Only the Italian version is authentic

UNIVERSITY OF MILAN

Reimbursement of Medical Expenses

OPERATIONAL MANUAL

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

GENERALI

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
- Guarantees
- How the services are delivered
- Claim settlement criteria
- Synoptic view of the main guarantees
- Insurance conditions
- Subject matter insured
    - B.1 hospitalization area
    - B.2 high specialization
    - B.3 specialist visits/diagnostic assessments
    - B.4 rehabilitation physiotherapy treatments following an illness or an accident
    - B.5 lenses and / or contact lenses (frames excluded)
    - B.6 dental care
    - B.7 prevention package
    - B.8 orthopaedic implants and hearing aids
    - B.9 guarantee for non-self-sufficiency conditions
    - B.10 maternity package
    - B.11 organizational and welfare-related advice
- Annex 1 medical expense reimbursement coverage
  Estimated number
- Annex 2 medical expense reimbursement insurance coverage
  Optional affiliation plan
- Annex to the list of major surgeries
- Annex 3 to insurance conditions
  Direct payment service
- Annex 4 to insurance conditions
  “Pronto-care” operating procedure – dental care

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

Accident	The event due to an incidental, violent, and external cause provoking bodily harm that is objectively apparent.
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.
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.
Claim	The occurrence of the event for which the insurance is provided.
Coinsurance	The sum, expressed as a percentage, that is borne by the Policyholder.
Company	Generali Italia S.p.A., who provides the insurance coverage and performs the operations specified in Article 2 of Legislative Decree no. 209 of 7 September 2005.
Compensation	The sum due to the Company in the event of a claim.
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.
Contracting Party	The Healthcare Fund (Support Fund) Cassa Previline, 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.
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.
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.
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.
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 the maximum expenditure the Company undertakes to incur for the Policyholder's benefit for the relevant guarantees and/or services provided for.
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.
Hospitalization	The stay in a healthcare establishment involving an overnight stay, as documented by a clinical record with a medical history form.
Insurance	The Contracting Party's insurance contract.
Partner	University of Milan.
Operations 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.
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).
Policy	Cassa Previline (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.
Premium	The sum due by the Contracting Party to the Company.
Hospitalization bill	Hotel stay and medical/nursing care.
Policyholder/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 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 (see Annex 2).
Surgery	Any bloody act, either by hand or by using tools, carried out for therapeutic purposes.
Outpatient surgery	Surgery that does not require the patient to remain under observation post-operatively, due to its nature.

TERRITORIAL EXTENSION

The insurance applies all over the world.
The Company, according to international agreements, may offer policyholders the opportunity to avail themselves of a network 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

Che cosa non è assicurato? What is not insured?

The main exclusions regard:

- the treatments and/or surgeries to remove or correct any physical defects or malformations existing before the conclusion of the contract;
- the treatment of mental illnesses and psychological conditions in general, including neurotic behaviours;
- dental prostheses, the treatment of periodontal diseases, dental care, and dental examinations (except if they are not explicitly included in the policy)
- 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.

The exclusions are contained in the insurance terms and conditions and are written in italics.

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.

GUARANTEES

Che cosa è assicurato? What is insured?

The Policyholder is entitled to receive an allowance upon hospital admission:

- With or without surgery
- Highly specialized surgery

Additional guarantees are available, such as the reimbursement following accident or disease of:

- Certain diagnostic and therapeutic services unrelated to the admission - High specialization
- Specialist visits, diagnostic tests, and laboratory examinations
- Physiotherapy and rehabilitation treatments
- Dental care
- Lenses
- Orthopaedic implants and hearing aids
- Guarantee for non-self-sufficiency
- Maternity Package

Ci sono i limiti di copertura? ARE THERE ANY COMPENSATION LIMITS?

The contract provides for compensation limits, deductibles (meaning the fixed amounts determined in the contract which is deducted from the compensation in the event of claims) and coinsurance (meaning the percentage of refundable damage that is borne by the Policyholder), which vary according to the active guarantees.

In order to receive the policy services, the Policyholder may access an affiliated network of healthcare facilities with lower deductibles and coinsurance than those applied by accessing unaffiliated healthcare facilities.

The contract may also envisage waiting periods (time that has to elapse before the coverage is active).

The deductibles, coinsurance, waiting periods and grounds for suspension are contained in the insurance conditions and are written in italics.

HOW THE SERVICES ARE DELIVERED

This coverage envisages two alternative schemes for the delivery of services:

A. Affiliated Healthcare Facilities: Healthcare establishment, health centre, specialist centre, including diagnostic centres (with both diagnostic imaging and laboratory diagnostics), dental practices with which the company Generali Italia S.p.A. has entered into an agreement for the direct payment of benefits to which the Insured Party may be directed by the Operations Centre to receive the healthcare services guaranteed by the policy, without any payments in advance, only any coinsurance and deductibles shall be borne by him/her as well as the amounts exceeding the limits and sub-limits of the policy. The operational conditions of the service are governed by this manual, in its Annexes 3 and 4.

Affiliated networks

Network of "Affiliated Facilities"

Generali Italia has studied and set up a service for accessing a network of affiliated clinics that the Policyholders may contact, through its Operations Centre, for the services envisaged by the contract with their costs being borne directly by the Company, *except for policy deductibles and expenditure not envisaged by the policy itself.* The operational conditions of the service are governed by the guide to the service, which is an integral part of this contract (**Annex 3**).

Pronto-Care network

Generali Italia, in collaboration with Pronto-Care, has studied and set up a service for accessing an affiliated network of dental practices where the Policyholders may receive dental care. Procedures according to **Annex 4** and/or completion of the **FORM FOR REQUESTING AN OFF-NETWORK REIMBURSEMENT OF DENTAL CARE**

B. Healthcare to be reimbursed: The Insured Party may choose to be treated at a facility and/or by a professional not affiliated with the Company, Generali Italia S.p.A. If that is the case, the Insured Party shall pay the expenses in advance, then apply for their reimbursement through the DenunciaOnLine (DOL) application. The operational conditions of the service are described in the Manual of DenunciaOnLine.

SETTLEMENT CRITERIA

The Company reimburses the expenses, after the treatment has been completed, directly to the Policyholder, upon submission of the photocopies of relevant bills, lists, invoices, and duly receipted receipts.
For any expenses incurred abroad, the reimbursement shall be carried out in Italy, in the currency being the legal tender in the Country, at the average exchange rate of the week when the expense has been incurred by the Policyholder, as gathered from official quotations.
In order to pay the compensation for the days spent in hospital, the Company pays the sums owed to the Policyholder after submission of the supporting documents (complete clinical record and medical documentation) certifying the duration and grounds for admission.
The application for reimbursement may be sent via a registered letter containing the appropriate signed form and the relevant documentation, or over the Internet. To access the web service (via pc, smartphone, or tablet) you need to browse the Generali website (http://www.generali.it/) and click "Area Clienti".
Alternatively, you can use the direct link to the application found on: https://areaclienti.spesemediche.generali.it/.

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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Description of the Guarantee	Upper Limit of Liability	Coinsurance and deductibles
B.1 Daily Allowance for Hospitalization	**€ 100** for up to 90 days **€ 150** for highly specialized surgery	
B.2 High specialization	**€ 50,000**	Coinsurance: *within the network:* 100% reimbursement

(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) In the event of **Oncology Treatments**	**€ 50,000**	*off-network:* 10% with a min. deductible of € 30 Co-payment: 100% reimbursement Coinsurance: *within the network:* 100% reimbursement *off-network:* 10% with a min. deductible of € 30 Co-payment: 100% reimbursement
B.3 Specialist visits/Diagnostic assessments of which **Diagnostic assessments and laboratory examinations (with diagnostic queries)**	**€ 5,000** **Sub-limit € 250**	Coinsurance: *within the network:* 100% reimbursement *off-network:* 20% with a min. deductible of € 30 per assessment Co-payment: 100% reimbursement Coinsurance: *within the network:* 100% reimbursement *off-network:* 20% with a min. deductible of € 30 per assessment Co-payment: 100% reimbursement
B.4 Rehabilitation physiotherapy treatments following a disease or an accident	**€ 500**	Coinsurance: *within the network*: 100% reimbursement *off-network:* Coins. of 25% with a minimum of € 30.00 per invoice or round of treatments Co-payment: 100% reimbursement
B.5 Lenses and/or contact lenses (frames excluded)	**€ 300 per policyholder**	Coinsurance: 0% 100% reimbursement
B.6 Dental care	**€ 700**	Coinsurance: *within the network*: 100% reimbursement *off-network:* 15%; Co-payment: 100% reimbursement
B.7 Prevention package:		Only network - in a single payment

Dental prevention *(specialist visit and a complete oral hygiene)* *of which* **Prevention** 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 - for this - cardiological examination + ECG under stress (this examination requires a medical prescription); mammography or, alternatively, breast ultrasound, at the policyholder's discretion – these examinations require medical prescriptions; dermatological visit for checking moles* Only for **men**: *PSA (prostate-specific antigen); urological visit; cardiological visit + ECG under stress - this examination requires a medical prescription; dermatological visit for checking moles.*	**Once a year** **Once a year**	100% reimbursement 100% reimbursement .
B.8 Orthopaedic implants and hearing aids	**€ 10,000**	20% coinsurance with a deductible of at least € 30 per invoice
B.9 Guarantee for non-self-sufficiency conditions	**€ 5,000.00** per policyholder for each month of the non-self-sufficient conditions (divisible into days).	100% reimbursement
B.10 Maternity Package ***(Within the network:)*** *Follow-up ultrasound scans, free B-hCG and PAPP-A test / nuchal translucency scans, foetal DNA test, amniocentesis, villus sampling, blood test for monitoring pregnancy* ***Including off-network:*** *Follow-up specialist gynaecological and obstetric visits for monitoring pregnancy.* ***After childbirth: a follow-up gynaecological examination)***	**€ 2,000 per event**	100% reimbursement

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 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.

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 **€ 10,000.00**.
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.2 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.

- Possibility to use healthcare facilities affiliated with the Company by obtaining direct payment (without advance payments by the policyholder) without application of any deductible for assessments and/or cycles of therapy. (100% reimbursement).
- Reimbursement of expenditure incurred by applying a 10% coinsurance with a minimum of € 30.00 per assessment and/or cycle of therapies if they are performed at a facility not affiliated with the Company.
- Co-payment reimbursed at 100%

A biopsy carried out following one of the examinations listed above is understood as being included in the guarantee.
Maximum sum insured per year: **€ 50,000.00** per policyholder, plus **€ 50,000.00** for oncology treatments.

B.3 SPECIALIST VISITS/DIAGNOSTIC ASSESSMENTS

Fees for specialist visits, with the exception of dental and orthodontic visits.
Maximum sum insured per year **€ 5,000** per insured person:

- Possibility to use healthcare facilities affiliated with the Company by obtaining direct payment (without advance payments by the policyholder) without application of any deductible for each assessment. (100% reimbursement).
- Reimbursement of expenditure incurred by applying a 20% coinsurance with a minimum of € 30.00 per assessment if they are performed at a facility not affiliated with the Company.
- Co-payment reimbursed at 100%

Sub-limit of € 250 for diagnostic tests and laboratory examinations (with diagnostic queries):

- Possibility to use healthcare facilities affiliated with the Company by obtaining direct payment (without advance payments by the policyholder) without application of any deductible for each assessment.
- Reimbursement of expenditure incurred by applying a 20% coinsurance with a minimum of € 30.00 per assessment if they are performed at a facility not affiliated with the Company.
- Co-payment reimbursed at 100%

If a diagnostic assessment is conducted during the specialist visit, a single coinsurance / deductible will be applied.

B.4 REHABILITATION PHYSIOTHERAPY TREATMENTS FOLLOWING A DISEASE OR AN ACCIDENT

Reimbursement of expenses for physiotherapy treatments only for rehabilitation purposes following illness or injury, including analgesic acupuncture, provided that they are prescribed by physicians and are delivered by medical or paramedical staff who is qualified for providing rehabilitation therapy.

- Possibility to use healthcare facilities affiliated with the Company by obtaining direct payment (without advance payments made by the policyholder) without application of any coinsurance and deductibles;
- Reimbursement of expenditure incurred by applying a 25% coinsurance with a minimum of € 30.00 per invoice or cycle of treatments, if they are performed at a facility not affiliated with the Company;
- co-payments reimbursed at 100%.

Maximum sum insured per year: **€ 500.00** per policyholder

B.5 LENSES AND / OR CONTACT LENSES (frames excluded)

A prescription by an ophthalmologist or a certificate issued from an optometrist, certifying a variation in vision are needed.
Maximum sum insured per year: **€ 300.00** per policyholder.

B.6 DENTAL CARE

It includes:
- Expenses for conservative treatment and orthodontics.
- Expenses for dental prostheses.

Coverage for preparatory dental tests for
those treatments is also included.

- Possibility to use healthcare facilities affiliated with the Company by obtaining direct payment (without advance payments by the policyholder) and reimbursement of expenditure incurred for each invoice, if the care is given at a facility not affiliated with the Company.
- Facility not affiliated with the Company: a 15% coinsurance applies
- Co-payments reimbursed at 100%

Maximum sum insured per year: **€ 700.00** per policyholder

Attention: for example, all expenses for preparatory dental tests for **CONSERVATIVE THERAPIES, ORTHODONTICS and DENTAL PROSTHESES** (including **implantology**) are included in the limits under this guarantee.

B.7 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 (a medical prescription is required for this examination)
- mammography or, alternatively, breast ultrasound as chosen by the policyholder (a medical prescription is required for these examinations);
- Dermatological examination for checking moles.

Medical services reserved for men, once a year:
- PSA (prostate-specific antigen);
- urological consultation;
- cardiological examination + ECG under stress (a medical prescription is required for this examination);
- 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.8 ORTHOPAEDIC IMPLANTS AND HEARING AIDS

Orthopaedic implants and hearing aids with application of a **20% coinsurance** and a non-indemnifiable minimum amount of **€ 30.00** per invoice.
Maximum sum insured per year: **€ 10,000.00** per policyholder.

B.9 GUARANTEE FOR NON-SELF-SUFFICIENCY CONDITIONS

DEFINITION OF THE GUARANTEE
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 € 5,000.00 per policyholder for each month of permanence of the documented non-self-sufficient conditions (divisible into days).**

B.10 MATERNITY PACKAGE

Upper Limit of indemnity **€ 2,000**
During pregnancy
Within the network: Follow-up ultrasound scans, free B-hCG and PAPP-A test / nuchal translucency scan, foetal DNA test, amniocentesis, villus sampling, blood test for monitoring pregnancy
Also, outside the network: Follow-up specialist gynaecological and obstetric examinations for monitoring pregnancy.
After childbirth: a follow-up gynaecological examination.
No coinsurance/deductible

B.11 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 1

MEDICAL EXPENSE REIMBURSEMENT INSURANCE COVERAGE

ESTIMATED NUMBER OF POLICYHOLDERS on 14.02.2019:

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 and PhD students with scholarships awarded by the Partner, i.e. the University of Milan.
The estimated number of beneficiaries of this policy is 3,922 people, a parameter used to calculate the tender premium upon submitting 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 ……(1,960 people)
- Teaching Staff ……..……..(1,390 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 € 60,001.00 and € 100,000.00, of which:

- Technical and Administrative Staff …… (8 people)
- Teaching Staff ……..…….....(564 people)

Estimated TOTAL of beneficiaries……..…… (3,922 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 € 100,001.00. Specifically, they are:

- Teaching staff ……(196 people)

D) People insured through optional affiliation belonging to the following categories:

- Temporary research fellows……..(676 people)
- PhD students with scholarships awarded by the University……...(734 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 that they are included in the marital status certificate (as defined on page 2).
We specify hereby that the number of family members that can be included is discretionary and that including all family members shown in the marital status certificate is not compulsory.

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:

€ 270.00 for the spouse or cohabiting partner
€ 250.00 for the children

The upper limits of indemnity of the plan shall remain *per capita*.

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 3 TO INSURANCE CONDITIONS

Direct payment service

The Network of "Affiliated Facilities" of Generali Italia

By "Network" the aggregate of healthcare facilities (hospitals, nursing homes and diagnostic centres) and professionals affiliated with Generali Italia is meant, to which the Policyholder may be referred by the Operations Centre to receive the healthcare guaranteed under the policy.

The list of affiliated healthcare facilities is available on the website of Generali Italia www.generali.it under "Strutture Convenzionate" (Affiliated Facilities) and is regularly updated. The Network may indeed be changed even in the current insurance year. The Affiliations office continuously updates its database, so it can provide the Policyholder with constantly updated information through the Operations Centre.

References for services managing the paperwork concerning the University of Milan, free of charge for policyholders.

Toll-free number: 800 533 438
Dedicated urban telephone number: 02.82954595
E-mail: UniversitastudiMilano@generali.com

Access to out-of-hospital services (high specialization, specialist visits, diagnostic assessments, rehabilitation physiotherapy treatments, if the respective guarantee and the direct payment service are both active)

If the Policyholder needs **an out-of-hospital service** at an affiliated healthcare facility, the Operations Centre needs to be contacted at least 2 working days before the date of the service so that it can check the agreement with the selected facility and with the physician in question, for specialist visits.

The request to activate the direct payment must be made by phone, by calling the dedicated number and providing:

- surname and name of the person who needs the service
- policyholder
- mobile phone number - to send the confirmation text message - of the individual who needs the service
- healthcare facility where the service will be provided
- date of the service
- medical certificate containing the request for the service with **diagnosis or presumptive diagnosis**

When the agreement, the healthcare facility and, in the event of a specialist visit, the specialist have been successfully verified, the Operations Centre, after assessing the medical/insurance consistency of the service, authorizes **within the next 24 hours** the affiliated facility to provide the service in compliance with the general insurance conditions (with evidence of any expenses not covered by the policy) without contacting the policyholder.

Should the authorization be denied, the Operations Centre shall send a fax with such denial to the healthcare facility and shall contact the policyholder.

The latter, upon his/her admission to the medical practices shall sign an "engagement letter" (a document containing the mutual obligations of the policyholder and of the affiliated healthcare facility) in connection with the service and under the insurance conditions, and shall hand the prescription transmitted by phone to the Operations Centre.

The affiliated healthcare facility shall transmit to Generali Italia the original copies of the invoices and of the request for the medical service for their payment in compliance with the existing agreements with the healthcare facilities.

Provided that the direct payment is a method envisaged by the policy, any failure to authorize the service by the Operations Centre shall not affect the eligibility for compensation of the claim by the Insurance Company through a reimbursement procedure.

NOTE

If the policyholder does not activate the Direct Care but avails him/herself nonetheless of an affiliated clinic, paying it out of his/her own pocket, (s)he shall be entitled to the agreed rates, by having him/herself recognized as a Generali insured. The expenditure incurred may be eligible for reimbursement if it falls under the healthcare plan underwritten with application of the deductibles for "off-network" services.

ANNEX 4 TO INSURANCE CONDITIONS

"Pronto-care" operating procedure – Dental care

Services provided by Pronto-Care

- Access to the Network and to the Pronto-Care Rate Sheet
- Customer Care Service with a TOLL-FREE NUMBER
- Possibility to identify the most suitable dentist within the Network according to the Insured Party's needs
- Appointment management
- Preventive authorization of the treatments for the Insured Parties who avail themselves of a dentist belonging to the Network.
- Inspection of the services provided in compliance with the reimbursement plan
- Input of claims into the IT system
- Return of the documentation to patients

Procedure

1. In order to find the name of a dentist, the Insured Party may consult the list of dental practices and of the specialized healthcare facilities affiliated to the Network in Italy by accessing the website www.pronto-care.com, by calling the **toll-free number of Pronto-Care 800 197 397**, or by sending an e-mail to: info@pronto-care.com**.**
   The Insured Party who wishes to request that his/her dentist become affiliated may send an e-mail with the details of the dental practice to: affiliazioni@pronto-care.com. The Pronto-Care affiliation office shall contact the practice within 7 days from the request to propose them to join the network.

2. The Insured Party may directly contact the selected facility to arrange an appointment. Within 24 hours before the visit, the Insured Party shall provide Pronto-Care, through the appropriate form available on their website (or alternatively by mail, fax, or telephone) the following information:
   - Policyholder with his/her date of birth
   - Name and surname of the Insured Party
   - Name of the selected dental practice, with municipality and province
   - Date and time of the appointment

   Pronto-Care shall confirm to the medical practice that it is handling the case.
   If the Insured Party wishes Pronto-Care to arrange an appointment at the practice, (s)he may contact Pronto-Care, by using the appropriate form on their website (or via e-mail, fax or phone), to provide them with the necessary information to identify and provide his/her preferred dates and time slots. A reminder service is also available: it reminds the user of the date and time of the visit.

3. The Insured Party is entitled to be charged the rates listed in the Rate Sheet of Affiliated Practices. Anyway (s)he may benefit from any discounts applying to all medical and healthcare services which are not included in the list in the said Rate Sheet.

4. The dental practice, before providing its services, is required to contact Pronto-Care to check whether they are included in the reimbursement plan.

5. Pronto-Care carries out all appropriate checks and promptly sends the Insured Party and the dental practice a confirmation through its website (or by fax, e-mail, or post) concerning the services required of the practice and included in the reimbursement plan. The document prepared by Pronto-Care shows the total of the estimated treatments according to the rate sheet, the rate of reimbursement borne by the Insurance according to the policy conditions and the coinsurance rate borne by itself.
6. After the treatments have been concluded, the dental practice sends Pronto-Care the original invoice (or a copy thereof, according to the policy conditions). Every single service is accompanied by the respective code and by a short description. Pronto-Care checks whether the services provided and the rates applied correspond to those mentioned in the Rate Sheet and whether the coverage meets the reimbursement conditions.

7. The Insured Parties availing themselves of dentists not belonging to the Pronto-Care network shall have their attending physicians fill in the appropriate reimbursement application form and send it together with the original invoice (or with a copy thereof, according to the policy conditions) to:

Pronto-Care
Via A. Ponti 8/10 - 20143 Milano

If the policy allows a copy of the invoice to be sent, the Insured Party may send the reimbursement application online by accessing the website with his/her credentials by completing the section “Off-network procedure – Off-network application for reimbursement”.

8. After conducting the appropriate checks, Pronto-Care enters the claim into the claim settlement system. Otherwise, Pronto-Care, within 30 days from receiving the paperwork, shall contact the Insured Party/dental practice to notify them of such irregularities and to ask for further documentation, if needed.

9. Pronto-Care, after settling the claim, shall inform the Insured Party about the successful settlement by an e-mail message and send the documentation to the Insured Party with the details of the claim settlement.