del D.Lgs. 286/98); as "reunited family members" we mean: the spouse, the common law partner and the children.

Duration of coverage: the insurance is valid for the period of collaboration in Italy of the Visitor, as communicated by the National Institute of Nuclear Physics (INFN) to the Insurance Company.

Policy sheet

POLIZZA RSMO 114011779 – ISTITUTO NAZIONALE DI FISICA NUCLEARE		
SERVICES	Hospitalization with or without surgery, Day Hospital (DH), outpatient surgery, caesarean / natural birth and therapeutic abortion	€ 100.000 Affiliated-facilities: no overdraft fee/deductible Non-Affiliated facilities: no overdraft fee/deductible
	Hospitalization fee	Included
	Pre-hospitalization assessments	60 days
	Post-hospitalization assessments	60 days
	Cesarean delivery / therapeutic abortion	€ 8.000
	Natural childbirth	€ 6.000
	Transport	Included
	Daily Allowance	€ 100 (€ 50 per i DH) per day, maximum 30 days per event

How to access the benefits

Refund: In the event of a health services carried out at non-affiliated facilities, the insured must pay the expenses and, afterwards, claim reimbursement from the Insurer filling out the specific claim form.

The reimbursement of the expenses is carried out, once the healthcare is finalized, submitting the receipted invoice or an accounting document of equal probative value, and the copy of the medical documentation containing, explicitly, the suspected or known disease, the injury (or the childbirth) which caused the health service; in case of either hospitalization or day-hospital, a copy of the complete medical record must be submitted.

The documentation can be sent as a copy, but the Insurer could request the originals.

The form and all the required documentation must be sent to (ordinary mail): MyAssistance, Via Montecuccoli, 20/2 – 20146 Milano (MI), or to (e-mail) corporate.groupama@myassistance.it

Direct Coverage Service: Groupama, through MyAssistance, makes available to the insured its network of affiliated doctors and health facilities where to benefit from the services provided.

In order to benefit from Direct Coverage Service, the Insured must obtain prior authorization from the Insurer by contacting the Operations Center (in Italian and English), at **800.010.300,** which will provide the insured with information about the status of the request, within three days from the procedure opening.

The Insured must present to the affiliated facility, at the time of the health care service, a document proving his / her identity and the doctor's certification indicating either the disease (suspected or known) or the injury for which the services are requested.

The list of affiliated facilities is available on www.myassistance.it

Useful references:
For any information about the insurance coverage, as well as for the procedures to be followed for the activation of the direct services and the reimbursements, the policyholders can contact
- Toll-free number 800.010.300
- Landline number 0039.02.303.500.003
- E-mail address corporate.groupama@myassistance.it

Each e-mail sent to My Assistance must have as subject "114011779 RSM Istituto Nazionale Fisica Nucleare"

Additional services
In addition to the reimbursement for hospital medical expenses, the policy stipulated by INFN also offers a series of consultancy and assistance services.

The following advisory services are provided (in Italian and English) by the Operations Center by calling the toll-free number **800.010.300**, from Monday to Friday from 8:00 to 18:00, or alternatively by contacting the number **0039.02.303.500.003**.

a) Telephone healthcare information
The Operations Center gives healthcare information regarding:
- public and private health facilities: location and specializations;
- healthcare facilities and affiliated doctors;
- information about the requirements for the use of the policy;
- specialized medical centers for specific diseases in Italy and abroad.

b) Reservation of health services
The Operations Center provides a booking service for health services offered by its affiliated network, whether these services are covered by this insurance policy (Direct Service or Refund) or not included in this policy.

c) Online doctor consultation
In case of accident or illness, if the Insured needs telephone advice from a doctor, the Operations Center will provide the needed information and advice through its doctors.

d) Doctor intervention
In case of an accident or illness, if the Insured, in Italy, needs a doctor (from 8 pm to 8 am on weekdays or for 24 hours on holidays) and he is unable to find him, the Operations Center will send, having ascertained the need for the service, at its own expense, one of the affiliated doctors. In the event of unavailability of affiliated doctor, the Operations Center will organize the transfer of the Insured to the nearest suitable medical center by means of an ambulance, bearing the related costs and charges.

e) Return from the first aid hospital
In case of an accident or illness, after the first aid hospitalization, if the Insured needs to be transported by ambulance, the Operations Center will send an ambulance directly, bearing the relative expense (up to the limit of an equivalent amount to complete a total distance of 500 km per event).

Age limit: none

Individuals who are not eligible for coverage: people suffering from alcoholism, drug addiction or the following mental illnesses: schizophrenia, manic-depressive forms or paranoid states, other mental illnesses characterized by organic brain syndromes.
The insurance ends with their occurrence; however, in case of occurrence after the effective date of the policy, the claim concerning the mental illnesses listed in the first paragraph will be eligible for insurance benefits, limited to the first hospitalization.
The possibility of accessing coverage is also provided for people with mental disabilities or who take psychotropic drugs for therapeutic purposes, within the limitation applied by exclusions.

Exclusions:
A. removal or correction of deformities and physical defects pre-existing at the date of stipulation/variation of the contract, as well as diseases related to them, with the exception of congenital malformations of which the Insured is an unconscious bearer;
B. mental illnesses and psychic disorders in general, including neurotic behaviors, with the exception of cases involving surgery for which only the reimbursement of expenses related to the intervention will be paid;
C. accidents resulting from willful crimes of the Insured (while accidents caused by gross negligence are covered)
D. injuries and intoxications resulting from alcohol abuse, or for non-therapeutic use of psychotropic drugs or narcotics;
E. voluntary non-therapeutic abortion;
F. cellular-tissue, physiotherapy, hydropinic and spa treatments in general (except for what is inlcuded in art. 32 "Services"), services having aesthetic purposes (except for plastic or dental reconstructive surgery made necessary by injury or demolition surgery, as long as they occur after the single insured person enters coverage);
G. dental treatment and periodontal diseases;
H. the purchase, maintenance and repair of prosthetic and therapeutic devices, with the exception of the costs related to the purchase of those applied following surgery;
I. the direct or indirect consequences of the transformation of energetic adjustments of the atom, whether natural or provoked, and the acceleration of atomic particles (nuclear fission and fusion, radioactive isotopes, accelerationn machines, X-rays, etc.)
J. the effect of wars, insurrections, earthquakes or volcanic eruptions;
K. admissions and day hospital hospitalization carried out for the purpose of carrying out preventive specialist visits and / or diagnostic tests and / or health checks;
L. hospitalizations for chronic diseases in long-term care facility (retirement homes, etc.) even if qualified as clinics or care institutions;
M. treatments and interventions relative to infertility and, in any case, those relating to artificial insemination.

IMPORTANT NOTE: this document has been drawn up for information purposes only, the original policy remains the only valid document.

DIRECT COVERAGE FOR AFFILIATED HEALTH FACILITY – CLAIM FORM

POLIZZA RSMO 114011779 – ISTITUTO NAZIONALE DI FISICA NUCLEARE

In order to claim for direct coverage and benefit from assistance with expenses paid by insurance company, fill out this form and send it, in advance, to MyAssistance via **fax 02.871.819.75** or E-mail **corporate.groupama@myassistance.it;** for information, please call **800.010.300**

From:

Policyholder (head of family)

_____

Date of birth_____ **Tax number** _____

Phone _____ **Mobile phone** _____

E-mail _____

I, the undersigned (either head or family member, the person who will undergo a medical examinations) _____

Covered by the Policy num.114011779 activated by INFN, with this form request the direct payment of the expenses incurred and invoiced by the healthcare facility and / or by the medical team and / or freelance medical professional affiliated with Myassistance S.r.l., complying with the conditions set out in the insurance coverage.

Details are listed here below:

Affiliated pre-selected facility: _____

Name of the doctor: _____

Healthcare service date (if already booked): _____

Pathology/suspected diagnosis/injury: _____

I, the undersigned, consistently with the contractual conditions defined in the insurance coverage:

- I am aware that benefits expressly excluded under the conditions defined in the coverage are not covered;
- I authorize the company to pay, in my name and on my own behalf, the services covered by the direct coverage procedure to the facility and / or medical professional;
- I undertake to provide further medical documentation in order to correctly evaluate the paperwork in case this is required;
- I undertake to pay to the medical facility all services not covered by the insurance coverage and any other expenses not included in the invoice of the healthcare facility and / or medical professional;
- I undertake to reimburse to the insurance company afterwards, through MyAssistance, any expenses that are not covered by the policy and to pay directly to the health facility and / or medical professional the amounts exceeding any global or event-related annual maximum coverage / limit, as well as the amounts relating to deductibles and / or overdrafts not applied by mistake.

_____ _____

Place and date — Signature of the Policyholder (head of family) for acceptance

I received the information in observance to D. Lgs.196/03, Reg. UE 679/2016, D.Lgs. di adeguamento 101/2018" Personal Data Protection Code"

and **I AGREE** to the processing and communication of my personal and sensitive data, required for the management and settlement of the claims covered by the health coverage I subscribed, to the subjects involved in the operational flow and precisely MyAssistance Srl, Health Facilities, Professional Doctors, Insurer, and within the limits of their competences. This expressed consent is conditional on compliance with the provisions of current legislation.

_____ _____

Place and date — Signature, for acceptance, of the person (head or family member) who request the service

REIMBURSEMENT OF MEDICAL EXPENSES – CLAIM FORM

POLIZZA RSMO 114011779 – ISTITUTO NAZIONALE DI FISICA NUCLEARE

This document must be sent by the Insured, together with all the required documentation, to **MyAssistance, Via Montecuccoli, 20/2 – 20146 Milano (MI)**, or via E-mail to **corporate.groupama@myassistance.it**, to request reimbursement for the incurred expenses. For information or support, please contact the number **800.010.300.**

Policyholder (head of family)

_____

Tax number _____ **Date of birth** _____

Bank details for reimbursement (registered to the head of the family)

IBAN ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐

Policyholder (head of the family or family member, to whom the healthcare costs refer)_____

Tax number _____ **Date of birth** _____

Pathology/suspected diagnosis/injury _____
As written in the medical certificate / medical record attached to this letter

e-mail _____

phone _____

The Insured hereby requests reimbursement of the following notes / invoices in compliance with the conditions set out in the insurance agreement:

Num. Invoice	Date	Amount		Num. Invoice	Date	Amount

USEFUL INFORMATION REGARDING THE DOCUMENTATION

1. Fill out a single form for one person and for each single claim;
2. Invoices or accounting documents not related to hospitalization must come with a medical certificate indicating the suspected/diagnosed disease, or injury;
3. Attach a copy of the reports and / or medical records;
4. For the reimbursement, it is mandatory to indicate the tax code of the bank account holder (head of the family) requesting the reimbursement and the bank details (IBAN).
5. **MyAssistance** may request further documentation in order to correctly evaluate the paperwork.

_____ _____

Place and date — Signature of the insured (head of the family) for acceptance

I received the information in observance to D. Lgs.196/03, Reg. UE 679/2016, D.Lgs. di adeguamento 101/2018" Personal Data Protection Code"

and **I AGREE** to the processing and communication of my personal and sensitive data, required for the management and settlement of the claims covered by the health coverage I subscribed, to the subjects involved in the operational flow and precisely MyAssistance Srl, Health Facilities, Professional Doctors, Insurer, and within the limits of their competences. This expressed consent is conditional on compliance with the provisions of current legislation.

_____ _____

Place and date — Signature, for acceptance, of the person (head or family member) who request the service