Posteassicura
GruppoAssicurativoPostevita

INSURANCE CONDITIONS REIMBURSEMENT OF MEDICAL EXPENSES ON A GROUP BASIS INFN GROUP AGREEMENT

CRN: 9181075EC1

between

POSTE VITA HEALTH ASSISTANCE FUND (Policyholder)
VIALE EUROPA 190 - 00144 ROME
Tax code/VAT no.: 97778630588

NATIONAL INSTITUTE OF NUCLEAR PHYSICS referred to as INFN (Member)
VIA ENRICO FERMI 54 - 00044 ROME
Tax code/VAT no.: 84001850589

AND

POSTE ASSICURA (COMPANY)
VIALE EUROPA 190 - 00144 ROME
Tax code/VAT no.: 07140521001

Effective from 12 midnight on **31/12/2022**
Expires at 12 midnight on **31/12/2026**

Poste Assicura S.p.A.
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PEC certified email:
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VAT No. and Tax Code 07140521001, Share Capital €25,000,000.00 fully paid up • Rome Company Register no. 07140521001, Economic and Administrative Index 1013058 • Registered in Section I of the Register of Insurance Companies under no. 1.00174 • Authorised to provide insurance pursuant to ISVAP resolution no. 2788/2010 • Company belonging to the Poste Vita insurance group, enrolled in the Register of Insurance Groups under no. 043 • Company with sole shareholder, Poste Vita S.p.A., subject to the latter's direction and coordination.

DEFINITIONS OF THE TERMS USED IN THE SPECIFICATIONS

Insurance
The healthcare coverage.

Policy
The document proving insurance cover.

Policyholder
The Poste Vita Healthcare Fund

Waiting Period
Period during which the insurance contract covers are not effective. Should the insured event occur during this period, the Company will not pay the insured benefit.

Member
The National Institute of Nuclear Physics (or INFN for short) associated with the Fund

Insured
The party in whose interest the insurance is taken out.

Company
The designated Insurance Company that will assume the risk of the services.

Premium
The sum owed by the Policyholder to the Company

Accident
The event due to a fortuitous, violent and external cause that causes bodily injury that is objectively ascertainable.

Illness
Any alteration of the state of health that is not a malformation or physical defect even if not due to an accident.

Malformation
Deviation from the normal morphological arrangement of an organism or parts of its organs due to congenital pathological conditions.

Physical defect
Deviation from the normal morphological arrangement of an organism or parts of its organs due to acquired pathological or traumatic conditions.

Healthcare facility
Hospital, clinic or university institution, nursing home, duly authorised by the competent authorities based on legal requirements to provide hospital care, including day hospital care, with the exclusion of spas, convalescent homes and clinics for dietary and aesthetic purposes.

Affiliated health facility
Health institution, clinic, specialist centre the company has an agreement with for the direct payment of services.

Hospitalisation
Convalescence in a Healthcare Facility involving an overnight stay.

Day hospital
Healthcare services relating to surgical and medical therapies performed in a day hospital and documented by medical records with a nosology sheet.

Surgery
Any manual or instrumental surgical procedure performed for therapeutic purposes.

Outpatient surgery
A surgical procedure that, due to its nature, does not require postoperative observation.

Diagnostic assessment/Examination
Instrumental medical procedure aimed at investigating and/or defining the presence and/or course of an illness, including invasive and/or surgical procedures.

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

Indemnity
The amount payable by the Company in the event of a claim.

Indemnity in lieu
Daily amount paid by the Company in the event of hospitalisation in the absence of a claim for reimbursement of the costs of services performed during the hospitalisation or in any way related to it.

Deductible
The fixed sum to be borne by the Insured.

When expressed in days, this is the number of days for which the guaranteed amount is not paid to the insured.

Self-insurance
The sum expressed in a percentage value to be borne by the Insured.

SECTION I - GENERAL TERMS AND CONDITIONS

Article 1 - Duration and commencement of insurance cover
This policy has a term of 48 months, from 12 midnight on 31/12/2022 to 12 midnight on 31/12/2026, with the right of cancellation granted to the parties from 12 midnight of the end of the second annual expiry and on the subsequent annual expiry provided that the cancellation is communicated by registered letter with return receipt or PEC certified email with 180 days' notice prior to the annual expiry.

Within 60 days of the expiry of the policy, INFN may request the Company to extend the policy for a maximum period of 180 (one hundred eighty) days, to allow the full completion of the procedures for the awarding of the new agreement. In this case the Company must extend the insurance cover for the period requested and at the same contractual and economic conditions, subject to payment of a premium corresponding to as many twelfths of the annual policy premium as the number of months of the extension requested by INFN.

For all intents and purposes, this policy operates – for the validity of the coverage and its terms and conditions – without a break in continuity with the policy taken out by INFN for the insured parties, as per Art. 6 of the General Terms and Conditions - Section I (no. 77959) stipulated with Poste Assicura (activated through the POSTE VITA HEALTH ASSISTANCE FUND), which already operated for all intents and purposes without a break in continuity with the policies taken out by INFN with RBM Assicurazione Salute (also through the Fund, nos: 31007048, 31007049, 31007050).

Article 2 - Withdrawal
Notwithstanding Art. 1898 of the Italian Civil Code, the Company waives the right to withdraw from the contract before its expiry.

Article 3 - Purpose of the insurance
The purpose of this policy is insurance for the reimbursement of medical and healthcare expenses incurred by the insured persons as a result of illness, accident and childbirth (or for preventive purposes where specifically envisaged) under the terms, to the extent and in the manner specified in this contract (Sections III, IV and V).

Article 4 - Effect of the insurance
The insurance takes effect at midnight on the day indicated in the policy if the premium or the first premium instalment has been paid, otherwise it takes effect at midnight on the day the premium is paid. For subsequent instalments, a 30-day grace period is granted for the payment of the amount due. If the premium or premium adjustment is not paid, the insurance remains suspended from 12 midnight on the

thirtieth day following the expiry and shall take effect again at 12 midnight on the day of payment, without prejudice to subsequent expiries. For the payment of the premium (first instalment, adjustment, subsequent instalments) made by INFN, notwithstanding Art. 1901 of the Italian Civil Code a 60-day delay is granted for the payment of the amount due. If the premium is not paid, the insurance remains suspended from 12 midnight on the 60th day following the expiry and resumes at midnight on the day of payment, without prejudice to subsequent due dates.

With regard to the premium relating to the insured parties referred to in Art. 6, letters a) and b), at the beginning of each insurance year INFN shall communicate the number of insured parties to be included in the cover and the overall premium shall be determined on this basis, paid in two six-monthly instalments in accordance with the procedures set forth in the following paragraph. For the insured parties joining during the year, the premiums shall be paid at the time of adjustment. The same methods of premium payment may also be adopted for family members of insured persons referred to in Art. 6 letters a) and b) below if the communication and payment of premiums are made through INFN.

Article 5 - Amendments

Any amendments to the contract following the stipulation of the policy must be approved in writing by the Parties.

Article 6 - Insured

The covers hereunder are provided collectively and at INFN's charge for:

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

The covers hereunder are provided on an individual basis and at the expense of each party concerned for:

c) INFN pensioners
d) Staff associated with INFN/staff seconded to INFN

The insured persons referred to in paragraph 1, letters a) and b), as well as the insured persons referred to in paragraph 2, letters c) and d) of this Article may on an individual basis and at their own expense extend the cover provided by this policy to the members of their household referred to in Article 7 below.

Article 7 - Family unit

A family unit includes the head of the household (employee/research grant or scholarship holder/pensioner/member/seconded staff), the spouse/partner living together or alternatively cohabiting as if married (regardless of gender) and the children shown on the family status certificate. Non-cohabiting children are also included if they are students up to the age of 26.

Also included in the household are the head of household's family members who live together and are listed in the family status certificate. Family members are understood to be ascendants, in-laws, siblings, grandchildren (understood to be the children's children) and children's spouses.

Article 8 - Premium

The annual premiums for all benefits under this contract for each category of insured, as identified in Art. 6 of this Section, are inclusive of tax, and are defined in Section VI of this policy.

Article 9 - Age limits

The insurance is valid for all insured persons without any age limit, except for the limit of 26 years of age for non-cohabiting children provided that they are students (see Art. 7 of the General Conditions - Section I).

Article 10 - Terms for enrolments and extensions

- **Collective enrolments**

Within 30 days of the commencement of cover, and each subsequent annual renewal, INFN shall notify the Company of the names of the insured persons referred to in the first paragraph of Art. 6 of the General Terms and Conditions - Section I, i.e:

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

Cover for the insured persons under a) and b) above commences on the effective date of the cover, or on the effective date of the subsequent renewals, subject to payment of the premium in accordance with the terms and conditions set out in this contract.

- **Individual enrolments**

By the effective date of the cover, and each annual renewal, the insured persons referred to in the third paragraph of Art. 6 of the General Terms and Conditions - Section I, namely:

c) INFN pensioners
d) Staff associated with INFN/staff seconded to INFN

may notify their wish to activate the cover and proceed to pay the premium. Once these terms have passed it will not be possible to activate the covers and the person concerned may do so at the next annual expiry. The cover for insured persons under letters
c) and d) shall commence from the effective date of the cover, or from the effective date of the annual renewals requested, subject to payment of the premium in accordance with the terms and conditions set out in this contract.

- **Extensions to family members**

The insured parties referred to in Art. 6 of the General Terms and Conditions - Section I may extend coverage to the members of their household and proceed to pay the relevant premium according to the same terms and conditions as for the insured person - head of household. Once these terms have passed it will not be

possible to activate the covers and the person concerned may do so at the next annual expiry. Cover for family members the cover has been extended to shall commence from the effective date of the cover, or from the effective date of its annual extended renewals, subject to payment of the premium in accordance with the terms and conditions set out in this contract.

Article 11 - Changes in insured persons during the year

- **Addition of new enrollees during the year.**

In the event of new hirings or new awards of research grants or scholarships, pursuant to Art. 6 , paragraph 1, letters a) and b) of the General Terms and Conditions - Section I, the covers envisaged by this policy shall commence from the date of hiring/award provided that INFN has provided the information of the newly insured persons within 90 days. After this term, the covers shall run from the date of communication to the Company. In the event of a new member or a new secondment pursuant to Art. 6, paragraph 2, letter d) of the General Terms and Conditions - Section I, the individual concerned shall have 30 days (from the commencement of the membership/secondment) to request the individual activation of the covers envisaged by this policy. Once this term has passed, it will no longer be possible to activate the cover during the year and may be postponed to the following annual expiry. Cover for new members/seconded staff shall commence at 12 midnight on the day of the activation request, subject to payment of the premium in accordance with the terms and conditions set out in this contract. For all enrolments made during the insurance year, the premium will be calculated on the basis of the date of entry into coverage, in whole twelfths (annual premium/12).

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

Within 30 days of the change in family status and following marriage/civil union, commencement of cohabitation as if married and birth/adoption of children, the head of household may extend the cover provided by this policy. In other cases of change of family status or if the 30-day period stipulated in the previous paragraph is exceeded, it will not be possible to extend cover during the year and will be postponed to the next annual expiry.

For all enrolments made during the insurance year, the premium will be calculated on the basis of the date of entry into coverage, in whole twelfths (annual premium/12).

- **Cancellation during the year**

Any cancellation (including death) occurring during the annual insurance period shall not take immediate effect and shall be deferred until the first annual expiry (therefore no premium will be refunded).

Article 12 - Records

The INFN agrees to provide the Company with the information of the collectively insured persons by means of a digital file within 30 days of the commencement of cover, and to submit updates on a monthly basis during the year. The Company collects the information on individual enrolments, possibly through the Funds.

Article 13 - Method for submitting information on claims

The Company shall provide INFN with quarterly statistics (for each insurance period, from the date of commencement of the cover to the end of the month of processing) divided by category of insured, summarising direct and indirect claims (with evidence of those also made to the National Health Service), settled, reserved and rejected, including in electronic format, broken down by type of cover and individual type of medical and healthcare services and sub-services, with an indication of the number of claims for each of the covers and the number of individual services and sub-services, as well as the amount (relating to the aforesaid claims, services and sub-services) claimed, paid and reserved. The Company agrees to provide the aforementioned information up to 12 months after the end of the contract.

Article 14 - Events for which insurance is provided and affiliated networks

This insurance is provided for the events indicated and the covers indicated in Sections III, IV and V. The Company shall make networks of affiliated doctors and medical facilities available to insured parties that guarantee subsidised rates and from which it is possible to obtain services with direct payment if indemnifiable under the terms of the policy, as governed by Art. 1, letter a) of Section IV.

The Company agrees to ensure that the network in Italy includes:

1) At least 200 nursing homes and/or hospitals, licensed for night and day hospitalisation
2) At least 400 diagnostic centres
3) At least 500 dental practices

In order to provide the insured with a network that guarantees an adequate distribution throughout the country, INFN reserves the right to specify the Company professionals and healthcare facilities to be affiliated in order to improve the service. The Company is required to notify INFN within three months of the notification of the outcome of the agreement procedure, and if this is not concluded it must also indicate the reasons for the refusal, providing monthly updates on the status of the request.

Article 15 - Exclusions

Subject to the exceptions indicated for each cover/insured service, the insurance does not apply to:

1. Treatments and/or operations for the elimination or correction of physical defects or malformations
   existing before the stipulation of the contract.
2. Treatments and operations aimed at the treatment of infertility and in any case those relating to artificial insemination.
3. The treatment of mental illnesses and mental disorders in general, including neurotic behaviour.
4. Dental prostheses, treatment of periodontal disease, dental treatment and dental examinations.
5. Medical services for aesthetic purposes (with the exception of reconstructive plastic surgery necessitated by accidents or tissue destruction occurring during the term of the contract).

6. Inpatient admissions, including day hospital admissions, during which only physical examinations or therapies are performed that, due to their technical nature, could also be performed on an outpatient basis.
7. Hospitalisations caused by the Insured's need to have third-party assistance to perform basic actions of daily life as well as long-stay hospitalisation.
   Long-stay hospitalisations are understood to be those caused by the physical condition of the Insured that no longer permits recovery with medical treatment and that make it necessary to stay in a nursing home for care or physiotherapeutic maintenance.
8. The treatment of illnesses resulting from the abuse of alcohol and psychotropic drugs, as well as the non-therapeutic use of narcotics or hallucinogens.
9. Accidents arising from the practice of aerial sports, participation in motor races and competitions and related training.
10. Injuries caused by wilful acts committed by the Insured.
11. The direct or indirect consequences of transmutation of the nucleus of the atom of radiation caused by artificial acceleration of atomic particles and exposure to ionising radiation, with the exception of those who work in the field and are exposed classified in category A pursuant to Italian Legislative Decree no. 203/95.
12. The consequences of war, insurrections, earthquakes and volcanic eruptions.

Article 16 - Additional exclusions for individually insured persons

In addition to the provisions of Art. 15 above, for individual members only (referred to in Articles 6 and 7 of the General Terms and Conditions - Section I), namely:

- INFN pensioners
- Staff associated with INFN and staff seconded to INFN
- Family members (of all insured categories under letters a, b, c, d of Art. 6 of Section I - General Terms and Conditions).

And limited to the treatments envisaged in Articles 1 (Hospital Covers) and 5 (Indemnity in Lieu) of Section III - Covers (subsections A, B and C), not covering treatments that are the consequences of:

a) Illnesses that occurred and/or were subject to examinations or treatment/therapy before the date of (first) enrolment in/activation of the cover.
b) Accidents occurring before the date of (first) enrolment in/activation of the cover.

Moreover, for the insured persons referred to in paragraph I of this Article, the following are excluded:

c) Expenses for childbirth/abortion (specifically letters B and D of Art. 1 of Section III - Subsections A, B and C - Covers) as well as all expenses related to pregnancy-related illnesses for treatments under all of Section III (Subsections A, B and C) - Covers if the pregnancy itself arose before the date of (first) enrolment in/activation of the cover.

The exclusions referred to in letters a), b) and c) above do not apply to the insured persons referred to in paragraph I of this article:

- Already covered upon the expiry of policy no. 77959 stipulated by INFN with Poste Assicura (activated through the POSTE VITA HEALTH ASSISTANCE FUND) who renewed the cover under this contract without interruption after the aforementioned policy expired.
- If the activation of individual cover takes place without interruption with the coverage enjoyed as an INFN employee.

If the Insured does not renew the individual cover from year to year, the last valid enrolment date shall be considered as the effective date of cover (i.e. without taking into account any previous enrolment periods with which there is a break in continuity) for the purposes of applying the exclusions referred to in points a), b) and c) above.

Article 17 - Waiting period

In addition to the provisions of Articles 15 and 16 of the General Terms and Conditions - Section I, solely for those enrolled individually (referred to in Articles 6 and 7 of the General Terms and Conditions - Section I), namely:

- INFN pensioners
- Staff associated with INFN and staff seconded to INFN
- Family members (of all insured categories under letters a, b, c, d of Art. 6 of Section I - General Terms and Conditions).

The insurance starts after a waiting period of 30 days from the date of (first) enrolment in/activation of the cover.

The waiting period does not apply:

- For accidents occurring after the date of enrolment.
- For all insured already covered upon the expiry of policy no. 77959 stipulated by INFN with Poste Assicura (activated through the POSTE VITA HEALTH ASSISTANCE FUND) who renewed the cover under this contract without interruption after the aforementioned policy expired.
- If the activation of individual cover takes place without interruption with the coverage enjoyed as an INFN employee.

If the Insured does not renew the individual cover from year to year, the last valid enrolment date shall be considered as the effective date of cover (i.e. without taking into account any previous enrolment periods with which there is a break in continuity) for the purposes of applying the aforementioned waiting period.

SECTION II - COMMON RULES

Article 18 - Insurance on behalf of others

This insurance policy is taken out on behalf of others to cover the risks indicated. The obligations arising from the Contract must be fulfilled by the Member and, where specified, by the Policyholder, except for those that due to their nature can only be fulfilled by the Insured as envisaged by Art. 1891 of the Italian Civil Code.

Article 19 - Territorial scope
The insurance cover is valid worldwide.

Article 20 - Health documentation
The risks shall be assumed by the Company without any request for medical documentation.

Article 21 - Tax charges
Taxes relating to the insurance shall be borne by the Policyholder.

Article 22 - Other insurance
The INFN must notify the Company of the possible or subsequent existence of other insurance policies taken out thereby for the same risk. The Company may withdraw from the contract within 30 (thirty) days of notification with at least 30 (thirty) days' notice.

The Insured is exempt from declaring to the Company the possible existence of other policies that they have taken out for the same risk, without prejudice to their obligation to notify the Company in the event of a claim.

Article 23 - Broker clause
INFN declares that it has entrusted the management of this policy to the insurance brokerage company ITAL BROKERS S.p.A., Via Albaro 3, Genoa - VAT no./Tax code 08536311007- RUI no.: B000059359.

Therefore, for the purposes of the terms and conditions of this policy, the Company acknowledges that any communication made by the Policyholder to the Broker shall be understood to have been made to the Company and vice versa, and any communication made by the Broker to the Company shall be understood to have been made by the Policyholder. Notwithstanding Art. 1901 of the Italian Civil Code and the provisions of Art. 11 of the General Terms and Conditions of Agreement, the Company also recognises that payment of premiums by INFN is made through the Broker designated above, and therefore that such payment is in full discharge of its obligations to the Policyholder.
The Broker in question will be remunerated in accordance with market practice, i.e. by the insurance companies through the payment of a commission of 3.00% of the premiums collected net of taxes.

Article 24 - Form of communications
All communications shall be made by registered letter, or by telegram, telefax, email, certified email.

Article 25 - Arbitration board with regard to the policy
With regard to this policy, disputes of a medical nature may be referred to the decision of an Arbitration Board composed of three doctors. The members of the Arbitration Board shall be appointed one by each party and the third by mutual agreement, or, in the event of disagreement, by the Board of the Medical Association having jurisdiction in the place where the Board is to meet.

The Medical Board resides in the municipality of the Institute of Forensic Medicine closest to the place of residence of the Insured.

Each Party bears its own costs and remunerates the doctor designated by it, contributing half of the costs and fees of the third doctor, excluding any joint and several liability.

The decisions of the Medical Board are taken by majority vote, exempt from all legal formalities, and are binding on the Parties, who hereby waive any appeal except in cases of violence, malice, error or breach of contract. The results of the arbitral proceedings shall be set out in minutes to be drawn up in duplicate, one for each party.

This without prejudice to the Parties' right to bring proceedings before the competent judicial authority. For anything not otherwise governed the rule of law shall apply.

Article 26 - Disputes and Jurisdiction over the Policy

For any disputes concerning the application and execution of this policy, the Parties may submit a joint application, or the party concerned may submit a specific application to a Mediation Body recognised by the Ministry of Justice and set up at the offices specifically envisaged for this purpose, which shall invite the other party to join and participate in the mediation aimed at conciliation pursuant to Italian Legislative Decree 28/2010, in compliance with the Conciliation Rules adopted by the latter. This body, at the option of the Policyholder or the Insured, shall be located in the same province where the latter resides.

In the event of more than one application relating to the same dispute, the criterion of chronological priority applies, i.e. mediation shall take place before the body where the first application for mediation was filed. If the mediation attempt is unsuccessful or is not carried out, the party concerned may take legal action before the competent Court of Rome, or the Court of residence of the insured party if the latter is a party to the proceedings.

Article 27 - Reference to the law

For anything not otherwise governed herein the rule of law shall apply.

Article 28 - Confidentiality

The Company must keep confidential any data and information it comes into possession of and is otherwise aware of, not disclose them in any way and not use them for any purpose other than those strictly necessary for the performance of the Contract.

In the event of non-compliance with the obligations of confidentiality, INFN shall be entitled to declare the Contract terminated, it being understood that the Company shall be obliged to indemnify all damages that INFN may suffer.

Article 29 - Policy privacy

The Policyholder and the Company agree to process the personal data supplied or in any case collected relating to this contractual relationship and the personnel involved exclusively for the purposes connected with the execution 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 - Express termination clause

Pursuant to and for the purposes of Art. 1456 of the Italian Civil Code, this policy shall be terminated by right upon the occurrence of one of the situations indicated below, without prejudice to INFN's right to take action for compensation for damages suffered:

1. Subcontracting of contractual services without INFN's authorisation.
2. Assignment of the contract.
3. After three breaches, contested by registered letter with return receipt/PEC certified email regarding the perfect execution of the service.
4. Measures against the contractor's representatives under current anti-Mafia laws.
5. Revocation of the authorisation to conduct insurance business.
6. Breach of confidentiality obligations.

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VAT No. and Tax Code 07140521001, Share Capital €25,000,000.00 fully paid up • Rome Company Register no. 07140521001, Economic and Administrative Index 1013058 • Registered in Section I of the Register of Insurance Companies under no. 1.00174 • Authorised to provide insurance pursuant to ISVAP resolution no. 2788/2010 • Company belonging to the Poste Vita insurance group, enrolled in the Register of Insurance Groups under no. 043 • Company with sole shareholder, Poste Vita S.p.A., subject to the latter's direction and coordination.

SECTION III - COVERS SUBSECTION A

INTRODUCTION.

The services envisaged in this Subsection III A are intended for:

- **INFN employees** - Art. 6, paragraph 1, letter a) of Section I General Terms and Conditions.
- **Holders of research grants and scholarships awarded by INFN: Art.** 6, paragraph 1, letter b) of Section I General Terms and Conditions.
- **Family members of the insured persons referred to above, to whom the cover** provided by this contract was extended pursuant to the last paragraph of Art. 6 of Section I General Terms and Conditions.

Article 1 - Hospital covers.

The Company reimburses expenses incurred as a result of illness or accident occurring during the insurance year:

A) In the event of surgery performed as an inpatient, day hospital or outpatient, the Company shall reimburse the following expenses:

1. Fees of the surgical team, as well as operating room fees and operating materials, including endoprostheses applied during surgery.
2. Medical and nursing care, treatment, physiotherapy and re-educational treatment, medicines, examinations and diagnostic tests relating to the period of hospitalisation or incurred during the day hospital or outpatient surgery.
3. Convalescence fees (excluding out-of-pocket expenses) up to €350 per day.
4. Examinations, diagnostic tests and specialist examinations performed in the 150 days preceding surgery or hospitalisation, provided that they are directly related to the illness or injury that led to the treatment.
5. Specialist examinations and visits, medicines, medical and nursing services, purchase and/or hire of prosthetic and medical equipment including orthopaedic wheelchairs, physiotherapy or re-educational treatments, spa treatments (excluding any hotel costs) performed within 150 days of the date of surgery or hospital discharge provided that they are directly related to the illness or injury that led to the treatment.
6. Removal of organs or parts of organs; donor-related hospitalisation and diagnostic tests, medical and nursing care, removal surgery, treatment, medication and hospitalisation fees.
7. Board and lodging in a healthcare facility, or hotel where there is no availability in the hospital, for a person accompanying the Insured with a daily limit of €150 and for a duration not exceeding the hospitalisation, with a maximum of 100 days per insurance year.
8. Transport of the Insured by ambulance, mobile coronary unit and medical aircraft to the medical institution and vice versa, with a maximum of €1,100 per operation or hospitalisation.
9. Transport of the Insured and any accompanying person abroad and back, by train or by airline (excluding private car), with a maximum of €2,000 per operation or hospitalisation.

10. In the event of death resulting from surgery abroad, the insurance is extended to the reimbursement of the costs of repatriating the body up to a maximum of €1,500.

B) In the event of childbirth by caesarean section and/or therapeutic abortion, the Company shall reimburse the following expenses including those for the newborn child, up to the limit of €5,000 per insurance year:

1. Fees of the surgical team, as well as operating room fees and operating materials during surgery.
2. Medical and nursing care, treatment, physiotherapy and re-educational treatment, medicines, examinations and diagnostic tests relating to the period of hospitalisation, including for the newborn child.
3. Convalescence fees (excluding out-of-pocket expenses) up to €350 per day.
4. Examinations, diagnostic tests and specialist examinations performed in the 150 days preceding surgery or hospitalisation, provided that they are directly related to the treatment.
5. Specialist examinations and visits, medicines, medical and nursing services, purchase and/or hire of prosthetic and medical equipment including orthopaedic wheelchairs, physiotherapy or re-educational treatments, spa treatments (excluding any hotel costs) performed within 150 days of the date of surgery or hospital discharge provided that they are directly related to the treatment.
6. Board and lodging in a healthcare facility, or hotel where there is no availability in the hospital, for a person accompanying the Insured with a daily limit of €150 and for a duration not exceeding the hospitalisation, with a maximum of 100 days per insurance year.
7. Transport of the Insured by ambulance, mobile coronary unit and medical aircraft to the medical institution and vice versa, with a maximum of €1,100 per operation or hospitalisation.

C) In the event of hospitalisation or day hospitalisation that does not involve surgery, the Company shall reimburse the following expenses:

1. Medical and nursing care, treatment, physiotherapy and re-educational treatment, medicines, examinations and diagnostic tests relating to the period of hospitalisation, or incurred during the day hospital visit.
2. Convalescence fees (excluding out-of-pocket expenses) up to €350 per day.
3. Examinations, diagnostic tests and specialist examinations performed in the 150 days preceding hospitalisation, provided that they are directly related to the illness or injury that led to the treatment.
4. Specialist examinations and visits, medicines, medical and nursing services, purchase and/or hire of prosthetic and medical equipment including orthopaedic wheelchairs, physiotherapy or re-educational treatments, spa treatments (excluding any hotel costs) performed within 150 days of hospital discharge provided that they are directly related to the illness or injury that led to the treatment.
5. Transport of the Insured by ambulance to the healthcare facility and back, with a maximum of €1,100 per hospitalisation.
6. Transport of the Insured Person and any accompanying person abroad and back, by train or airline (excluding private car), up to a maximum of €2,000 per operation or hospitalisation.

D) In the event of childbirth without caesarean section and/or miscarriage, the Company shall reimburse the following expenses including those for the newborn child, up to the limit of €3,000

per insurance year:

1. Fees of the medical team, as well as operating room fees and operating materials during treatment.
2. Medical and nursing care, treatment, physiotherapy and re-educational treatment, medicines, examinations and diagnostic tests relating to the period of hospitalisation, including for the newborn child.
3. Convalescence fees (excluding out-of-pocket expenses) up to €350 per day.
4. Examinations, diagnostic tests and specialist examinations performed in the 150 days preceding hospitalisation, provided that they are directly related to the childbirth.
5. Specialist examinations and visits, medicines, medical and nursing services, purchase and/or hire of prosthetic and medical equipment including orthopaedic wheelchairs, physiotherapy or re-educational treatments, spa treatments (excluding any hotel costs) performed within 150 days of the date of hospital discharge provided that they are directly related to the childbirth.
6. Board and lodging in a healthcare facility, or hotel where there is no availability in the hospital, for a person accompanying the Insured with a daily limit of €150 and for a duration not exceeding the hospitalisation, with a maximum of 100 days per insurance year.
7. Transport of the Insured by ambulance, mobile coronary unit and medical aircraft to the medical institution and vice versa, with a maximum of €1,100 per operation or hospitalisation.

Article 2 - Cover operability

This insurance is provided independent of and in addition to the National Health Service.

Article 3 - Limit

The cover referred to in Art. 1 - Hospital Covers of this Section is provided up to a maximum amount of €500,000, to be understood as a single availability per insurance year and per insured party (or per family unit where the cover has been extended thereto), without prejudice to any further sub-limits specifically envisaged.

Article 4 - Self-insurance and deductibles

The expenses set forth in Art. 1 - Hospital Covers of this Section shall be reimbursed subject to the following self-insurance and deductibles, differentiated according to the type of insured party and type of service/guarantee and access to services:

a) **For the employee, research grant and scholarship holder** of INFN referred to in Art. 6, paragraph 1, letters a) and b) of Section I General Terms and Conditions:

1. Hospitalisation and day hospital referred to in points A) and C):

- Affiliated facilities with direct payment (Art. 3, Section IV): deductible of €950 (reduced to €200 for outpatient procedures)
- Unaffiliated facilities, or affiliated facilities without direct payment (Art. 3, Section IV): 30% self-insurance with a minimum of €2,000 and a maximum of €10,000 (the minimum does not apply to outpatient treatment)

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

- Facilities with direct payment (Art. 3, Section IV): deductible of €500
- Unaffiliated facilities, or affiliated facilities without direct payment (Art. 3, Section IV): 30% self-insurance

b) **For family members** (of employees/research grant and scholarship holders of INFN as per Art. 6, paragraph 1, letters a) and b) of Section I General Terms and Conditions), to whom cover under this contract has been extended pursuant to the last paragraph of Art. 6 of Section I General Terms and Conditions:

1. Hospitalisation and day hospital referred to in points A) and C):

- Facilities with direct payment (Art. 3, Section IV): deductible of €1,500 (reduced to €300 for outpatient procedures)
- Unaffiliated facilities, or affiliated facilities without direct payment (Art. 3, Section IV): 30% self-insurance with a minimum of €2,500 and a maximum of €10,000 (the minimum does not apply to outpatient treatment)

2. Caesarean section/therapeutic abortion and natural childbirth under points B) and D):

- Facilities with direct payment (Art. 3, Section IV): deductible of €500
- Unaffiliated facilities, or affiliated facilities without direct payment (Art. 3, Section IV): 30% self-insurance

c) **For all insured persons:** National Health Service supplement (co-payment only) full reimbursement without self-insurance and deductibles

Article 5 - Indemnity in lieu

If the Insured does not request any reimbursement from the Company, either for the hospitalisation/day hospital or for any other service connected thereto, they shall be entitled to an indemnity of €100.00 – reduced to 50% for day hospital – for each day of hospitalisation for a period not exceeding 60 days per stay.

This indemnity shall also be due if, as an alternative to or concurrent with hospitalisation in National Health Service facilities, the Insured resorts to the following forms of home healthcare on the instructions of the National Health Service facility:

- Hospitalisation at home (Home Care) whereby the hospital manages the care by sending medical and nursing staff to the patient's home.
- Supported Home Discharge (SHD) whereby the hospital promptly discharges the patient, indicating their needs and the necessary equipment, and the relevant local health service provides for their supply and care with its own personnel.

Article 6 - Out-of-Hospital Covers.

Article 6.1 - Advanced diagnostics

and therapies

The Company shall pay or reimburse expenses for the following services.

Activation of the cover requires a medical prescription containing the working diagnosis or pathology that made the service necessary. In the event of an accident, it is necessary to produce an Emergency

Room certificate, or alternatively a medical certificate indicating the type of accident and the date/period it took place.

Advanced diagnostic radiological (including digital), stratigraphic and contrastographic examinations:

- Angiography
- Arthrography
- Bronchography
- Cisternography
- Cystography
- Cystourethrography
- Barium enema
- Intravenous cholangiography
- Percutaneous cholangiography (PTC)
- Trans-Kehr cholangiography
- Cholecystography
- Colonoscopy
- Dacryocystography
- Defecography
- Discography
- Fistulography
- Phlebography
- Fluorangiography
- Galactography
- Gastroscopy
- Hysterosalpingography
- Lymphography
- Myelography
- Pneumoencephalography
- Retinography
- X-ray oesophagus with contrast medium
- X-ray stomach and duodenum with contrast medium
- X-ray small intestine and colon with contrast medium
- X-ray chest
- Rectoscopy
- Sialography
- Splenoportography
- Renal cavity tomography
- Tomoxerography
- Chest tomography
- Tomography in general
- Urography
- Vesiculo deferentography
- Video angiography
- Wirsung-graphy

Other Assessments

- Amniocentesis and villocentesis

- Computerized bone mineralometry (CBM)
- Echocardiography
- Electroencephalogram
- Electromyography
- Mammogram or Digital Mammogram
- Nuclear Magnetic Resonance Imaging (MRI) (including MRI angiography)
- Scintigraphy
- Computed Axial Tomography (CT) (including virtual)

Therapies

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

Article 6.1.1 - Limit

The annual limit for all benefits under Art. 6.1 - Advanced diagnostics and therapies is €10,000, to be understood as a single limit per insurance year and per insured person (or per family unit if cover has been extended thereto).

Article 6.1.2 - Self-insurance and deductibles for employees/research grant and scholarship holders.

For the employee, research grant and scholarship holder of INFN referred to in Art. 6, paragraph 1, letters a) and b) of Section I General Terms and Conditions the following conditions apply.

For the services referred to in Art. 6.1 - Advanced diagnostics and therapies, in the event of the use of healthcare facilities affiliated with the Company with direct payment for services (as per Art. 3, Section IV), the expenses for the services provided to the Insured shall be paid directly by the Company to the facilities themselves with the application of a deductible of €30 per service, which the Insured must pay directly to the healthcare facility.

If on the other hand the Insured uses healthcare facilities that are not affiliated with the Company (i.e. does not make use of direct payments for services as per Art. 3, Section IV), the expenses incurred shall be reimbursed to the Insured deducing self-insurance of 30% for each service or course of treatment (meaning the assessments and/or therapies related to the same pathology/accident, prescribed by the doctor at the same time and presented to the Company in a single request for reimbursement).

If the enrollee submits a bill for treatments referred to in Articles 6.1 and 6.2 of this Subsection, unless the specific amounts of each service used are specified (and the relevant statement issued by the issuer of the bill indicating the amounts of each individual service is attached), the reimbursement shall be calculated by applying the self-insurance envisaged in the preceding paragraph to the entire amount and the limit (for the entire bill reimbursed) will be equal to the amount specified in Art. 6.1.1.

If the Insured makes use of the National Health Service, the Company shall fully reimburse the co-payments charged to the Insured.

Article 6.1.3 - Self-insurance and deductibles for family members

For family members (of employees/research grant and scholarship holders of INFN as per Art. 6, paragraph 1, letters a) and b) of Section I General Terms and Conditions), to whom cover under this contract has been extended pursuant to the last paragraph of Art. 6 of Section I General Terms and Conditions the following conditions apply.

For the services referred to in Art. 6.1 - Advanced diagnostics and therapies, in the event of the use of healthcare facilities affiliated with the Company with direct payment for services (as per Art. 3, Section IV), the expenses for the services provided to the Insured shall be paid directly by the Company to the facilities themselves with the application of a deductible of €30 per service, which the Insured must pay directly to the healthcare facility.

If on the other hand the Insured uses healthcare facilities that are not affiliated with the Company (i.e. does not make use of direct payments for services as per Art. 3, Section IV), the expenses incurred shall be reimbursed to the Insured deducing self-insurance of 30% for each service or course of treatment (meaning the assessments and/or therapies related to the same pathology/accident, prescribed by the doctor at the same time and presented to the Company in a single request for reimbursement).

If the enrollee submits a bill for treatments referred to in Articles 6.1 and 6.2 of this Subsection, unless the specific amounts of each service used are specified (and the relevant statement issued by the issuer of the bill indicating the amounts of each individual service is attached), the reimbursement shall be calculated by applying the self-insurance envisaged in the preceding paragraph to the entire amount and the limit (for the entire bill reimbursed) will be equal to the amount specified in Art. 6.1.1.

If the Insured makes use of the National Health Service, the Company shall fully reimburse the co-payments charged to the Insured.

Article 6.2 - Diagnostic and laboratory visits and tests

The Company provides payment or reimbursement of expenses for specialist visits, examinations and diagnostic and laboratory tests resulting from illness or injury, with the exclusion of paediatric examinations for routine check-ups related to growth and dental and orthodontic examinations and tests.

Activation of the cover requires a medical prescription containing the working diagnosis or pathology that made the service necessary. In the event of an accident, it is necessary to produce an Emergency Room certificate, or alternatively a medical certificate indicating the type of accident and the period it took place

With regard to specialist visits, the expense documents (bills and/or receipts) must specify the doctor's speciality, which, for the purposes of reimbursement, must be relevant to the illness claimed.

Article 6.2.1 - Limit
The annual limit for all services under Art. 6.2 - Diagnostic and laboratory visits and tests is €3,000, to be understood as a single availability per insurance year and per insured party (or per family unit if coverage has been extended thereto).

Article 6.2.2 - Self-insurance and deductibles for employees/research grant and scholarship holders.
For the employee, research grant and scholarship holder of INFN referred to in Art. 6, paragraph 1, letters a) and b) of Section I General Terms and Conditions the following conditions apply.

For the services referred to in Art. 6.2 - Diagnostic and laboratory visits and tests, in the event of the use of healthcare facilities affiliated with the Company with direct payment for services (as per Art. 3, Section IV), the expenses for the services provided to the Insured shall be paid directly by the Company to the facilities themselves with the application of a deductible of €20, which the Insured must pay directly to the healthcare facility.

If on the other hand the Insured uses healthcare facilities that are not affiliated with the Company (i.e. does not make use of direct payments for services as per Art. 3, Section IV), the expenses incurred shall be reimbursed to the Insured deducing self-insurance of 20% with a minimum of €65 for each service or course of treatment (meaning the assessments and/or visits related to the same pathology/accident, prescribed by the doctor at the same time and presented to the Company in a single request for reimbursement).

If the Insured makes use of the National Health Service, the Company shall fully reimburse the co-payments charged to the Insured.

Article 6.2.3 - Self-insurance and deductibles for family members
For family members (of employees/research grant and scholarship holders of INFN as per Art. 6, paragraph 1, letters a) and b) of Section I General Terms and Conditions), to whom cover under this contract has been extended pursuant to the last paragraph of Art. 6 of Section I General Terms and Conditions the following conditions apply.

For the services referred to in Art. 6.2 - Diagnostic and laboratory visits and tests, in the event of the use of healthcare facilities affiliated with the Company with direct payment for services (as per Art. 3, Section IV), the expenses for the services provided to the Insured shall be paid directly by the Company to the facilities themselves with the application of a deductible of €20, which the Insured must pay directly to the healthcare facility.

If on the other hand the Insured uses healthcare facilities that are not affiliated with the Company (i.e. does not make use of direct payments for services as per Art. 3, Section IV), the expenses incurred shall be reimbursed to the Insured deducing self-insurance of 20% with a minimum of €65 for each service or course of treatment (meaning the assessments and/or visits related to the same pathology/accident, prescribed by the doctor at the same time and presented to the Company in a single request for reimbursement).

If the Insured makes use of the National Health Service, the Company shall fully reimburse the co-payments charged to the Insured.

Article 7 - Orthopaedic prosthetics and hearing aids
The Company reimburses the expenses incurred by the insured for the purchase of orthopaedic prosthetics and hearing aids with self-insurance of 20%.

A medical certificate indicating the illness or injury that made the purchase of the prosthesis necessary is required to activate the cover.

The annual limit insured for all services under this Article is €5,000, to be understood as a single availability per insurance year and per insured party (or per family unit if coverage has been extended thereto).

Article 8 - Oncological treatments
The Company provides payment or reimbursement of expenses for specialist visits, examinations, diagnostic and laboratory tests, therapies (including rehabilitation therapies) and drugs related to cancer treatment.

A medical certificate indicating the illness that made the service necessary.

The annual limit insured for all services under this Article is €10.000, to be understood as a single availability per insurance year and per insured (i.e. per family unit where cover has been extended thereto).

For the services referred to in this Article, in the event of the use of healthcare facilities affiliated with direct payment for services (as per Art. 3, Section IV), the expenses for the services provided to the Insured shall be paid directly by the Company to the facilities themselves without the application of self-insurance or deductibles.

If the Insured uses healthcare facilities that are not affiliated with the Company (i.e. does not make use of direct payment for services as per Art. 3, Section IV), the expenses incurred shall be reimbursed to the Insured with the application of 20% self-insurance.

If the Insured makes use of the National Health Service, the Company shall fully reimburse the co-payments charged to the Insured. The cover envisaged in this Article shall operate in addition to the covers envisaged in this Subsection.

Article 9 - Accident-related dental care
As a partial exception to Art. 15 - Exclusions of the General Terms and Conditions - Section I, the Company shall reimburse expenses sustained for dental treatment and prostheses only if resulting from an accident, provided that such accident is documented by a certificate from the emergency room or other similar hospital facility that provided immediate care, up to a maximum of €3,000 per insurance year and per insured party (or per family unit, if coverage has been extended thereto).

Article 10 - Dental prevention

As a partial exception to Art. 15 - Exclusions of the General Terms and Conditions - Section I, the Company shall pay the costs of a specialised dental examination and an oral hygiene session performed once a year for each insured party by affiliated facilities and doctors (reimbursement is therefore excluded if the insured party pays for the services directly).

Article 11 - Physiotherapy and rehabilitation treatments.

The Company shall provide payment or reimbursement of expenses for physiotherapy and rehabilitation services following an accident certified by an emergency room report and provided that the services are prescribed by a doctor and performed either by medical specialists or by medical personnel with a diploma or degree.

Article 11.1 - Limit

The annual limit for all services under Art. 11 - Physiotherapy and rehabilitation treatments is €500, to be understood as a single availability per insurance year and per insured party (or per family unit if coverage has been extended thereto).

Article 11.2 - Self-insurance and deductibles for employees/research grant and scholarship holders.

For the employee, research grant and scholarship holder of INFN referred to in Art. 6, paragraph 1, letters a) and b) of Section I General Terms and Conditions the following conditions apply.

For the services referred to in Art. 11 - Physiotherapy and rehabilitation treatments, in the event of the use of healthcare facilities affiliated with the Company with the use of the direct payment for the services (as per Art. 3, Section IV), the expenses for the services provided to the Insured shall be paid directly by the Company to the facilities themselves with the application of a deductible of €15 for each daily session.

If the Insured uses healthcare facilities that are not affiliated with the Company (i.e. does not make use of direct payments for services as per Art. 3, Section IV), the expenses incurred shall be reimbursed to the Insured with the application of a deductible of €100 for each bill or course of therapy (understood as the set of services relating to the same illness/accident prescribed by the doctor at the same time and presented to the Company in a single request for reimbursement).

Article 11.3 Self-insurance and deductibles for family members

For family members (of employees/research grant and scholarship holders of INFN as per Art. 6, paragraph 1, letters a) and b) of Section I General Terms and Conditions), to whom cover under this contract has been extended pursuant to the last paragraph of Art. 6 of Section I General Terms and Conditions the following conditions apply. For the services referred to in Art. 11 - Physiotherapy and rehabilitation treatments, in the event of the use of healthcare facilities affiliated with the Company with the use of the direct payment for the services (as per Art. 3, Section IV), the expenses for the services provided to the Insured shall be paid directly by the Company to the facilities themselves with the application of a deductible of €15 for each daily session.

If the Insured uses healthcare facilities that are not affiliated with the Company (i.e. does not make use of direct payments for services as per Art. 3, Section IV), the expenses incurred shall be reimbursed to the Insured with the application of a deductible of €100 for each bill or course of therapy (understood as the set of services relating to the same illness/accident prescribed by the doctor at the same time and presented to the Company in a single request for reimbursement).

Article 12 - Outpatient dental surgery

As a partial exception to Art. 15 - Exclusions of the General Terms and Conditions, the Company shall pay or reimburse the expenses incurred for surgery resulting from the following illnesses, including dental implant surgery related to the following operations:

1. Maxillary osteitis
2. Bone neoplasms of the mandible or maxilla
3. Follicular cysts
4. Root cysts
5. Adamantinoma
6. Odontoma

Activation of the cover requires a medical prescription containing the working diagnosis or pathology that made the service necessary. The medical documentation required to obtain reimbursement of the costs incurred includes:

- X-rays and radiological reports for the cases referred to in points 1, 2, 3, 4, 5, 6 above.
- (In addition to the above) histological reports for bone neoplasms of the mandible or maxilla, follicular cysts and root cysts.

The annual limit insured for all services under this Article is €10.000, to be understood as a single availability per insurance year and per insured (i.e. per family unit where cover has been extended thereto).

For the services referred to in this Article, in the event of the use of healthcare facilities affiliated with the Company, the expenses for the services provided to the Insured shall be paid directly by the Company to the facilities themselves without the application of self-insurance or deductibles.

If the Insured uses healthcare facilities that are not affiliated with the Company, the expenses incurred shall be fully reimbursed to the Insured.

If the Insured makes use of the National Health Service, the Company shall fully reimburse the co-payments charged to the Insured.

SECTION III - COVERS SUBSECTION B

INTRODUCTION.

The services envisaged in this Subsection III B are intended for:

- **INFN pensioners** - Art. 6, paragraph 2, letter c) of Section II General Terms and Conditions.
- **Family members of the insured persons referred to above**, to whom the cover provided by this contract was extended pursuant to the last paragraph of Art. 6 of Section I General Terms and Conditions.

Article 1 - Hospital covers.

The Company reimburses expenses incurred as a result of illness or accident occurring during the insurance year:

A) In the event of surgery performed as an inpatient, day hospital or outpatient, the Company shall reimburse the following expenses:

1. Fees of the surgical team, as well as operating room fees and operating materials, including endoprostheses applied during surgery.
2. Medical and nursing care, treatment, physiotherapy and re-educational treatment, medicines, examinations and diagnostic tests relating to the period of hospitalisation or incurred during the day hospital or outpatient surgery.
3. Convalescence fees (excluding out-of-pocket expenses) up to €350 per day.
4. Examinations, diagnostic tests and specialist examinations performed in the 150 days preceding surgery or hospitalisation, provided that they are directly related to the illness or injury that led to the treatment.
5. Specialist examinations and visits, medicines, medical and nursing services, purchase and/or hire of prosthetic and medical equipment including orthopaedic wheelchairs, physiotherapy or re-educational treatments, spa treatments (excluding any hotel costs) performed within 150 days of the date of surgery or hospital discharge provided that they are directly related to the illness or injury that led to the treatment.
6. Removal of organs or parts of organs; donor-related hospitalisation and diagnostic tests, medical and nursing care, removal surgery, treatment, medication and hospitalisation fees.
7. Board and lodging in a healthcare facility, or hotel where there is no availability in the hospital, for a person accompanying the Insured with a daily limit of €150 and for a duration not exceeding the hospitalisation, with a maximum of 100 days per insurance year.
8. Transport of the Insured by ambulance, mobile coronary unit and medical aircraft to the medical institution and vice versa, with a maximum of €1,100 per operation or hospitalisation.
9. Transport of the Insured and any accompanying person abroad and back, by train or by airline (excluding private car), with a maximum of €2,000 per operation or hospitalisation.
10. In the event of death resulting from surgery abroad, the insurance is extended to the reimbursement of the costs of repatriating the body up to a maximum of €1,500.

B) In the event of childbirth by caesarean section and/or therapeutic abortion, the Company shall reimburse the following expenses including those for the newborn child, up to the limit of €5,000 per insurance year:

1. Fees of the surgical team, as well as operating room fees and operating materials during surgery.
2. Medical and nursing care, treatment, physiotherapy and re-educational treatment, medicines, examinations and diagnostic tests relating to the period of hospitalisation, including for the newborn child.
3. Convalescence fees (excluding out-of-pocket expenses) up to €350 per day.
4. Examinations, diagnostic tests and specialist examinations performed in the 150 days preceding surgery or hospitalisation, provided that they are directly related to the treatment.
5. Specialist examinations and visits, medicines, medical and nursing services, purchase and/or hire of prosthetic and medical equipment including orthopaedic wheelchairs, physiotherapy or re-educational treatments, spa treatments (excluding any hotel costs) performed within 150 days of the date of surgery or hospital discharge provided that they are directly related to the treatment.
6. Board and lodging in a healthcare facility, or hotel where there is no availability in the hospital, for a person accompanying the Insured with a daily limit of €150 and for a duration not exceeding the hospitalisation, with a maximum of 100 days per insurance year.
7. Transport of the Insured by ambulance, mobile coronary unit and medical aircraft to the medical institution and vice versa, with a maximum of €1,100 per operation or hospitalisation.

C) In the event of hospitalisation or day hospitalisation that does not involve surgery, the Company shall reimburse the following expenses:

1. Medical and nursing care, treatment, physiotherapy and re-educational treatment, medicines, examinations and diagnostic tests relating to the period of hospitalisation, or incurred during the day hospital visit.
2. Convalescence fees (excluding out-of-pocket expenses) up to €350 per day.
3. Examinations, diagnostic tests and specialist examinations performed in the 150 days preceding hospitalisation, provided that they are directly related to the illness or injury that led to the treatment.
4. Specialist examinations and visits, medicines, medical and nursing services, purchase and/or hire of prosthetic and medical equipment including orthopaedic wheelchairs, physiotherapy or re-educational treatments, spa treatments (excluding any hotel costs) performed within 150 days of hospital discharge provided that they are directly related to the illness or injury that led to the treatment.
5. Transport of the Insured by ambulance to the healthcare facility and back, with a maximum of €1,100 per hospitalisation.
6. Transport of the Insured and any accompanying person abroad and back, by train or by airline (excluding private car), with a maximum of €2,000 per operation or hospitalisation.

D) In the event of childbirth without caesarean section and/or miscarriage, the Company shall reimburse the following expenses including those for the newborn child, up to the limit of €3,000 per insurance year:

1. Fees of the medical team, as well as operating room fees and operating materials during treatment.
2. Medical and nursing care, treatment, physiotherapy and re-educational treatment, medicines, examinations and diagnostic tests relating to the period of hospitalisation, including for the newborn child.

3. Convalescence fees (excluding out-of-pocket expenses) up to €350 per day.
4. Examinations, diagnostic tests and specialist examinations performed in the 150 days preceding hospitalisation, provided that they are directly related to the childbirth.
5. Specialist examinations and visits, medicines, medical and nursing services, purchase and/or hire of prosthetic and medical equipment including orthopaedic wheelchairs, physiotherapy or re-educational treatments, spa treatments (excluding any hotel costs) performed within 150 days of the date of hospital discharge provided that they are directly related to the childbirth.
6. Board and lodging in a healthcare facility, or hotel where there is no availability in the hospital, for a person accompanying the Insured with a daily limit of €150 and for a duration not exceeding the hospitalisation, with a maximum of 100 days per insurance year.
7. Transport of the Insured by ambulance, mobile coronary unit and medical plane to the healthcare facility and back, up to a maximum of €1,100 per operation or hospitalisation.

Article 2 - Cover operability

This insurance is provided independent of and in addition to the National Health Service.

Article 3 - Limit

The cover referred to in Art. 1 - Hospital Covers of this Section is provided up to a maximum amount of €500,000, to be understood as a single availability per insurance year and per insured party (or per family unit where the cover has been extended thereto), without prejudice to any further sub-limits specifically envisaged.

Article 4 - Self-insurance and deductibles

The expenses set forth in Art. 1 - Hospital Covers of this Section shall be reimbursed subject to the following self-insurance and deductibles, differentiated according to the type of service/guarantee and access to services:

1. **Hospitalisation and day hospital referred to in points A) and C):**
   - Contracted facilities with direct payment (Art. 3, Section IV): deductible of €1,500 (reduced to €300 for outpatient procedures)
   - Unaffiliated facilities, or affiliated facilities without direct payment (Art. 3, Section IV): 30% self-insurance with a minimum of €2,500 and a maximum of €10,000 (the minimum does not apply to outpatient treatment)
   - National Health Service supplement (co-payment only): full reimbursement without self-insurance and deductibles.

2. **Caesarean section/therapeutic abortion and natural childbirth under points B) and D):**
   - Facilities with direct payment (Art. 3, Section IV): deductible of €500
   - Unaffiliated facilities, or affiliated facilities without direct payment (Art. 3, Section IV): 30% self-insurance
   - National Health Service supplement (co-payment only): full reimbursement without self-insurance and deductibles.

Article 5 - Indemnity in lieu

If the Insured does not request any reimbursement from the Company, either for the hospitalisation/day hospital or for any other service connected thereto, they shall be entitled to an indemnity of € 75.00 – reduced to 50% for day hospital – for each day of hospitalisation for a period not exceeding 60 days per stay.

This indemnity shall also be due if, as an alternative to or concurrent with hospitalisation in National Health Service facilities, the Insured resorts to the following forms of home healthcare on the instructions of the National Health Service facility:

- Hospitalisation at home (Home Care) whereby the hospital manages the care by sending medical and nursing staff to the patient's home.
- Supported Home Discharge (SHD) whereby the hospital promptly discharges the patient, indicating their needs and the necessary equipment, and the relevant local health service provides for their supply and care with its own personnel.

Article 6 - Out-of-Hospital Covers.

Article 6.1 - Advanced diagnostics

and therapies

The Company shall pay or reimburse expenses for the following services.

Activation of the cover requires a medical prescription containing the working diagnosis or pathology that made the service necessary. In the event of an accident, it is necessary to produce an Emergency Room certificate, or alternatively a medical certificate indicating the type of accident and the date/period it took place.

Advanced diagnostic radiological (including digital), stratigraphic and contrastographic examinations:

- Angiography
- Arthrography
- Bronchography
- Cisternography
- Cystography
- Cystourethrography
- Barium enema
- Intravenous cholangiography
- Percutaneous cholangiography (PTC)
- Trans-Kehr cholangiography
- Cholecystography
- Colonoscopy
- Dacryocystography
- Defecography
- Discography
- Fistulography
- Phlebography

- Fluorangiography
- Galactography
- Gastroscopy
- Hysterosalpingography
- Lymphography
- Myelography
- Pneumoencephalography
- Retinography
- X-ray oesophagus with contrast medium
- X-ray stomach and duodenum with contrast medium
- X-ray small intestine and colon with contrast medium
- X-ray chest
- Rectoscopy
- Sialography
- Splenoportography
- Renal cavity tomography
- Tomoxerography
- Chest tomography
- Tomography in general
- Urography
- Vesiculo deferentography
- Video angiography
- Wirsung-graphy

Other Assessments

- Amniocentesis and villocentesis
- Computerized bone mineralometry (CBM)
- Echocardiography
- Electroencephalogram
- Electromyography
- Mammogram or Digital Mammogram
- Nuclear Magnetic Resonance Imaging (MRI) (including MRI angiography)
- Scintigraphy
- Computed Axial Tomography (CT) (including virtual)

Therapies

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

Article 6.1.1 - Limit

The annual limit for all benefits under Art. 6.1 - Advanced diagnostics and therapies is €10,000, to be understood as a single limit per insurance year and per insured person (or per family unit if cover has been extended thereto).

Article 6.30.2 - Self-insurance and deductibles

For the services referred to in Art. 6.1 - Advanced diagnostics and therapies, in the event of the use of healthcare facilities affiliated with the Company with direct payment for services (as per Art. 3, Section IV), the expenses for the services provided to the Insured shall be paid directly by the Company to the facilities themselves with the application of a deductible of €30 per service, which the Insured must pay directly to the healthcare facility.

If on the other hand the Insured uses healthcare facilities that are not affiliated with the Company (i.e. does not make use of direct payments for services as per Art. 3, Section IV), the expenses incurred shall be reimbursed to the Insured deducing self-insurance of 30% for each service or course of treatment (meaning the assessments and/or therapies related to the same pathology/accident, prescribed by the doctor at the same time and presented to the Company in a single request for reimbursement).

If the enrollee submits a bill for treatments referred to in Articles 6.1 and 6.2 of this Subsection, unless the specific amounts of each service used are specified (and the relevant statement issued by the issuer of the bill indicating the amounts of each individual service is attached), the reimbursement shall be calculated by applying the self-insurance envisaged in the preceding paragraph to the entire amount and the limit (for the entire bill reimbursed) will be equal to the amount specified in Art. 6.1.1.

If the Insured makes use of the National Health Service, the Company shall fully reimburse the co-payments charged to the Insured.

Article 6.2 - Diagnostic and laboratory visits and tests

The Company provides payment or reimbursement of expenses for specialist visits, examinations and diagnostic and laboratory tests resulting from illness or injury, with the exclusion of paediatric examinations for routine check-ups related to growth and dental and orthodontic examinations and tests.

Activation of the cover requires a medical prescription containing the working diagnosis or pathology that made the service necessary. In the event of an accident, it is necessary to produce an Emergency Room certificate, or alternatively a medical certificate indicating the type of accident and the period it took place

With regard to specialist visits, the expense documents (bills and/or receipts) must specify the doctor's speciality, which, for the purposes of reimbursement, must be relevant to the illness claimed.

Article 6.2.1 - Limit

The annual limit for all services under Art. 6.2 - Diagnostic and laboratory visits and tests is €3,000, to be understood as a single availability per insurance year and per insured party (or per family unit if coverage has been extended thereto).

Article 6.2.2 - Self-insurance and deductibles

For the services referred to in Art. 6.2 - Diagnostic and laboratory visits and tests, in the event of the use of healthcare facilities affiliated with the Company with direct payment for services (as per Art. 3, Section IV), the expenses for the services provided to the Insured shall be paid directly by the Company to the facilities themselves with the application of a deductible of €20, which the Insured must pay directly to the healthcare facility.

If on the other hand the Insured uses healthcare facilities that are not affiliated with the Company (i.e. does not make use of direct payments for services as per Art. 3, Section IV), the expenses incurred shall be reimbursed to the Insured deducing self-insurance of 20% with a minimum of €65 for each service or course of treatment (meaning the assessments and/or visits related to the same pathology/accident, prescribed by the doctor at the same time and presented to the Company in a single request for reimbursement).

If the Insured makes use of the National Health Service, the Company shall fully reimburse the co-payments charged to the Insured.

Article 7 - Orthopaedic prosthetics and hearing aids

The Company reimburses the expenses incurred by the insured for the purchase of orthopaedic prosthetics and hearing aids with self-insurance of 20%.

A medical certificate indicating the illness or injury that made the purchase of the prosthesis necessary is required to activate the cover.

The annual limit insured for all services under this Article is €5,000, to be understood as a single availability per insurance year and per insured party (or per family unit if coverage has been extended thereto).

Article 8 - Oncological treatments

The Company provides payment or reimbursement of expenses for specialist visits, examinations, diagnostic and laboratory tests, therapies (including rehabilitation therapies) and drugs related to cancer treatment.
A medical certificate indicating the illness that made the service necessary.

The annual limit insured for all services under this Article is €10,000, to be understood as a single limit per insurance year and per insured person (or per family unit if cover has been extended thereto).

For the services referred to in this Article, in the event of the use of healthcare facilities affiliated with the Company with direct payment for services (as per Art. 3, Section IV), the expenses for the services provided to the Insured shall be paid directly by the Company to the facilities themselves without the application of self-insurance or deductibles.

If the Insured uses healthcare facilities that are not affiliated with the Company (i.e. does not make use of direct payment for services as per Art. 3, Section IV), the expenses incurred shall be reimbursed to the Insured with the application of 20% self-insurance.

If the Insured makes use of the National Health Service, the Company shall fully reimburse the co-payments charged to the Insured.

The cover envisaged in this Article shall operate in addition to the covers envisaged in this Subsection.

Article 9 - Accident-related dental care

As a partial exception to Art. 15 - Exclusions of the General Terms and Conditions - Section I, the Company shall reimburse expenses sustained for dental treatment and prostheses only if resulting from an accident, provided that such accident is documented by a certificate from the emergency room or other similar hospital facility that provided immediate care, up to a maximum of €3,000 per insurance year and per insured party (or per family unit, if coverage has been extended thereto).

Article 10 - Dental prevention

As a partial exception to Art. 15 - Exclusions of the General Terms and Conditions - Section I, the Company shall pay the costs of a specialised dental examination and an oral hygiene session performed once a year for each insured party by affiliated facilities and doctors (reimbursement is therefore excluded if the insured party pays for the services directly).

Article 11 - Physiotherapy and rehabilitation treatments.

The Company shall provide payment or reimbursement of expenses for physiotherapy and rehabilitation services following an accident certified by an emergency room report and provided that the services are prescribed by a doctor and performed either by medical specialists or by medical personnel with a diploma or degree.

Article 11.1 - Limit

The annual limit for all services under Art. 11 - Physiotherapy and rehabilitation treatments is €500, to be understood as a single availability per insurance year and per insured party (or per family unit if coverage has been extended thereto).

Article 11.2 - Self-insurance and deductibles

For the services referred to in Art. 11 - Physiotherapy and rehabilitation treatments, in the event of the use of healthcare facilities affiliated with the Company with the use of the direct payment for the services (as per Art. 3, Section IV), the expenses for the services provided to the Insured shall be paid directly by the Company to the facilities themselves with the application of a deductible of €15 for each daily session. If the Insured uses healthcare facilities that are not affiliated with the Company (i.e. does not make use of direct payments for services as per Art. 3, Section IV), the expenses incurred shall be reimbursed to the Insured with the application of a deductible of €100 for each bill or course of therapy (understood as the set of services

relating to the same illness/accident prescribed by the doctor at the same time and presented to the Company in a single request for reimbursement).

Article 12 - Outpatient dental surgery

As a partial exception to Art. 15 - Exclusions of the General Terms and Conditions, the Company shall pay or reimburse the expenses incurred for surgery resulting from the following illnesses, including dental implant surgery related to the following operations:

1. Maxillary osteitis
2. Bone neoplasms of the mandible or maxilla
3. Follicular cysts
4. Root cysts
5. Adamantinoma
6. Odontoma

Activation of the cover requires a medical prescription containing the working diagnosis or pathology that made the service necessary. The medical documentation required to obtain reimbursement of the costs incurred includes:

- X-rays and radiological reports for the cases referred to in points 1, 2, 3, 4, 5, 6 above.
- (In addition to the above) histological reports for bone neoplasms of the mandible or maxilla, follicular cysts and root cysts.

The annual limit insured for all services under this Article is €5,000, to be understood as a single availability per insurance year and per insured party (or per family unit if coverage has been extended thereto).

For the services referred to in this Article, in the event of the use of healthcare facilities affiliated with the Company, the expenses for the services provided to the Insured shall be paid directly by the Company to the facilities themselves without the application of self-insurance or deductibles.

If the Insured uses healthcare facilities that are not affiliated with the Company, the expenses incurred shall be fully reimbursed to the Insured.

If the Insured makes use of the National Health Service, the Company shall fully reimburse the co-payments charged to the Insured.

SECTION III - COVERS SUBSECTION C

INTRODUCTION.

The services envisaged in this Subsection III C are intended for:

- **personnel associated with INFN/personnel seconded to INFN** - Art. 6, paragraph 2, letter d) of Section I General Terms and Conditions
- **Family members of the insured persons referred to above**, to whom the cover provided by this contract was extended pursuant to the last paragraph of Art. 6 of Section I General Terms and Conditions.

Article 1 - Hospital covers.

The Company reimburses expenses incurred as a result of illness or accident occurring during the insurance year:

A) In the event of surgery performed as an inpatient, day hospital or outpatient, the Company shall reimburse the following expenses:

1. Fees of the surgical team, as well as operating room fees and operating materials, including endoprostheses applied during surgery.
2. Medical and nursing care, treatment, physiotherapy and re-educational treatment, medicines, examinations and diagnostic tests relating to the period of hospitalisation or incurred during the day hospital or outpatient surgery.
3. Convalescence fees (excluding out-of-pocket expenses) up to €350 per day.
4. Examinations, diagnostic tests and specialist examinations performed in the 150 days preceding surgery or hospitalisation, provided that they are directly related to the illness or injury that led to the treatment.
5. Specialist examinations and visits, medicines, medical and nursing services, purchase and/or hire of prosthetic and medical equipment including orthopaedic wheelchairs, physiotherapy or re-educational treatments, spa treatments (excluding any hotel costs) performed within 150 days of the date of surgery or hospital discharge provided that they are directly related to the illness or injury that led to the treatment.
6. Removal of organs or parts of organs; donor-related hospitalisation and diagnostic tests, medical and nursing care, removal surgery, treatment, medication and hospitalisation fees.
7. Board and lodging in a healthcare facility, or hotel where there is no availability in the hospital, for a person accompanying the Insured with a daily limit of €150 and for a duration not exceeding the hospitalisation, with a maximum of 100 days per insurance year.
8. Transport of the Insured by ambulance, mobile coronary unit and medical aircraft to the medical institution and vice versa, with a maximum of €1,100 per operation or hospitalisation.
9. Transport of the Insured and any accompanying person abroad and back, by train or by airline (excluding private car), with a maximum of €2,000 per operation or hospitalisation.
10. In the event of death resulting from surgery abroad, the insurance extends to reimbursement of the costs of repatriating the body up to a maximum of €1,500.

B) In the event of childbirth by caesarean section and/or therapeutic abortion, the Company shall reimburse the following expenses including those for the newborn child, up to the limit of €5,000 per insurance year:

1. Fees of the surgical team, as well as operating room fees and operating materials during surgery.
2. Medical and nursing care, treatment, physiotherapy and re-educational treatment, medicines, examinations and diagnostic tests relating to the period of hospitalisation, including for the newborn child.
3. Convalescence fees (excluding out-of-pocket expenses) up to €350 per day.
4. Examinations, diagnostic tests and specialist examinations performed in the 150 days preceding surgery or hospitalisation, provided that they are directly related to the treatment.
5. Specialist examinations and visits, medicines, medical and nursing services, purchase and/or hire of prosthetic and medical equipment including orthopaedic wheelchairs, physiotherapy or re-educational treatments, spa treatments (excluding any hotel costs) performed within 150 days of the date of surgery or hospital discharge provided that they are directly related to the treatment.
6. Board and lodging in a healthcare facility, or hotel where there is no availability in the hospital, for a person accompanying the Insured with a daily limit of €150 and for a duration not exceeding the hospitalisation, with a maximum of 100 days per insurance year.
7. Transport of the Insured by ambulance, mobile coronary unit and medical aircraft to the medical institution and vice versa, with a maximum of €1,100 per operation or hospitalisation.

C) In the event of hospitalisation or day hospitalisation that does not involve surgery, the Company shall reimburse the following expenses:

1. Medical and nursing care, treatment, physiotherapy and re-educational treatment, medicines, examinations and diagnostic tests relating to the period of hospitalisation, or incurred during the day hospital visit.
2. Convalescence fees (excluding out-of-pocket expenses) up to €350 per day.
3. Examinations, diagnostic tests and specialist examinations performed in the 150 days preceding hospitalisation, provided that they are directly related to the illness or injury that led to the treatment.
4. Specialist examinations and visits, medicines, medical and nursing services, purchase and/or hire of prosthetic and medical equipment including orthopaedic wheelchairs, physiotherapy or re-educational treatments, spa treatments (excluding any hotel costs) performed within 150 days of hospital discharge provided that they are directly related to the illness or injury that led to the treatment.
5. Transport of the Insured by ambulance to the healthcare facility and back, with a maximum of €1,100 per hospitalisation.
6. Transport of the Insured and any accompanying person abroad and back, by train or by airline (excluding private car), with a maximum of €2,000 per operation or hospitalisation.

D) In the event of childbirth without caesarean section and/or miscarriage, the Company shall reimburse the following expenses including those for the newborn child, up to the limit of €3,000 per insurance year:

1. Fees of the medical team, as well as operating room fees and operating materials during treatment.

2. Medical and nursing care, treatment, physiotherapy and re-educational treatment, medicines, examinations and diagnostic tests relating to the period of hospitalisation, including for the newborn child.
3. Convalescence fees (excluding out-of-pocket expenses) up to €350 per day.
4. Examinations, diagnostic tests and specialist examinations performed in the 150 days preceding hospitalisation, provided that they are directly related to the childbirth.
5. Specialist examinations and visits, medicines, medical and nursing services, purchase and/or hire of prosthetic and medical equipment including orthopaedic wheelchairs, physiotherapy or re-educational treatments, spa treatments (excluding any hotel costs) performed within 150 days of the date of hospital discharge provided that they are directly related to the childbirth.
6. Board and lodging in a healthcare facility, or hotel where there is no availability in the hospital, for a person accompanying the Insured with a daily limit of €150 and for a duration not exceeding the hospitalisation, with a maximum of 100 days per insurance year.
7. Transport of the Insured by ambulance, mobile coronary unit and medical aircraft to the medical institution and vice versa, with a maximum of €1,100 per operation or hospitalisation.

Article 2 - Cover operability

This insurance is provided independent of and in addition to the National Health Service.

Article 3 - Limit

The cover referred to in Art. 1 - Hospital Covers of this Section is provided up to a maximum amount of €500,000, to be understood as a single availability per insurance year and per insured party (or per family unit where the cover has been extended thereto), without prejudice to any further sub-limits specifically envisaged.

Article 4 - Self-insurance and deductibles

The expenses set forth in Art. 1 - Hospital Covers of this Section shall be reimbursed subject to the following self-insurance and deductibles, differentiated according to the type of service/guarantee and access to services:

3. **Hospitalisation and day hospital referred to in points A) and C):**
   - Contracted facilities with direct payment (Art. 3, Section IV): deductible of €1,500 (reduced to €300 for outpatient procedures)
   - Unaffiliated facilities, or affiliated facilities without direct payment (Art. 3, Section IV): 30% self-insurance with a minimum of €2,500 and a maximum of €10,000 (the minimum does not apply to outpatient treatment)
   - National Health Service supplement (co-payment only): full reimbursement without self-insurance and deductibles.

4. **Caesarean section/therapeutic abortion and natural childbirth under points B) and D):**
   - Facilities with direct payment (Art. 3, Section IV): deductible of €500
   - Unaffiliated facilities, or affiliated facilities without direct payment (Art. 3, Section IV): 30% self-insurance
   - National Health Service supplement (co-payment only): full reimbursement without self-insurance and deductibles.

Article 5 - Indemnity in lieu

If the Insured does not request any reimbursement from the Company, either for the hospitalisation/day hospital or for any other service connected thereto, they shall be entitled to an indemnity of € 75.00 – reduced to 50% for day hospital – for each day of hospitalisation for a period not exceeding 60 days per stay.

This indemnity shall also be due if, as an alternative to or concurrent with hospitalisation in National Health Service facilities, the Insured resorts to the following forms of home healthcare on the instructions of the National Health Service facility:

- Hospitalisation at home (Home Care) whereby the hospital manages the care by sending medical and nursing staff to the patient's home.
- Supported Home Discharge (SHD) whereby the hospital promptly discharges the patient, indicating their needs and the necessary equipment, and the relevant local health service provides for their supply and care with its own personnel.

Article 6 - Out-of-Hospital Covers.

Article 6.1 - Advanced diagnostics

and therapies

The Company shall pay or reimburse expenses for the following services.

Activation of the cover requires a medical prescription containing the working diagnosis or pathology that made the service necessary. In the event of an accident, it is necessary to produce an Emergency Room certificate, or alternatively a medical certificate indicating the type of accident and the date/period it took place.

Advanced diagnostic radiological (including digital), stratigraphic and contrastographic examinations:

- Angiography
- Arthrography
- Bronchography
- Cisternography
- Cystography
- Cystourethrography
- Barium enema
- Intravenous cholangiography
- Percutaneous cholangiography (PTC)
- Trans-Kehr cholangiography
- Cholecystography
- Colonoscopy
- Dacryocystography
- Defecography
- Discography
- Fistulography
- Phlebography

- Fluorangiography
- Galactography
- Gastroscopy
- Hysterosalpingography
- Lymphography
- Myelography
- Pneumoencephalography
- Retinography
- X-ray oesophagus with contrast medium
- X-ray stomach and duodenum with contrast medium
- X-ray small intestine and colon with contrast medium
- X-ray chest
- Rectoscopy
- Sialography
- Splenoportography
- Renal cavity tomography
- Tomoxerography
- Chest tomography
- Tomography in general
- Urography
- Vesiculo deferentography
- Video angiography
- Wirsung-graphy

Other Assessments

- Amniocentesis and villocentesis
- Computerized bone mineralometry (CBM)
- Echocardiography
- Electroencephalogram
- Electromyography
- Mammogram or Digital Mammogram
- Nuclear Magnetic Resonance Imaging (MRI) (including MRI angiography)
- Scintigraphy
- Computed Axial Tomography (CT) (including virtual)

Therapies

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

Article 6.1.1 - Limit

The annual limit for all benefits under Art. 6.1 - Advanced diagnostics and therapies is €10,000, to be understood as a single limit per insurance year and per insured person (or per family unit if cover has been extended thereto).

Article 6.39.2 - Self-insurance and deductibles

For the services referred to in Art. 6.1 - Advanced diagnostics and therapies, in the event of the use of healthcare facilities affiliated with the Company with direct payment for services (as per Art. 3, Section IV), the expenses for the services provided to the Insured shall be paid directly by the Company to the facilities themselves with the application of a deductible of €30 per service, which the Insured must pay directly to the healthcare facility.

If on the other hand the Insured uses healthcare facilities that are not affiliated with the Company (i.e. does not make use of direct payments for services as per Art. 3, Section IV), the expenses incurred shall be reimbursed to the Insured deducing self-insurance of 30% for each service or course of treatment (meaning the assessments and/or therapies related to the same pathology/accident, prescribed by the doctor at the same time and presented to the Company in a single request for reimbursement).

If the enrollee submits a bill for treatments referred to in Articles 6.1 and 6.2 of this Subsection, unless the specific amounts of each service used are specified (and the relevant statement issued by the issuer of the bill indicating the amounts of each individual service is attached), the reimbursement shall be calculated by applying the self-insurance envisaged in the preceding paragraph to the entire amount and the limit (for the entire bill reimbursed) will be equal to the amount specified in Art. 6.1.1.

If the Insured makes use of the National Health Service, the Company shall fully reimburse the co-payments charged to the Insured.

Article 6.2 - Diagnostic and laboratory visits and tests

The Company provides payment or reimbursement of expenses for specialist visits, examinations and diagnostic and laboratory tests resulting from illness or injury, with the exclusion of paediatric examinations for routine check-ups related to growth and dental and orthodontic examinations and tests.

Activation of the cover requires a medical prescription containing the working diagnosis or pathology that made the service necessary. In the event of an accident, it is necessary to produce an Emergency Room certificate, or alternatively a medical certificate indicating the type of accident and the period it took place

With regard to specialist visits, the expense documents (bills and/or receipts) must specify the doctor's speciality, which, for the purposes of reimbursement, must be relevant to the illness claimed.

Article 6.2.1 - Limit

The annual limit for all services under Art. 6.2 - Diagnostic and laboratory visits and tests is €3,000, to be understood as a single availability per insurance year and per insured party (or per family unit if coverage has been extended thereto).

Article 6.2.2 - Self-insurance and deductibles
For the services referred to in Art. 6.2 - Diagnostic and laboratory visits and tests, in the event of the use of healthcare facilities affiliated with the Company with direct payment for services (as per Art. 3, Section IV), the expenses for the services provided to the Insured shall be paid directly by the Company to the facilities themselves with the application of a deductible of €20, which the Insured must pay directly to the healthcare facility.

If on the other hand the Insured uses healthcare facilities that are not affiliated with the Company (i.e. does not make use of direct payments for services as per Art. 3, Section IV), the expenses incurred shall be reimbursed to the Insured deducing self-insurance of 20% with a minimum of €65 for each service or course of treatment (meaning the assessments and/or visits related to the same pathology/accident, prescribed by the doctor at the same time and presented to the Company in a single request for reimbursement).

If the Insured makes use of the National Health Service, the Company shall fully reimburse the co-payments charged to the Insured.

Article 7 - Orthopaedic prosthetics and hearing aids
The Company reimburses the expenses incurred by the insured for the purchase of orthopaedic prosthetics and hearing aids with self-insurance of 20%.

A medical certificate indicating the illness or injury that made the purchase of the prosthesis necessary is required to activate the cover.

The annual limit insured for all services under this Article is €5,000, to be understood as a single availability per insurance year and per insured party (or per family unit if coverage has been extended thereto).

Article 8 - Oncological treatments
The Company provides payment or reimbursement of expenses for specialist visits, examinations, diagnostic and laboratory tests, therapies (including rehabilitation therapies) and drugs related to cancer treatment.
A medical certificate indicating the illness that made the service necessary.

The annual limit insured for all services under this Article is €10,000, to be understood as a single limit per insurance year and per insured person (or per family unit if cover has been extended thereto).

For the services referred to in this Article, in the event of the use of healthcare facilities affiliated with the Company with direct payment for services (as per Art. 3, Section IV), the expenses for the services provided to the Insured shall be paid directly by the Company to the facilities themselves without the application of self-insurance or deductibles.

If the Insured uses healthcare facilities that are not affiliated with the Company (i.e. does not make use of direct payment for services as per Art. 3, Section IV), the expenses incurred shall be reimbursed to the Insured with the application of 20% self-insurance.

If the Insured makes use of the National Health Service, the Company shall fully reimburse the co-payments charged to the Insured.

The cover envisaged in this Article shall operate in addition to the covers envisaged in this Subsection.

Article 9 - Accident-related dental care

As a partial exception to Art. 15 - Exclusions of the General Terms and Conditions - Section I, the Company shall reimburse expenses sustained for dental treatment and prostheses only if resulting from an accident, provided that such accident is documented by a certificate from the emergency room or other similar hospital facility that provided immediate care, up to a maximum of €3,000 per insurance year and per insured party (or per family unit, if coverage has been extended thereto).

Article 10 - Dental prevention

As a partial exception to Art. 15 - Exclusions of the General Terms and Conditions - Section I, the Company shall pay the costs of a specialised dental examination and an oral hygiene session performed once a year for each insured party by affiliated facilities and doctors (reimbursement is therefore excluded if the insured party pays for the services directly).

Article 11 - Physiotherapy and rehabilitation treatments.

The Company shall provide payment or reimbursement of expenses for physiotherapy and rehabilitation services following an accident certified by an emergency room report and provided that the services are prescribed by a doctor and performed either by medical specialists or by medical personnel with a diploma or degree.

Article 11.1 - Limit

The annual limit for all services under Art. 11 - Physiotherapy and rehabilitation treatments is €500, to be understood as a single availability per insurance year and per insured party (or per family unit if coverage has been extended thereto).

Article 11.2 - Self-insurance and deductibles

For the services referred to in Art. 11 - Physiotherapy and rehabilitation treatments, in the event of the use of healthcare facilities affiliated with the Company with the use of the direct payment for the services (as per Art. 3, Section IV), the expenses for the services provided to the Insured shall be paid directly by the Company to the facilities themselves with the application of a deductible of €15 for each daily session. If the Insured uses healthcare facilities that are not affiliated with the Company (i.e. does not make use of direct payments for services as per Art. 3, Section IV), the expenses incurred shall be reimbursed to the Insured with the application of a deductible of €100 for each bill or course of therapy (understood as the set of services

relating to the same illness/accident prescribed by the doctor at the same time and presented to the Company in a single request for reimbursement).

Article 12 - Outpatient dental surgery

As a partial exception to Art. 15 - Exclusions of the General Terms and Conditions, the Company shall pay or reimburse the expenses incurred for surgery resulting from the following illnesses, including dental implant surgery related to the following operations:

1. Maxillary osteitis
2. Bone neoplasms of the mandible or maxilla
3. Follicular cysts
4. Root cysts
5. Adamantinoma
6. Odontoma

Activation of the cover requires a medical prescription containing the working diagnosis or pathology that made the service necessary. The medical documentation required to obtain reimbursement of the costs incurred includes:

- X-rays and radiological reports for the cases referred to in points 1, 2, 3, 4, 5, 6 above.
- (In addition to the above) histological reports for bone neoplasms of the mandible or maxilla, follicular cysts and root cysts.

The annual limit insured for all services under this Article is €5,000, to be understood as a single availability per insurance year and per insured party (or per family unit if coverage has been extended thereto).

For the services referred to in this Article, in the event of the use of healthcare facilities affiliated with the Company, the expenses for the services provided to the Insured shall be paid directly by the Company to the facilities themselves without the application of self-insurance or deductibles.

If the Insured uses healthcare facilities that are not affiliated with the Company, the expenses incurred shall be fully reimbursed to the Insured.

If the Insured makes use of the National Health Service, the Company shall fully reimburse the co-payments charged to the Insured.

SECTION IV - RULES IN THE EVENT OF A CLAIM

Article 1 - Methods for providing services

The services covered by this contract, specifically those envisaged in Section III (Subsections A, B and C), may be provided in the following manner:

a) **Affiliated facilities**: in private or public healthcare facilities affiliated with the Company and performed by affiliated doctors.

In this case, the expenses related to the services provided are settled directly by the Company to the affiliated healthcare facilities with the possible application of the self-insurance and deductibles envisaged for each type of cover and service, which must then be paid by the interested party directly to the facility/professional that provided the service.

Notwithstanding the foregoing, with regard to the following service under Art. 1
Hospital Covers in Section III (subsections A, B and C), the costs of

- board and lodging for a person accompanying the Insured;
- transport of the Insured by ambulance, mobile coronary unit and medical aircraft;
- transport of the Insured and any accompanying person abroad and back, by train or by plane;
- expenses for the repatriation of the body;

shall be reimbursed to the Insured without application of deductibles/self-insurance without prejudice to the limits specifically envisaged.

Moreover, with regard to the hospital services referred to in Art. 1 Hospital Covers of Section III (subsections A, B, and C), in the event of hospitalisation/day hospital at affiliated facilities and with affiliated doctors, the payment of hospitalisation expenses (in any case excluding any unnecessary expenses) shall be made without application of the limit indicated in the aforementioned Article.

In the event of hospitalisation/day hospital/outpatient treatment performed in private/public healthcare facilities that are affiliated with the Company but by doctors who are not affiliated with the Company, it will not be possible for the Company to directly settle the expenses. Therefore, the enrollee must pay the expenses incurred and subsequently request reimbursement according to the procedures outlined in point b).

b) **Unaffiliated facilities**: in private or public healthcare facilities not affiliated with the Company and performed by unaffiliated doctors.

In this case, the expenses incurred by the Insured shall be reimbursed by the Company in accordance with the procedures (self-insurance, deductibles) envisaged for each type of cover and service.

Notwithstanding the foregoing, with regard to the following service under Art. 1 Hospital Covers in Section III (Subsections A, B and C), the costs of:

- board and lodging for a person accompanying the Insured;
- transport of the Insured by ambulance, mobile coronary unit and medical aircraft;
- transport of the Insured and any accompanying person abroad and back, by train or by plane;
- expenses for the repatriation of the body;

shall be reimbursed to the Insured without application of deductibles/self-insurance without prejudice to the limits specifically envisaged.

c) <u>Services of the National Health Service</u>

In the event of hospitalisation in facilities of the National Health Service or accredited thereby in the form of direct assistance, and therefore with the cost fully borne by the National Health Service, the expenses incurred by the Insured shall be fully reimbursed by the Company, without prejudice to the possibility for the Insured to activate the "Indemnity in lieu" cover as an alternative to reimbursement of expenses in the event of hospitalisation/day hospital.

Article 2 - Charges borne by the Insured

In order to obtain reimbursement of the expenses incurred (i.e. recognition of the indemnity in lieu), the Insured must report the claim to the Company in accordance with the procedures agreed to by the Company and INFN.

The claim must be accompanied by a copy of the medical documentation, indicating the diagnosis or working diagnosis relating to the service for which reimbursement is requested, or by a copy of the medical report attesting to the nature of the illness or accident (for the latter, the insured must produce a copy of the emergency room report, or alternatively suitable medical certificates and/or reports of any diagnostic tests performed from which it is possible to determine the cause of the accident and the date it occurred). The Insured is obliged to submit a copy of the medical records (even in electronic format) relating to any hospitalisation.

The Insured must provide any information and allow the Company's doctors to visit them for any investigation or assessment that the Company deems necessary, releasing the doctors who have examined and treated them from their professional secrecy for this purpose alone.

As specified above, the documents must be submitted as copies, it being understood that the Company may at any time (either before or after payment) request the production of the originals or copies conforming to the originals should the documents submitted be wholly or partially illegible, incomplete or have different handwriting, or to perform statistical checks.

Upon completion of the claim assessment, no later than 30 days after the submission of the claim report, the Company shall send the insured a communication outlining the outcome of the assessment made (stating the details of the direct settlements and reimbursements arranged, or the reasons for the lack of settlement).

Article 3 - Activation of direct services at Affiliated Facilities

With regard to the method of accessing services envisaged by Art. 1, letter a) of this Section, the expenses related to the services provided are settled directly by the Company with the affiliated healthcare facilities and with the fully affiliated doctors, that is, with the application of the self-insurance and deductibles envisaged for each type of cover and service, which must then be paid by the Insured directly to the facility/professional that provided the service.

In order to be entitled to such direct assistance, the Insured must obtain prior authorisation from the Company by contacting the Company's offices (Operations Centre), which within three working days of activation shall provide the Insured with information regarding the acceptance of the request.

At the time the service is rendered, the Insured must provide the affiliated facility with a document proving their identity and a prescription from the treating doctor indicating the nature of the illness (ascertained or presumed) or injury for which the services are requested.

In any event, the healthcare facility may not request payment from the Insured nor take any action against them, except in the case of receivables relating to expenses for services that are not included in the policy covers, any self-insurance and deductibles envisaged in the individual covers, and for expenses that exceed the insured limit or that were not authorised.

Article 4 - Indemnity advances

In the event of hospitalisation as referred to in Art. 1 Hospital Covers of Section III (subsections A, B and C) in a healthcare facility that is not affiliated with the Company, the Insured may request an advance on the budgeted expenses to an extent not exceeding 80% thereof and subject to the submission of the relevant documentation to the Company. On average the advance shall be paid by the Company within 5 days of receipt of the necessary documentation.

Upon completion of the treatment, upon presentation of the original cost statements by the Insured, the Company shall make the corresponding adjustment when settling the claim.

If the insured is able to provide the Company with the exact amount of the reimbursement based on a declaration of the healthcare facility, the Company shall pay the advance up to 100% of the expense incurred within the contractual limits.

Article 5 - Operational management portal

The Company makes a portal available to insured persons, through which they can:

a. Check their personal information.
b. Submit claims (minimum upload capacity per document guaranteed by the portal: 5 mb).

c. Submit any documentation required to complete claims already submitted (minimum upload capacity per document guaranteed by the portal: 5 mb).
d. Check the status of their claims in a simple, intuitive manner: submitted, reimbursed, refused.
e. View/download the Company's communications.

Moreover, with regard to direct services and treatments:

f. Consult the list of facilities and doctors belonging to the affiliated networks.
g. Request the activation of direct services at Affiliated Facilities.
h. Submit the documentation required for the management and completion of claims (minimum upload capacity per document: 5 mb).
i. Check the status of their claims and view/download communications from the Company.

In this same personal area, the Company will make the following available to insured persons:
- The contractual documentation.
- Any operational guides.
- Statements of insurance (summarising the benefits and conditions applicable to each insured person) in Italian and English for each insured person, broken down by head of household and individual family member.

The aforementioned services will be made available to insured persons in their personal areas, which can be accessed after registering on the portal made available by the Company. Registration may only be completed by the insured person that is the head of the household for the management of its claims and those of family members the insurance cover may have been extended to.

SECTION V - SUPPORT

Introduction: the services envisaged in this section are made available to all insured persons under Art. 6 of Section I General Terms and Conditions, in addition to those envisaged in Section III Covers.

Article 1 - CONSULTANCY AND SUPPORT SERVICES
The following consultancy services are provided by the successful tenderer's Operations Centre by calling the toll-free number 800.186.035.

From abroad, the Operations Centre can be contacted by calling 06.89320211.

For the consultancy and support services offered, as a rule the Company agrees to guarantee response times of no more than ten minutes.

Article 2 - CONSULTANCY SERVICES

Advisory services are provided by the Operations Centre Monday to Friday from 8 am to 6 pm.

Any changes must be communicated to the INFN Administration and promptly updated on the dedicated service portal.

a) Health information available by telephone

The Operations Centre provides health information regarding:

- Public and private healthcare facilities: locations and specialisations.
- Affiliated healthcare facilities and doctors.
- Guidance on how to use the policy and on clarification of claims and direct support cases.
- Specialised medical centres for particular illnesses in Italy and abroad.

b) Booking of healthcare services

The Operations Centre provides a booking service for healthcare services covered by the plan in the form of direct assistance in healthcare facilities that are affiliated with the Company.

c) Immediate medical opinions

If as a result of an accident or illness the Insured requires medical advice by telephone, the Operations Centre will provide the requested information and advice through its doctors.
As a partial exception to the first paragraph of this Article, immediate medical opinions are provided by the Operations Centre 24 hours a day, 7 days a week, including holidays.

Article 3 - SUPPORT IN ITALY

Support services are provided by the Operations Centre 24 hours a day, 7 days a week, holidays included.

d) Sending of a doctor

If as a result of an accident or illness the Insured needs a doctor in Italy from 8 pm to 8 am on weekdays or 24 hours a day on weekends and holidays and cannot find one, the Operative Centre, having ascertained the need for the service, shall send an affiliated doctor at its own expense. If an affiliated doctor is unable to intervene personally, as an alternative the Operations Centre shall organise the transfer of the Insured to the nearest suitable medical centre by ambulance, bearing the relative expenses.

e) Return from ER hospitalisation

If as a result of injury or illness the Insured requires transportation by ambulance following treatment in the emergency room, the Operations Centre shall directly send an ambulance, bearing the relative expenses up to an amount equal to that necessary to travel a total distance of 500 km per event.

f) Medicine procurement and delivery

The Insured may ask the Operations Centre to deliver medicines prescribed by their doctor from the pharmaceutical handbook to their home. In compliance with the regulations governing the purchase and transport of medicines, the Operations Centre shall send a correspondent to collect the money and prescription necessary for the purchase from the Insured's home, and will then deliver the requested medicines. The service is provided in the shortest possible time as soon as the required medicines are available.

g) Taking blood samples at home

If in the event of illness (certain or presumed) or accident a request has been made by the attending physician, the Insured may ask the Operations Centre to organise the taking of blood samples at their home. The service is provided with 5 (five) working days' notice.

Article 4 - SECOND OPINIONS

This service is provided by the Operations Centre Monday to Friday from 8 am to 6 pm.

h) Second Opinions

If the patient feels the need to get a second opinion from the best experts in the various specialist areas about the diagnosis or therapeutic approach of the treating doctors, they may contact the Operations Centre directly.

This way the insured person will be informed in good time of the procedure to be followed in order to receive the covered service.

This service is available with the following diagnosed or ascertained serious illnesses:

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

In order to activate this cover, the Insured must provide the Company with the clinical documentation in their possession that the Company's doctor will request with respect to the specific pathology for which a second opinion is requested. This documentation will then be sent by the Company at

its own expense to external medical consultants for the identification of the best external physician for that pathology.

Article 5 - INTERNATIONAL SUPPORT

Support services are provided by the Operations Centre 24 hours a day, 7 days a week, holidays included.

i) Travel of a family member abroad

If as a result of illness or injury the Insured requires hospitalisation for a period of more than 10 days, the Operations Centre, bearing the costs, will provide a member of the Insured's family residing in Italy with a round-trip airline ticket (economy class) or train ticket (first class) and will pay lodging costs up to a limit of €2,000.00 per claim.

j) Sending urgent medicines abroad

If as a result of illness or injury the Insured needs medicines for treatment that cannot be found locally (provided that they are sold in Italy), the Operations Centre shall send them by the quickest means of transport, consistent with local regulations on the transport of medicines, bearing the relative expenses.

The cost of purchasing the medicines remains the responsibility of the Insured.

k) Medical repatriation

If the Insured is abroad and, as a result of injury or sudden illness, their health conditions, as ascertained through direct contact and/or by other means of telecommunication between the doctors of the Operations Centre and the doctor on site, make it necessary to transport the Insured to a hospital in Italy or near their residence, the Operations Centre shall provide transport, bearing the relative expenses, with the means that the Operation Centre's doctors deem most appropriate based on the Insured's condition from among those listed below:

- Air ambulance
- Scheduled airline, economy class, possibly on a stretcher
- Train, first class, if necessary in a sleeping car
- Ambulance without route limits

Transfers from non-European countries are made exclusively using commercial airlines, in economy class. Transport is fully organised by the Operations Centre, including medical and/or nursing assistance during the trip, if deemed necessary by its doctors.

The service is not provided for injuries or infirmities that in the opinion of the doctors can be treated locally or that do not prevent the Insured from continuing the trip.

If the Operations Centre returns the Insured home at its own expense, it may ask the latter to return any unused airline or train ticket.

SECTION VI - PREMIUMS

INTRODUCTION.
The annual premiums for all services under this contract for each insured person named below, including taxes, are defined as follows.

Article 1 INFN employees/holders of research grants and scholarships awarded by INFN.
The annual premium for INFN employees/holders of research grant and scholarships awarded by INFN (Art. 6, paragraph 1, letters a) and b) of Section I General Terms and Conditions is set at **€409.02**.

For members of the Insured's household as per subsection I to whom cover has been extended pursuant to the last subsection of Art. 6 of Section I General Terms and Conditions, the premium per year/person is established as follows:

1. **Fiscally dependent spouse/civil partner: €327.21**
2. **Non-fiscally dependent spouse/civil partner/cohabitant as if married €368.11**
3. **Child: €286.31**
4. **Other family member: €613.52**

With regard to the insured persons referred to in points 1 and 2 above, a change in the tax burden during the year shall not entail any change (reduction/increase) in the premium already calculated/paid, without prejudice to the possible re-determination of such premium on the first annual expiry.

Article 2 - INFN Pensioner
The annual premium for the **INFN Pensioner** (Art. 6, paragraph 2, letter c of Section I General Terms and Conditions) is set at **€1,227.05**, as per paragraph 1 of Art. 1 of this Section.
For members of the Insured's household as per subsection I to whom cover has been extended pursuant to the last subsection of Art. 6 of Section I General Terms and Conditions, the premium per year/person is established as follows:

1. **Fiscally dependent spouse/civil partner: €981.64**
2. **Non-fiscally dependent spouse/civil partner/cohabitant as if married: € 1,104.34**
3. **Child: €858.93**
4. **Other family member: €1,840.57**

With regard to the insured persons referred to in points 1 and 2 above, a change in the tax burden during the year shall not entail any change (reduction/increase) in the premium already calculated/paid, without prejudice to the possible re-determination of such premium on the first annual expiry.

Article 3 - INFN associate/Seconded to INFN
The annual premiums for all services under this contract for each insured person named below, including taxes, are defined as follows:

The annual premium for the **INFN Associate/Seconded to INFN** (Art. 6, paragraph 2, letter d of Section I General Terms and Conditions) is set at €1,227.05, as per paragraph 1 of Art. 1 of this Section.

For members of the Insured's household as per subsection I to whom cover has been extended pursuant to the last subsection of Art. 6 of Section I General Terms and Conditions, the premium per year/person is established as follows:

1. **Fiscally dependent spouse/civil partner: €981.64**
2. **Non-fiscally dependent spouse/civil partner/cohabitant as if married: €1,104.34**
3. **Child: €858.93**
4. **Other family member: €1,840.57**

With regard to the insured persons referred to in points 1 and 2 above, a change in the tax burden during the year shall not entail any change (reduction/increase) in the premium already calculated/paid, without prejudice to the possible re-determination of such premium on the first annual expiry.

Untrue, inaccurate or reticent declarations made by the person entitled to provide the information required for the conclusion of this contract may jeopardise the right to the service, pursuant to Articles 1892, 1893 and 1894 of the Italian Civil Code.

The Policyholder_____

Pursuant to Articles 1341 and 1342 of the Italian Civil Code, the Policyholder specifically approves: Sec. I, Art. 1, 9, 10, 11 - Sec. II, Art. 19 - Sec. IV, Art. 2 of the Insurance Conditions

The Policyholder_____

OBLIGATIONS OF THE POLICYHOLDER
If the Insured bear all or part of the costs related to the payment of the premiums, and consequently bear an interest in the service either directly or through their assignees, the Policyholder agrees to provide them with the Insurance Conditions.

The Policyholder_____

PRE-CONTRACTUAL INFORMATION

The Policyholder declares that it has received and read the Conditions of Insurance. It also declares that it has read and received (in the cases envisaged by applicable law) the document summarising the main obligations of conduct of intermediaries, that it has read and received the statement containing general information on the intermediary, in accordance with applicable legal and regulatory provisions.

The Policyholder_____

Privacy policy pursuant to Regulation 2016/679/EU "European regulation on the protection of personal data" (Articles 13 et seq.)

Poste Assicura S.p.A. (hereinafter the Company) part of the Poste Vita Insurance Group belonging to the Poste Italiane Group with head office at Viale Europa 190, Rome, which acts as "Data Controller" of the processing, wishes to provide you with clear and simple information regarding the processing of your personal data. Should you have any questions with respect to the following, please contact us at the addresses of the Company's Privacy Office provided below.

SOME MAIN 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 which is performed on personal data or on sets of personal data, whether or not by automated means, such as collection, recording, organisation, structuring, storage, adaptation or alteration, retrieval, consultation, use, disclosure by transmission, dissemination or otherwise making available, alignment or 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.

The "**Joint Data Controller**" is the legal person that jointly determines with one or more Data Controllers the purposes and means of the processing of the data subject's personal data and the responsibilities with regard to compliance with the obligations arising from the applicable law.

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

"**Consent**" of the data subject means any 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 the performance of activities of a commercial, advertising and promotional nature, including but not limited to the sending of advertising materials, direct sales, the performance of market research or commercial communications or promotions carried out in the context of events and contests promoted by the Company.

"**Profiling**" means any form of automated processing of personal data consisting of the use of personal data to evaluate certain personal aspects relating to

that natural person's performance at work, economic situation, health, personal preferences, interests, reliability, behaviour, location or movements.

PERSONS AUTHORISED TO PROCESS PERSONAL DATA

With regard to the individual service requested, the Company may process your personal data together with others:

- Data Controllers, when they determine the purposes and means of processing exclusively for the part they are responsible for when performing the requested service. These parties must provide their privacy policies to the customer.
- Joint Data Controllers, when they jointly determine with the Poste Vita Insurance Group the purposes and means of the processing in the context of the performance of a specific service requested. In this case, the privacy policy is provided by the Joint Controller in conjunction with the Poste Vita Insurance Group.

The appointees are the employees of the Poste Vita Insurance Group and similar persons who are materially assigned and authorised to process the personal data by the Data Controller, directly or through delegates.

Furthermore, for the performance of certain activities instrumental to the execution of the requested service, or in connection with legal obligations and in any case in compliance with data protection laws, the Company may appoint external data processors (third parties who process personal data on behalf of the Company).

For detailed information on the presence of any Data Controllers, Joint Data Controllers and the main Data Processors according to the service requested, please contact the Privacy Office of the Poste Vita Insurance Group through the following channels: email: privacy@postevita.it; post: Viale Europa 190 – 00144 Rome.

CATEGORIES OF DATA RECIPIENTS

Without requiring explicit consent, the Company may disclose your personal data to the following categories of parties:

- Insurance and reinsurance brokers and other channels for acquiring insurance contracts; technical consultants and other parties that perform auxiliary activities on behalf of the Company, such as legal professionals, appraisers and doctors; affiliated clinics; service companies that the management, settlement and payment of claims are entrusted to; consulting firms for legal protection.
- Computer, electronic and telecommunication service companies; companies for data processing, elaboration and storage; postal service companies for direct communications to data subjects; companies (e.g. call centres) for support services; auditing and certification companies for the activities carried out by the Company also in the interest of customers;

assistance and consultancy firms; fraud control service companies; debt collection companies; cheque guarantee companies.

- Supervisory and control authorities and bodies, and public or private entities in general with public-sector functions (e.g. IVASS, CONSOB, COVIP, ANIA, CIRT, CONSAP, Bank of Italy, FIU, etc.); entities operating national and international systems to control fraud against financial intermediaries.
- Entities operating, for instance, in the areas of electronic systems, service, consulting, quality, printing and envelope stuffing, financial and insurance services, debt collection, auditing and certification, and mass processing of documents.
- Parties to which such disclosure must be made in order to comply with requirements established by national and EU regulations (e.g. anti-terrorism, prevention of payment card fraud, tax audits, provision of investment services) as well as provisions issued by Supervisory and Control Bodies.

Moreover, for administrative and accounting purposes, the Company may disclose personal data to the Companies of the Poste Italiane Group. Such processing is connected with the performance of organisational, administrative, financial and accounting activities, irrespective of the nature of the data processed (specifically, internal organisational activities, those functional to the fulfilment of contractual and pre-contractual obligations, the keeping of accounts and the application of tax, social security, health, hygiene and safety at work regulations).

DATA PROTECTION OFFICER

The Data Protection Officer (DPO) is appointed by the Data Controller to perform the functions expressly envisaged in the European Data Protection Regulation. The DPO can be reached at the office of the Data Protection Officer of Poste Italiane, Viale Europa 175 - 00144 Rome, email: ufficiorpd@posteitaliane.it.

ORIGIN OF THE PERSONAL DATA

In order to provide the services and/or insurance products requested or envisaged for the data subject, the personal data processed by the Company are collected from the data subject when requesting the product or service or during the contractual relationship, as well as from other parties involved in the contractual relationship (e.g. insurance policyholders in which the data subject is an insured party, beneficiary, jointly liable party, etc.) and/or insurance and reinsurance intermediaries (such as Poste Italiane S.p.A. - Patrimonio Bancoposta, people involved in intermediation such as employees, contractors and other appointees of the intermediary for activities performed outside the premises where the intermediary operates; agents; insurance brokers, etc.).

Personal data may also be collected by telephone through contact centres or electronic correspondence, or may be obtained through other channels such as

websites (social networks, chats, apps, installation of cookies: for third-party cookies please see the relevant policies published on the third-party websites). Your data may be associated with online identifiers produced by the devices, applications, tools and protocols used, such as IP addresses, temporary markers (cookies) or other identifiers. Such identifiers can leave traces which, when combined with unique identifiers and other information received by the servers, can be used with your consent to create individual profiles.

LEGAL BASIS, PURPOSE OF THE PROCESSING AND PROVISION OF DATA

The Company processes your personal data for "insurance" purposes when it is necessary within the framework of a contract or for the conclusion and execution of a contract or the performance of pre- and post-contractual measures (e.g. preparation and conclusion of insurance policies; collection of premiums; settlement of claims or payment of other benefits). The processing of your data may also take place in compliance with a legal obligation (e.g. in order to comply with current laws on the prevention of the use of the financial system for the purpose of financing international terrorism).

For administrative and accounting purposes, the Company may disclose your personal data to Poste Italiane S.p.A. and/or companies of the Poste Italiane Group. Such processing is connected with the performance of organisational, administrative, financial and accounting activities, irrespective of the nature of the data processed (specifically, internal organisational activities, those functional to the fulfilment of contractual and pre-contractual obligations, the keeping of accounts and the application of tax, social security, health, hygiene and safety at work regulations).

For these purposes the provision of data is necessary. Without them we cannot provide you with the requested service.

The processing of your personal data may also be considered lawful when:

- It is necessary for the performance of a task carried out in the public interest.
- It is based on the law of the European Union or of a Member State for the exercise of public authority.
- It is necessary to protect an essential interest in the life of the data subject or of another natural person.
- It is done for purposes other than those for which the personal data were initially collected, if compatible with the purposes for which the personal data were initially collected.
- It is done for legitimate interests of the Data Controller, or of third parties.

Furthermore, the Company may process your personal data if you have given your explicit and optional consent for marketing or profiling.

With your consent to profiling, the Company will use automated computerised means, analysis or processing aimed at detecting your preferences in the use of the services

offered in order to improve them and tailor them to your needs, either by aggregating the data into homogeneous classes or by developing individual profiles. Finally, for the provision of insurance products and/or services, and in particular both for certain types of product offered under the Protection line and the claims settlement service, the Company needs to process **special categories of personal data** such as health-related information.

Your explicit consent for the processing of such data, collected within the limits of the insurance purposes described above, will be requested in specific forms made available to the Data Subject (please refer to what is included in the margin of this policy). The company processes such data exclusively for the purpose of providing specific services and operations requested by customers, e.g. claims settlement. The Company may only process personal data relating to criminal convictions and offences in cases authorised by the law or public authority.

DATA PROCESSING AND STORAGE METHODS

Your personal data will be processed in such a way as to ensure adequate security and confidentiality and to prevent unauthorised access 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 limitation of the storage period through the adoption of technical and organisational measures appropriate to the level of risk of the processing and for a period of time not exceeding the achievement of the purposes for which they are processed, in any case for the period envisaged by law.

RIGHTS OF THE DATA SUBJECT

You have the right to the following information from the Company: the purposes of the processing, the categories of personal data, the recipients or categories of recipients the personal data have been or will be disclosed to (including recipients in third countries or international organisations), the expected storage period of the personal data, or if this is not possible the criteria used to determine this period, the origin of the personal data, the existence of a profiling process and information on the logic used.

Furthermore, you have the right to:

- The correction of inaccurate personal data.
- The completion of incomplete personal data.
- The restriction of processing of personal data (in which case the data are processed only with your consent, except for their necessary storage).
- Object to their processing.
- Their erasure (“right to be forgotten”).
- Data portability, i.e. the transmission of your personal data from one data controller to another, where technically feasible.

In order to exercise your rights, you may contact the Company's **Privacy Office** via the following channels: email: privacy@postevita.it; post: Viale Europa 190, 00144 Rome.

RIGHT TO LODGE A COMPLAINT

If you believe that the processing performed by the Company may have violated the rules of the European Data Protection Regulation, you have the right to lodge a complaint with the Data Protection Authority pursuant to Article 77 of Regulation 2016/679/EU.

RIGHT OF WITHDRAWAL OF CONSENT AND CONTACT CHANNELS

Note that any consent given (e.g. for marketing or profiling purposes) can always be withdrawn. Withdrawal does not affect the lawfulness of the processing done based on the consent given before such withdrawal. The contact channels used by the Poste Vita Insurance Group for marketing are: telephone with or without operator, post, email, fax, text messages, multimedia messages, or other messages, and websites. You may object at any time to the processing of your personal data for marketing purposes, including related profiling purposes. Furthermore, if you prefer to be contacted exclusively by traditional means (post, telephone with operator), at any time you may object to automated means of contact (email, text message, multimedia message, fax, telephone without operator).

TRANSFER OF PERSONAL DATA TO A THIRD COUNTRY

In principle the transfer of personal data from EU countries to “third” countries outside the EU is prohibited unless the data controller or data processor ensures an “adequate” level of protection. No data will be transferred to third countries, except for services expressly requested by the customer or specific cases for which the Company will adopt adequate safeguards and inform the data subject.

PROTECTION OF MINORS

Minors may be less aware of the risks, consequences and their rights with respect to the processing of personal data, and therefore the Poste Vita Insurance Group provides them with specific protection, particularly with regard to the use of personal data for marketing purposes or the creation of individual profiles, and to the collection of personal data as part of services provided directly to minors. With regard to the direct provision of information society services (i.e. any service provided electronically), the processing of personal data requires the explicit consent of the child and is lawful if the child has reached the minimum age required by the applicable law.

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

Privacy policy pursuant to Regulation 2016/679/EU "European regulation on the protection of personal data" (Articles 13 et seq.)

With regard to the Privacy Policy in accordance with the European Data Protection Regulation 2016/679/EU (GDPR) received when signing the policy through the Policyholder and in any case available on the website www.poste-assicura.it, we would like to note that for claims management and settlement Poste Assicura S.p.A (hereinafter the Company), as Data Controller, makes use of various entities to which it may disclose your data. These include insurance and reinsurance brokers (e.g. brokers, agents), technical consultants and other parties that perform auxiliary activities on behalf of the Company such as legal professionals, appraisers and doctors; affiliated clinics; service companies that the management, settlement and payment of claims are entrusted to. These parties act as autonomous Data Controllers or Data Processors.

Note that a detailed list of these parties is available by writing to the Company's Privacy Office via the following channels: email privacy@postevita.it, post: Viale Europa,190 00144 Rome.

In light of the above, I hereby consent to the processing of my personal health data for the purpose of claims handling and settlement.

If the insurance cover is extended to the members of your household, limited to minor children, you shall personally assume all liability with respect to all personal data relating to the health of the aforementioned family members for the purpose of claims handling and settlement provided to us.

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

Signature of the Insured (or their legal representative) .....

Note that consent to the processing of health-related data is necessary and that without it it will not be possible to initiate the settlement procedure.