UNIVERSITY OF MILAN

Reimbursement of Medical Expenses

OPERATIONAL MANUAL

This illustrative manual has no contract value. Please, always refer to the policy conditions.

FOREWORD

This Manual is intended to provide an instrument allowing the services offered by the Reimbursement of Medical Expenses insurance plan to be understood clearly and easily, in addition to providing all the forms needed to report claims.

In order to illustrate the extent of the medical expense reimbursement coverage, the following information is provided:

- Definitions
- Territorial extension
- Exclusions from the insurance
- Age limits
- How the services are delivered
- How to use the service
- Synoptic view of the main guarantees
- Insurance conditions
- Subject matter insured
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The goal is to simplify understanding the contents of the plan adopted by the University of Milan, however this description is still indicative and not binding. In the event of dubious interpretations, the contents of the policy underwritten by the Company shall prevail.

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DEFINITIONS

Diagnostic Assessment
Diagnostic medical service aimed at searching for and/or defining the presence and/or course of a disease, also when bloody and/or invasive.

Insurance
The Contracting Party's insurance contract.

Insured/Beneficiary
The subject on whose behalf the insurance is taken out, specifically:

- Technical-administrative staff (temporarily and permanently employed, collaborators and linguistic experts, executives) and teaching staff (research fellows, associate professors; full professors), as well as temporary research fellows, trainees and PhD students with scholarships awarded by the Partner, i.e. the University of Milan (see Annex 1)
- Household of the technical-administrative and teaching staff, i.e. the spouse or cohabiting partner and their children, until their thirtieth year of age, even if non- cohabiting, on condition that they are included in the marital status certificate (seeAnnex 2).

Direct assistance
All the insurance services effected in case of hospitalization in private facilities and medical staff both in network; in this case all the expenses related to the services are paid by the Insurer directly to the facilities and medical staff.

Indirect assistance
The payment due, according to policy conditions, by the Insurer to the Insured; to get this payment it will be necessary present the related invoices and/or other requested documents.

Associate
University of Milan.

Broker
The subject tasked by the Partner with managing and performing the contract, as acknowledged by the Company.

Case Manager
Nurse responsible for ascertaining the problems of patients and of their families: (s)he identifies any existing or potential problems, by assessing the physical, psychological, social and emotional conditions of the patient, then (s)he develops the individual care plan (PAI) that meets the needs identified.

Operation Centre
It is the Company's structure which consists of healthcare professionals, physicians, paramedics, and technicians and which delivers the services included in the policy, whose costs are borne by the Company. The Operations Centre with a toll-free telephone line provides to: organize and book, at the Policyholder's request, a direct access to the Affiliated Healthcare Facilities, provide information on insurance guarantees, on the agreements with the Affiliated Healthcare Facilities, their location and on the healthcare services they provide.

Policy holder
The Healthcare Fund (Support Fund) enrolled in the Register of Healthcare Funds, as per Health Minister's Decrees of 31 March 2008 and 27 October 2009, which takes out the policy on the Partner's behalf.

Date of event
For surgeries is the date of hospitalization, to which refers all the expenses related to the event (previous, subsequent and concurrent, even if not in force of contract in post-hospitalization), reimbursable according to the coverage.

Day-hospital
The healthcare services for any surgical and medical therapies practiced within the healthcare institution during the day and documented by a clinical record with a medical history form.

Physical defect
Deviation from the normal morphologic system of an organism or of parts of its organs due to acquired morbid or traumatic conditions.

Medical documents
Clinical record and/or all medical certification consisting of diagnoses, healthcare professionals' opinions and prescriptions, X-rays, diagnostic examinations, and evidence of expenditure (including bills and receipts for drugs).

Deductible
The fixed sum that is borne by the Policyholder. If it is expressed in days, it is the number of days for which the guaranteed amount is not paid.

Pay in lieu of notice (daily allowance)
Daily amount paid by the Company in case of hospitalization and failing a reimbursement application of the expenses for the services provided during hospitalization or connected therewith.

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

Accident
Event due to an accident, violent and external, which provokes injuries

Surgery
Every act, manual or instrumental, done for therapeutic purposes

Outpatient surgery
Surgical procedure which doesn't require the person to stay in the clinic in the post-surgical period.

Healthcare facility
Hospital, clinic or university institute, nursing home, duly authorized by the competent authorities, as required by the law, to provide hospital assistance, including as day hospital, excluding spas, convalescence and residence homes and clinics with dietary and aesthetic goals.

Disease
Any clinically diagnosable alteration of health conditions that is not a malformation or a physical defect and is not caused by an accident.

Malformation
Deviation from the normal morphologic system of an organism or of parts of its organs due to congenital morbid conditions.

Upper Limit of Liability
The maximum amount defined in specific articles of the policy, which represents themaximum expenditure the Company undertakes to incur for the Policyholder's benefit for the relevant guarantees and/or services provided for.

Network
Network of facilities and medical staff, that the insured person can contact to carry out the hospitalization or a medical service included in the direct assistance

Family Unit
Spouse fiscally in charge or not (or a cohabitant more-uxorio), part of civil union, children fiscally in charge, even if non cohabitants, till 30 years

Policy
The document that proves the insurance.

Premium
The sum due by the Contracting Party to the Company.

Co-insurance
Sum expressed in percentage which remains in charge of the insured person

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

Affiliated healthcare facility (Affiliated Centres)
Healthcare establishment, health centre, specialist centre, including diagnostic centres (with both diagnostic imaging and laboratory diagnostics), dental practices, physiotherapy studios, and private practices and their physicians and surgeons, with which the Company has entered into an agreement for the direct payment of services.

TERRITORIAL EXTENSION

The Company, according to international agreements, may offer policyholders the opportunity to avail themselves of anetwork of affiliated facilities, including abroad, thus obtaining a direct payment (without advance by policyholders), subject to authorization by the operations centre.

EXCLUSIONS FROM THE INSURANCE

The main exclusions regard:

- the treatments and/or surgeries to remove or correct any physical defects or malformations existing be- fore the conclusion of the contract;
- the treatment of mental illnesses and psychological conditions in general, including neurotic behaviours;
- medical services for aesthetic purposes (except for reconstructive plastic surgery required by accidents or by destructive surgery occurred during the operation of the contract);
- hospitalizations in which only physical tests or therapies are conducted which, owing to their technical nature, may also be carried out in a laboratory;
- tests for infertility and medical practices aimed at artificial insemination;
- hospitalizations caused by the Policyholder's need to be assisted by third parties to perform the basic acts of daily life, as well as admissions for chronic care; admissions for chronic care are those called for by the Policyholder's physical conditions that cannot be cured through medical treatments and that require him/her to remain within the healthcare establishment for maintenance care or physiotherapy;
- operations for replacing any kind of orthopaedic implants;
- treatment of diseases resulting from the abuse of alcohol or psychoactive drugs, as well as the non- therapeutic use of narcotics or hallucinogens;
- accidents while practicing extreme and dangerous sports, such as aviation and motor sports, free climbing, rafting and extreme mountaineering, as well as ensuing from the participation in competitions and training, official or otherwise;
- accidents caused by criminal actions perpetrated by the Policyholder;
- direct or indirect consequences of atomic transmutation, of radiation generated by artificial acceleration of atomic particles and exposure to ionizing radiation;
- consequences of war, insurrections, earthquakes, and volcanic eruptions;
- therapies not recognized by official medicine.

AGE LIMITS

The insurance can be taken out or renewed until the Policyholder reaches the 75th year of age, while automatically ceasing at the first annual expiry of the policy after the Policyholder has reached the above age.

HOW THE SERVICES ARE DELIVERED

All the services of this health plan are provided by **PosteAssicura S.p.A,** which offers the insurance coverages, and by **PosteWelfareServizi,** which operates in managing them, the so called Fondi Sanitari Integrativi and the network of the health facilities "**PosteProtezione**".

All people insured in **the University of Milan** policy, in addition to what is reported in the operating manual, can obtain **discounted rates** at the private facilities provided by PosteProtezione even for all that services non provided by the policy general conditions, communicating of being an insured person of PosteProtezione network.

CONTACTS
Contact Center: **800 178 411**
If by mobile: toll number **06-99503501**
The service is active **from Monday to Friday, 9.00-17.00**
Otherwise, it is possible send an e-mail to: **infounimi@postewelfareservizi.it**

To ask for an appointment to the organization centre, it will be necessary sending an e-mail to prenotazioni@postewelfareservizi.it with the indication of name, surname, location code, selected clinic, eventual medical partner, service to be provided and phone number. The Organization Centre will reply with the appointment once agreed by the clinic. After booking it will be possible asking for the authorization to carry out the service through the reserved area.
There won't be taken into consideration any e-mail containing documents with sensitive data. Otherwise, it will be possible calling the contact center.

Website: www.postewelfareservizi.it
Here is possible consulting the list of the facilities and accessing to the reserved area to benefit of all the on-line services.
To access the reserved area it is necessary to use Code and Password, which are unique and reserved, that the insured person will receive to his/her e-mail address with the Welcome Kit.

Within the website www.postewelfareservizi.it is available a tutorial showing all the functions of the reserved area.

HOW TO USE THE SERVICES

Through the network PosteProtezione the insured person has the list of medical facilities, that guarantee a good offer in terms of medical skills, technology, comfort and hospitality. Using the facilities, the insured person shall not be charged for any cost (excepting of what is provided in the plan under every single guarantee) since the payment is made directly by PosteAssicura to the Facility.
It will be possible looking for a facility or a medical partner through a specific function in the reserved area (in the case the chosen doctor is not a medical partner it will be possible anticipate the expenses and then ask for a reimbursement).
After booking, the insured person has two ways to use the coverage:

1. **Ask to take in charge the service, directly by the reserved area;**

By appointment, the insured person has to access his/her reserved area (www.postewelfareservizi.it) and insert the request, attaching the medical prescription, with diagnosis and any other documentation or specific information necessary to authorize the service, as reported in the General Insurance Conditions (which must be always verified).
It is important to remember that the request must be inserted at least 3 working days before the date of the appointment as agreed with the facility, in order to let the Operation Centre to evaluate the documentation and authorize the service.
In this case the insured person has to inform the Facility in case he proceeds autonomously with the authorization through his/her reserved area.

2. **Ask to the facility to take in charge the service;**

By appointment, the insured person has to access his/her reserved area (www.postewelfareservizi.it) and insert the request, attaching the medical prescription, with diagnosis and any other documentation or specific information necessary to authorize the service, as reported in the General Insurance Conditions (which must be always verified).
It is important to remember that the request must be inserted at least 3 working days before the date of the appointment.
If it's up to the facility sending the request, but the prescription is missing, the insured person will receive a communication by e-mail asking to upload all the necessary documents directly by the website www.postewelfareservizi.it.
The Operation Centre, once received the request to take charge, within 48 hours from the receipt of the complete documentation, after the necessary administrative checks, will proceed with the evaluation of the request (verification of the assistance, analysis of the pertinence of the service according to diagnosis and disease, ceilings etc.)

This analysis can have two results:

- **Refused:** the Operation Centre, in case of service not authorizable will communicate it to the insured person;

- **Approved**: the Operation Centre, case of positive outcome, will send an e-mail to the insured person and authorize the Clinic to activate the service using the system of direct payment, indicating the expenses remained in charge of the insured person according to the Policy General Conditions. Under no circumstances the authorization shall be considered binding compared to the following reimbursement which can be processed only after the receipt of all the documentation by the Clinic and its evaluation. If during the authorized examination/hospitalization comes out the necessity to provide a different service, the insured person will have to ask the correction of take charge, which will be subject to a new authorization by the Operation Centre.

Here below is reported the documentation that must be uploaded in the reserved area or delivered to the Clinic:

- In case of illness: prescription of the general practitioner, reporting the nature of the disease, diagnosed or suspected, and all the diagnostic services and/or the treatment requested.
- In case of accident: minutes of first aid or self-declaration reporting the date and the detailed circumstances which caused the trauma and/or injury, prescription of the general practitioner, reporting the nature of the disease, diagnosed or suspected, and all the diagnostic services and/or the treatment requested.
- Other medical documentation

When the assisted person goes to the Clinic, has to show the Card, printable by the reserved area, which reports the Subscription Code to use for the reimbursements; otherwise, he/she can communicate directly to the Clinic:

- Network **PosteProtezione**
- Polizza Collettiva Poste Assicura **University of Milan**
- Received authorization number which the Clinic can find in the portal, section Autorizzazione di Poste Assicura Collettive
- Subscription code (location code): code used to access the reserved area

The insured person will have to pay the only charge against him (deductible, guarantees not included) and will have to sign the declaration of responsibility for the Clinic. Without this document it won't be possible use the service in a direct form.

In case of services not included in the guarantees, the expenses will be paid by the insured person directly, who will be considered liable to the Clinic.

IMPORTANT: the insured person must necessarily contact the Clinic before asking for authorization.
Pre-hospitalization expenses are never authorizable in a direct form.

NOTE

If the insured person doesn't active the direct assistance but uses an affiliated clinic anyway, paying by his/herself, he/she can take advantage from special rates, making itself known as an insured person of PosteProtezione Network.
The assisted person can ask for the reimbursement of the incurred expenses if included in the medical plan and with the application of deductibles as provided for the services outside Network.

Use of a structure outside network

The medical plan provides the possibility to use also clinic outside the network, public or private; in this case the reimbursement of the incurred expenses will take place according to what is provided in the single guarantee.

At the end of the service and/or clinical cure, the insured person will have to send a request of reimbursement to PosteAssicura, using the specific function available in the reserved area, a channel which provides a direct and sure contact with the Insurer.

This request need information related to expense documentation and/or hospitalization allowance with the related certification attached (medical record, prescription etc.)

The following documentation has to be sent to Poste Assicura:

- Digital copy (PDF, JPG) of all the invoices fiscally regular and receipted;
- Digital copy (PDF, JPG) of the complete medical record, results and medical examination, medical prescriptions, therapies and treatments, along with the diagnosis.

DOCUMENTS TO BE PRESENTED IN CASE OF REIMBURSEMENT

Since every disease or accident causes a different event, is considered complete every request of reimbursement comprehensive of:

- Expense documentation;
- Medical certification;
- In case of expenses referred to an accident: minutes of first aid or, in case of lack of access, self-declaration attesting the date and the dynamics of the event;
- If present, the document attesting the liquidation of the Fund which operates at first risk.

N.B. All the documents related to costs incurred abroad must be have the complete translation of the listed items.

SUBSTITUTE ALLOWANCE

- Medical record with clinical diary and letter of discharge from the hospital;
- If present, the document attesting the liquidation of the Fund which operates at first risk.

HIGH SPECIALIZATION (list of guarantees available in the summary)

- Invoices related to the costs incurred;
- Medical prescription with indication of the disease and/or report indicating the disease, for which the examination has been carried out.

ONCOLOGY TREATMENTS

- Invoices related to the costs incurred;
- Medical prescription with indication of the disease and/or report indicating the disease, for which the examination has been carried out.

SPECIALISTIC VISITS

- Invoices related to the costs incurred;
- Medical prescription with indication of the disease and/or report indicating the disease, for which the examination has been carried out.

DENTAL CARE

- Invoices related to the costs incurred;
- Complete clinical diary or care plan prepared by the doctor who has carried out the treatment, indicating the dental elements subject to care

ORTHOPAEDIC IMPLANTS AND HEARING AIDS

- Invoices related to the costs incurred;
- Medical prescription with indication of the disease and/or report indicating the disease, for which the prothesis has been

carried out.

GUARANTEE FOR NON-SELF-SUFFICIENCY CONDITIONS

- Medical documentation attesting the inability to make at least 3 of the following activities: moving, washing, getting dressed, feeding.

MATERNITY PACKAGE

- Invoices related to the costs incurred;
- Medical prescription with indication of the status of pregnancy.

PREVENTION PACKAGE

This kind of service is available only in a direct form, at the facilities included in the Network Poste Protezione, prior authorization of the Authorization Centre, in one solution, once a year per insured person.

SYNOPTIC VIEW OF THE MAIN GUARANTEES

All expenses specified under these paragraphs are included until the reference amount has been reached, except where a limit is specifically indicated.
The guarantees also include accidents and diseases that are the expression or direct consequence of pathological conditions arisen before the insured parties were protected under this insurance coverage.
These guarantees are delivered independently and as a supplement of the Italian national health service (S.S.N.).

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Guarantee	Annual limit	Deductible
B.1 Daily Allowance for Hospitalization	**€ 100** for up to 90 days **€ 150** for highly specialized surgery	
B.2 Home hospitalization	**€10.000**	Coinsurance: • *within the network:* 100% reimbursement • off-network: 30%
B.3 High specialization (Angiography, chemotherapy and radiation therapies, cobalt therapy, X-ray diagnostics, dialysis, doppler, ultrasound, echocardiography, electrocardiography, electroencephalography, endoscopy, colonoscopy, laser therapy for physiotherapy, radiotherapy, nuclear magnetic resonance, scintigraphy, PET, CT, MOC, teleradiography of the heart, arthrography, bronchography, cystography, cystourethrography, barium enema, endoscopic retrograde cholangiopancreatography (ERCP), percutaneous transhepatic cholangiography (PTC), T- tube cholangiogram, cholecystogram, dacryocystography, defecography, fistulography, phlebography, fluorangiography, galactography, hysterosalpingography, myelography, retinography, contrast-enhanced oesophagus X-ray, contrast-enhanced stomach and duodenum X-ray, contrast-enhanced small intestine and colon X-ray, sialography, splenoportography, urography, vesiculodeferentography, videoangiography, X-ray of Wirsung's duct, electroencephalogram, electromyography; see the list of services). Extraction (e.g., polypectomy) and biopsy performed as a result of any of the examinations listed above are understood to be included in the guarantee. In case of **Oncology Treatments**	**€10.000** **€ 20.000**	Coinsurance: • *within the network:* 10% with a min. deductible of € 50 per assessment or round of treatments • off-network: 15% with a min. deductible of € 75 per assessment or round of treatments • co-payment: 100% reimbursement Coinsurance: • *within the network:* 10% with a min. deductible of € 50 per assessment or round of treatments • off-network: 15% with a min. deductible of € 75 per assessment or round of treatments • co-payment: 100% reimbursement
B.4 Specialist visits	**€ 5.000**	Coinsurance: • *within the network*: deductible of €40 per assessment

		• off-network: 20% with a min. of €70 • co-payment: 100% reimbursement
B.5 Dental care *(only within the network)*	**€ 550**	Coinsurance: • within the network: 10% per invoice
B.6 Prevention package: **Dental prevention** *(specialist visit and a complete oral hygiene)* **Prevention *(only within the network)*** For **everybody**: *alanine aminotransferase (ALT), aspartate aminotransferase (AST), HDL cholesterol, total cholesterol, creatinine, complete blood count and morphological examination, GT range, glucose, triglycerides, partial thromboplastin time (PTT), prothrombin time (PT), TSH with reflex, urea, ESR, urine - chemical, physical and microscopic examination, faeces (occult blood test).*) Only for **women**: *gynaecological visit + pap test; cardiological visit + ECG under stress or alternatively ECG at rest; mammography or, alternatively, breast ultrasound, at the policyholder's discretion; dermatological visit for checking moles* Only for **men**: *PSA (prostate-specific antigen); urological visit; cardiological visit + ECG under stress or alternatively ECG at rest; dermatological visit for checking moles*	**Once a year** **Once a year**	• Only within the network .
B.7 Orthopaedic implants and hearing aids	**€ 2.000**	• 20% coinsurance with a deductible of €70 per invoice
B.8 Guarantee for non-self-sufficiency conditions	**€ 1.000** per policyholder for each month of the non-self-sufficient conditions (divisible into days).	100% reimbursement
B.9 Maternity package *available within network and off-network: control ultrasounds, bitest/ nuchal translucency, fetal DNA testing, amniocentesis, villocentesis, blood tests for pregnancy monitoring, specialized gynecological and obstetrical checkups on pregnancy progress, a gynecological visit for follow-up after giving birth.*	**€1.500**	• No coinsurance • co-payment: 100% reimbursement
B.10 Social welfare organizational consulting	Reference is made to Article B.10	

INSURANCE CONDITIONS

SUBJECT MATTER INSURED

The insurance coverage is afforded to technical-administrative staff (temporarily and permanently employed, collaborators and linguistic experts, executives) and teaching staff (research fellows; associate professors; full professors), as well as temporary research fellows, trainees and PhD students with scholarships awarded by the Partner, i.e. the University of Milan (see Annex 1)
Furthermore, the option to extend this insurance coverage, with the same guarantees, to the entire household, i.e. the spouse or cohabiting partner and children, until their thirtieth year of age, even if non-cohabiting, on condition that they are included in the marital status certificate (see Annex 2).
The insurance coverage, which is afforded without prior completion of the healthcare questionnaire, reimburses any healthcare expenditure incurred for:

B.1 HOSPITALIZATION AREA

If hospitalized in a public or private facility with or without surgery, the policyholder will be entitled to a compensation of €100.00 for each day of hospitalization, but not exceeding 90 days for each admission. The above allowance shall be raised to € 150.00 for each day of hospitalization for major surgeries, as listed in Annex A.

B.2 HOME HOSPITALIZATION

The Company, for 90 days after the discharge, following a compensable admission under the policy, offers through its affiliated network such services as home care, medical, rehabilitation, nursing and drug treatments, aiming at recovering the physical functions, up to a limit of indemnity of € 10.000
The Company will agree on the medical / rehabilitation programme with the Policyholder according to the prescriptions of the health professionals who managed the discharge, by implementing the items contained therein.
The guarantee may also be provided, in the reimbursement procedure, at healthcare facilities not affiliated with the Company, upon evaluation of the above medical / rehabilitation programme. In that case the expenditure incurred shall be reimbursed by applying a 30% coinsurance for each claim

B.3 HIGH SPECIALIZATION

Angiography, chemotherapy and radiation therapies, cobalt therapy, X-ray diagnostics, dialysis, doppler, ultrasound, echocardiography, electrocardiography, electroencephalography, endoscopy, colonoscopy, laser therapy for physiother- apy, radiotherapy, nuclear magnetic resonance, scintigraphy, PET, CT, MOC, teleradiography of the heart, arthrography, bronchography, cystography, cystourethrography, barium enema, endoscopic retrograde cholangiopancreatography (ERCP), percutaneous transhepatic cholangiography (PTC), T-tube cholangiogram, cholecystogram, dacryocystography, defecography, fistulography, phlebography, fluorangiography, galactography, hysterosalpingography, myelography, reti- nography, contrast-enhanced oesophagus X-ray, contrast-enhanced stomach and duodenum X-ray, contrast-enhanced small intestine and colon X-ray, sialography, splenoportography, urography, vesiculodeferentography, videoangiography, X-ray of Wirsung's duct, electroencephalogram, electromyography.

- Possibility to use healthcare facilities affiliated with the Company by obtaining direct payment (without advance payments by the policyholder) by applying a 10% coinsurance with a minimum of €50 per assessment and /or cycle of therapies
- Reimbursement of expenditure incurred by applying a 15% coinsurance with a minimum of €75 per assessment and/or cycle of therapies if they are performed at a facility not affiliated with the Company.
- Co-payment reimbursed at 100%
- Extraction (e.g., polypectomy) and biopsy performed as a result of any of the examinations listed above are understood to be included in the guarantee.

Maximum sum insured per year: **€10.000** per policyholder, raised to **€20.000** for oncology treatments.

B.4 SPECIALIST VISITS

Fees for specialist visits, with the exception of dental and orthodontic visits.

- Possibility to use healthcare facilities affiliated with the Company by obtaining direct payment (without advance payments by the policyholder) with deductible of €40 per assessment
- Reimbursement of expenditure incurred by applying a 20% coinsurance with a minimum of €70 per assessment if they are performed at a facility not affiliated with the Company.
- Co-payment reimbursed at 100%

Maximum sum insured per year: **€5.000.**

B.5 DENTAL CARE

All expenses for dental and orthodontic treatment are included, including but not limited to conservative therapies and expenses for prostheses and extractions as well as dental examinations preparatory to these services.

It is possible to benefit from the services exclusively at health facilities affiliated with the Company by obtaining direct payment (without advance payment by the Insured) with application of a **10% coinsurance** per invoice.

Maximum sum insured per year: **€ 550**

B.6 PREVENTION PACKAGE

DENTAL PREVENTION (in a single payment* and only at affiliated centres)

Once a year full payment of the following is required:

- a specialist visit;
- a professional whole mouth care intervention.

PREVENTION (in a single payment* and only at affiliated centres)

The insurance Company provides for direct payment (without advance payments made by the policyholder) of the prevention care given only at affiliated healthcare facilities. List of valid examinations for all policyholders once a year: alanine aminotransferase (ALT), aspartate aminotransferase (AST), HDL cholesterol, total cholesterol, creatinine, complete blood count and morphological examination, GT range, glucose, triglycerides, partial thromboplastin time (PTT), prothrombin time (PT), TSH with reflex, urea, ESR, urine (chemical, physical and microscopic examination), faeces (occult blood test).

Medical services reserved for women, once a year:

- Gynaecological examination + pap test;
- Cardiological examination + ECG under stress or alternatively ECG at rest;
- Mammography or, alternatively, breast ultrasound as chosen by the policyholder;
- Dermatological examination for checking moles.

Medical services reserved for men, once a year:

- PSA (prostate-specific antigen);
- urological consultation;
- Cardiological examination + ECG under stress or alternatively ECG at rest;
- Dermatological examination for checking moles.

*** The expression "In a single payment" means that the healthcare services need to be requested together and in a single time frame. One or more healthcare services included in the prevention package may also be requested. The services included in the package that are not requested together cannot be provided in the same insurance year.**

B.7 ORTHOPAEDIC IMPLANTS AND HEARING AIDS

Orthopaedic implants and hearing aids with application of a **20% coinsurance** and a non-indemnifiable minimum amount of **€ 70** per invoice.

Maximum sum insured per year: **€ 2.000**.

B.8 GUARANTEE FOR NON-SELF-SUFFICIENCY CONDITIONS

GUARANTEE DEFINITION
The Company guarantees the reimbursement of healthcare expenditure or the provision of assistance for a value corresponding to the sum guaranteed to the policyholder if the latter is not self-sufficient, as specified at the item "Definition of temporary non-self-sufficiency conditions" below.
The guarantee only triggers for a temporary non-self-sufficiency case.

CONDITIONS OF INSURABILITY
In order for this guarantee to be enforceable, the policyholder must not fall under one of the following conditions of non-insurability upon his/her inclusion in the policy.
Needing the assistance of a third party to perform one or more of the following actions: moving, washing, getting dressed, eating. Being entitled to receive an invalidity pension or to apply for a permanent invalidity pension corresponding to a level of invalidity exceeding 40%. Presenting sequelae of diseases or accidents that limit their physical or mental abilities in daily or professional life. Being affected by Alzheimer's disease, Parkinson's disease, disseminated sclerosis or uncontrolled hypertension (the latter being particular forms of hypertension which, although drugs for treating it are taken, show particularly high-pressure levels that cannot be clinically lowered).

DEFINITION OF TEMPORARY NON-SELF-SUFFICIENCY CONDITIONS
A policyholder is regarded as temporarily non-self-sufficient if (s)he needs to be assisted by a third party to perform at least three of the following actions: moving, washing, getting dressed, eating, according to the following definitions:

- Moving: ability to move from one room to another inside one's usual residence, also by using supports of any kind;
- Washing: ability to reach a level of bodily hygiene up to the usual standards, i.e. to wash the high and low portions of one's own body;
- Getting dressed: ability to put on or remove one's clothes or any orthopaedic implants usually worn;
- Eating: ability to consume food already cooked and made available, or to bring food to one's mouth and to swallow.

The Company pays the guaranteed amount as an insured sum for the period, calculated in days, for which the temporary non-self-sufficiency conditions last.

SUM INSURED
The upper limit of indemnity of the guarantee, if the policyholder finds him/herself under one of the conditions specified in item "Definition of temporary non-self-sufficiency conditions", **amounts to € 1,000.00 per policyholder for each month of permanence of the documented non-self-sufficient conditions (divisible into days).**

B.9 MATERNITY PACKAGE

Benefits, available within network and off-network, related to pregnancy status: control ultrasounds, bitest/ nuchal translucency, fetal DNA testing, amniocentesis, villocentesis, blood tests for pregnancy monitoring, specialized gynecological and obstetrical checkups on pregnancy progress, a gynecological visit for follow-up after giving birth.

- No coinsurance.
- co-payment: 100% reimbursement.

Maximum sum insured per year: € 1.500.

B.10 ORGANIZATIONAL AND WELFARE-RELATED ADVICE

The Company provides a welfare-related specialist consultancy to any policyholder who finds him/herself – because of illness or following an accident occurred after the conclusion of the contract – in a non-self-sufficiency condition, meaning a condition where (s)he needs the assistance of a third party to perform one or more of the following ordinary, everyday actions, such as moving, washing, getting dressed and eating.
In these cases, the Company shall provide an operations centre that the policyholder or a member of his/her family may contact to have his/her case examined.

The Company, after carrying out a specific assessment of that individual position and considering its specific needs through an adequate telephone interview directly conducted by its own Case Manager, will:

- refer to the most appropriate healthcare / social services for the non-self-sufficient individual;
- provide information on the healthcare / social services offered by local social / healthcare facilities, with indications of the relevant offices carrying out those tasks;
- provide the policyholder with the "General Guide" containing all various bureaucratic, administrative, and regulatory formalities applying to non-self-sufficient people that should be completed to protect any policyholder in that condition.

ANNEX A

LIST OF MAJOR SURGERIES

NEUROSURGERY
1. Neurosurgery under a craniotomy or with a transoral approach
2. Cranioplasty operations
3. Transsphenoidal pituitary surgery
4. Removal of orbital tumours
5. Removal of (intramedullary and/or extramedullary) space-occupying lesions of the spine
6. Surgery for herniated discs and/or cervical myelopathy from other causes with an anterior or posterior approach
7. Brachial plexus surgery
OPHTHALMOLOGY
8. Surgery for eyeball neoplasms
9. Eyeball enucleation procedure
OTOLARYNGOLOGY
10. Removal of malignant mouth tumours
11. Removal of tumours of the parapharyngeal space, of the uvula (uvulotomy) and of vocal cords (cordectomy)
12. Destructive surgery of the larynx (total or partial laryngectomy)
13. Removal of malignant tumours from the ethmoid, frontal, sphenoid and maxillary sinuses
14. Ossicular chain reconstruction
15. Surgery for acoustic (8th nerve) neurinomas
16. Removal of jugulotympanic paragangliomas
NECK SURGERY
17. Total thyroidectomy with ipsilateral or bilateral neck dissection
18. Surgical removal of a retrosternal goitre with mediastinotomy
RESPIRATORY SYSTEM SURGERY
19. Surgery procedures for tracheal, bronchial, lung or pleural tumours
20. Surgery for bronchial fistulae
21. Surgery for lung echinococcosis
22. Total or partial pneumonectomy
23. Surgery procedures for mediastinal cysts or tumours
CARDIOVASCULAR SURGERY
24. Thoracotomy heart surgery
25. Thoracotomy surgery of the thoracic great vessels
26. Laparotomy surgical procedures on the abdominal aorta
27. Endarterectomy of the carotid and vertebral arteries
28. Decompression of the vertebral artery in the transverse foramen
29. Aneurysm surgical procedures: resection and transplantation with prosthetics
30. Removal of a carotid glomus tumour
DIGESTIVE SYSTEM SURGERY
31. (Total or partial) surgical resection of the oesophagus
32. Surgery with oesophagoplasty
33. Surgery for megaoesophagus
34. Total gastric resection
35. Gastro-jejunal resection
36. Surgery for gastrojejunocolic fistulae

37. Procedures of total colectomy, hemicolectomy and rectocolic resections with an anterior approach (with or without colostomy)
38. Rectum amputation
39. Megacolon surgery with an anterior or abdominoperineal approach
40. Excision of tumours in the retroperitoneal space
41. Draining of liver abscesses
42. Surgery for liver echinococcosis
43. Liver resections
44. Biliary reconstruction reoperations
45. Surgical procedures for portal hypertension
46. Laparotomy surgical procedures for acute or chronic pancreatitis
47. Laparotomy surgical procedures for pancreatic cysts, pseudocysts, or fistulae
48. Surgical procedures for pancreatic neoplasms
UROLOGY
49. Radical nephroureterectomy
50. Adrenalectomy
51. Total cystectomy procedures
52. Vesical reconstructive operations with or without ureterosigmoidostomy
53. Radical cystectomy (including the removal of prostate and seminal vesicles)
54. Radical perineal, retropubic or transsacral prostatectomy procedures
55. Orchiectomy with lymphadenectomy for testicular cancer
GYNAECOLOGY
56. Radical abdominal or vaginal hysterectomy with lymphadenectomy
57. Complete radical vulvectomy with inguinal and/or pelvic lymphadenectomy
58. Radical surgery for vaginal tumours with lymphadenectomy
ORTHOPAEDICS AND TRAUMATOLOGY
59. Cervical rib surgery
60. Spine stabilization procedures
61. Vertebral body resections
62. Treatment of dysmetria and/or deviations of lower limbs with external implants
63. Destructive procedures for removal of bone tumours
64. Operations for applying shoulder, elbow, hip, or knee implants
PAEDIATRIC SURGERY (the procedures listed below are included in the guarantee only for new-born babies who have been insured within 18 months from birth)
65. Cystic and polycystic lung (lobectomy, pneumonectomy)
66. Surgical correction of congenital atresias and/or fistulae
67. Surgical correction of congenital megaureters
68. Surgical correction of congenital megacolons
ORGAN TRANSPLANTS
69. All
GENERAL SURGERY
70. Unilateral and/or bilateral mastectomy and further reconstructive procedures

ANNEX 1

MEDICAL EXPENSE REIMBURSEMENT INSURANCE COVERAGE

ESTIMATED NUMBER OF POLICYHOLDERS
on 13.04.2022:

Technical-administrative staff (temporarily and permanently employed, collaborators and linguistic experts, executives) and teaching staff (research fellows, associate professors, full professors), as well as temporary research fellows, trainees and PhD students with scholarships awarded by the Partner, i.e. the University of Milan.

The estimated number of beneficiaries of this policy is **3.909 people**, a parameter used to calculate the tender premium upon sub- mitting the financial quotation and calculated as follows:

A) Policyholders, staff with employee income, as shown in the Single Certification (CU), up to € 60,000.00, of which:

- Technical and Administrative Staff and Teaching Staff..... **(3.039 people)**

B) People insured through optional affiliation (however included in the calculation of the overall number of people to define the estimated number of beneficiaries, which is the parameter for calculating the premium when submitting the financial quotation), staff with employee income, as shown in the Single Certification (CU), between € 60,000.01 and € 100,000.00, of which:
- - Technical and Administrative Staff and Teaching Staff .....**(870 people)**

Estimated TOTAL of beneficiaries.....(3,909 people)

Furthermore, the following categories of people (these staff members shall not be counted towards the estimated number of beneficiaries, which is the parameter for calculating the premium upon submitting the financial quotation) are also policy beneficiaries through optional affiliation:

C) People insured through optional affiliation, staff with employee income, as shown in the Single Certification (CU), starting from € 100.000,01 **(330 people)**

D) People insured through optional affiliation belonging to the following categories:
- Temporary research fellows..... **(735 people)**
- PhD students with scholarships awarded by the University .....**(1096 people)**
- Trainees with scholarships awarded by the University..... **(2868 people)**

The individuals of categories C) and D) - should they take out this policy - shall be considered, for all intents and purposes, policy beneficiaries under the same technical and economic conditions of the individuals of categories A) and B).

ANNEX 2

MEDICAL EXPENSE REIMBURSEMENT INSURANCE COVERAGE

OPTIONAL AFFILIATION PLAN

Family members of the technical-administrative staff (both temporarily and permanently employed, collaborators and linguistic experts, executives) and of the teaching staff (research fellows, associate professors, full professors), of the Partner, i.e. the University of Milan, as appears in their marital status certificates: the spouse or cohabiting partner and children, until their thirtieth year of age, even if non-cohabiting, on condition thatthey are included in the marital status certificate**.**

The family members - should this policy be taken out - shall be considered, for all intents and purposes, beneficiaries under the same technical conditions of the individuals of categories A), B), C) and D) of Annex 1, and under the following specific economic conditions (which are fixed and cannot be lowered).

additional gross annual premium per capita for family members:

- **€ 0 (free)** for children up to the age of 10 (in the case of reaching the age of 10 during the year, the premium will be paid from the following year);
- **€ 350** a family member (spouse/partner more uxorio or son/daughter);
- **€ 550** for the family unit (two or more family members).

Regardless of the number of family members included, the same policyholder limits will apply to the family unit.

EXAMPLES

Nucleus 1: 1 child up to age 10:

- ✓ Individual limits equal to those of the policyholder;
- ✓ premium paid 0 euro.

Nucleus 2: spouse:

- ✓ Individual limits equal to those of the policyholder;
- ✓ premium paid 350 euro.

Nucleus 2: 1 child up to age 10 + Spouse or 1 child over age 10:

- ✓ limits per nucleus equal to those of the policyholder;
- ✓ premium paid 350 euro.

Nucleus 3: spouse + 2 children over 10 years old:

- ✓ limits per nucleus equal to those of the policyholder;
- ✓ premium paid 550 euro.

Nucleus 4: 1 child under 10 years old + 1 child over 10 years old + spouse:

- ✓ limits per nucleus equal to those of the policyholder;
- ✓ premium paid 550 euro.