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san edil
FONDO SANITARIO LAVORATORI EDILI

GUIDE

to the **Healthcare Plan**

SANEDIL FUND
Construction Workers
Healthcare Fund

In compliance with the new provisions of Legislative Decree 209/2005, Article 185, "Contracting Party Disclosure", the Company wishes to inform you that:

- the contract is governed by Italian law;
- any complaints regarding the contractual relationship or the handling of claims must be submitted in writing to:

Unisalute S.p.A. - Funzione Reclami Via Larga, 8 - 40138 Bologna fax 051- 7096892 e-mail: reclami@unisalute.it.

If the claimant is unsatisfied with the outcome of the complaint, or if there is no reply within a maximum term of forty-five days, it is possible to contact the Consumer Protections Service of IVASS (the Italian Insurance Supervisory Authority), Via del Quirinale, 21 - 00187 Rome, telephone 06 42133.1.

Any complaints submitted to IVASS must include:

a) Name, surname and address of the claimant, possibly also including a telephone number;
b) Identification of the person or persons whose work is disputed;
c) Short description of the reason for the complaint;
d) Copy of the complaint submitted to the Company and any responses from the same;
e) Any documents useful for providing a detailed description of the circumstances.

Useful information for submitting complaints is also available on the website of the Company: www.fondosanedil.it. It should be noted that disputes regarding the quantification of benefits and the attribution of liability fall exclusively under the competence of the Judicial Authorities, with possibility of recourse to conciliation systems, where present.

The benefits of the plan are guaranteed by:

UniSalute
SPECIALISTI NELL'ASSICURAZIONE SALUTE

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This guide has been prepared as a streamlined explanatory tool; under no circumstances may it replace the contract, of which it exclusively illustrates the main characteristics. Therefore, the contract remains the only valid tool for complete and comprehensive reference.

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WELCOME

This **"Guide to the Healthcare Plan"** is a useful supporting tool for understanding and accessing healthcare benefits. We advise you to follow the instructions in this Guide each time you need to make use of the Plan.

HOW TO USE THE HEALTHCARE PLAN BENEFITS

HEALTHCARE FACILITIES AFFILIATED WITH UNISALUTE ON BEHALF OF THE SANEDIL FUND

The Sanedil Fund, through UniSalute, has partnered with a network of private healthcare facilities that provide high standards in terms of medical expertise, healthcare technology, comfort and hospitality.

How to book services at the partner health care facilities

Sanedil Fund Members who need to book a healthcare service at an affiliated facility have two options:
- they can contact the relevant construction workers' healthcare fund/Edilcassa
- or they can contact the Facilitator-Delegate

Members who contact the construction workers' healthcare fund/Edilcassa directly must:
- fill out the benefit request form that can be downloaded from the Sanedil Fund website www.fondosanedil.it
- explain their requirements and provide the construction workers' healthcare fund/Edilcassa staff with the doctor's prescription for the requested benefit

Members who contact the Facilitator-Delegate must:
- fill out the benefit request form that can be downloaded from the Sanedil Fund website www.fondosanedil.it and present it to the Facilitator-Delegate
- explain their requirements and provide the Facilitator-Delegate with the doctor's prescription for the requested benefit

- The Facilitator-Delegate will process the request, contact the relevant construction workers' healthcare fund/Edilcassa and ask for authorisation for the benefit to be provided to the Member.

In both cases, the staff of the construction workers' healthcare fund/Edilcassa will check the Sanedil Fund membership requirements, after which it will be possible to enable two types of process in order to book benefits at affiliated facilities:

1) "COMPLETE PROCESS":
If the benefit is included in the Healthcare Plan, the staff of the construction workers' healthcare fund/Edilcassa will complete the booking for the requested benefit once the Member, or the Facilitator-Delegate acting on his/her behalf, has provided the details for the appointment: name of chosen facility, name of physician, date and time.

2) "AUTHORISATION PROCESS":
If the benefit is included in the Healthcare Plan, the staff of the construction workers' healthcare fund/Edilcassa will initiate the request; however, it is the Member's duty to complete the booking of the benefit using the link sent by UniSalute in a text message or e-mail and following the instructions provided.
If the Member opts to receive the authorisation message from UniSalute and book the benefit him/herself ("Authorisation process"), what must he/she do?

The Member must:
- open the authorisation message sent by UniSalute
- click the "affiliated facilities" link
- consult the list of affiliated facilities close to the address provided
- choose the preferred healthcare facility
- contact the facility, specifying that he/she is insured with UniSalute, and make an appointment
- inform UniSalute of the date and time of the appointment by clicking the dedicated link in the message.

The Member may also choose a facility that is not included in those that appear when he/she opens the link in the message. So do so, he/she must:
- visit the Fund's website at www.fondosanedil.it and download the list of facilities affiliated with UniSalute on behalf of the Sanedil Fund from the appropriate section
- choose the preferred healthcare facility
- contact the facility, specifying that he/she is insured with UniSalute, and make an appointment
- go back to the message received and use the dedicated link to notify UniSalute of the facility, physician and date and time of the appointment.

UniSalute will then send the Member a message/e-mail confirming that the benefit that has been booked.

At the time you receive the benefit, you must present your ID at the affiliated facility and, if required, also the prescription issued by your treating physician indicating the working diagnosis and the diagnostic services and/or treatment requested. Working diagnosis means the confirmed or suspected diagnosis or the prevalent symptom, which must be stated on the request for investigations or doctor's consultations.

The Sanedil Fund, through UniSalute, will directly pay the affiliated facility any expenses incurred for authorised healthcare benefits. You will only incur expenses at the affiliated facility if part of a service is not included among the benefits of the Healthcare Plan.

REIMBURSEMENT OF NATIONAL HEALTH SERVICE (NHS) CO-PAYMENT OR INVOICES ISSUED BY NON-AFFILIATED HEALTHCARE FACILITIES

(non-affiliated facilities may only be used if the Member lives in a province in which there are no affiliated facilities for the requested benefit)

How to claim reimbursement for benefits provided by the National Health Service (NHS) or by a non-affiliated healthcare facility (for provinces in which there are no affiliated facilities only)

Sanedil Fund members who need to claim reimbursement for a healthcare benefit that has already been provided have two options:

- they can contact the relevant construction workers' healthcare fund/Edilcassa
- or they can contact the Facilitator-Delegate

In both cases, the Member must:

- fill out the benefit request form that can be downloaded from the Sanedil Fund website www.fondosanedil.it
- present the completed form and documentation indicated for the specific benefit to the relevant construction workers' healthcare fund/Edilcassa or to the Facilitator-Delegate

In both cases, the construction workers' healthcare fund/Edilcassa staff will check the Sanedil Fund membership requirements and initiate the reimbursement claim process.

The documentation usually required to claim reimbursement for medical expenses is as follows, unless indicated otherwise for the individual guarantees of the Healthcare Plan:

- the **reimbursement request form** completed and signed, which can be downloaded from the Sanedil Fund website;
- in case of **hospitalisation**, a true copy of the original medical records including the hospital discharge form;
- in case of **daily hospitalisation allowance**, a true copy of the original medical records including the hospital discharge form;

All the medical documentation regarding any connected services provided before and after the hospitalisation must be sent together with that for the event it refers to.

- in case of **non-hospital services**, a copy of the prescription issued by the treating physician describing the presumed or confirmed medical condition;
- any other specific documentation required for the specific guarantees;
- a copy of **expense documentation** (invoices and receipts), duly receipted.

In order to allow the proper assessment of reimbursement claims, the Sanedil Fund, through UniSalute, will always be entitled to request the original copy.

The Sanedil Fund, through UniSalute, may also request medical checks by issuing specific authorisation overriding the obligation of professional secrecy that the physicians carrying out examinations and treatment are subject to.

The relevant construction workers' healthcare fund/Edilcassa will forward all the documentation for reimbursement to UniSalute, which will perform the appropriate checks and will send the Member a text message/e-mail indicating the outcome of the claim.

Members who wish to track the status of their reimbursement claims, may do so by contacting the relevant construction workers' healthcare fund/Edilcassa, either directly or through the Facilitator-Delegate.

PERSONS COVERED BY THE HEALTHCARE PLAN

The Healthcare Plan is provided to Sanedil Fund members who are employed according to the terms of one of the national collective bargaining agreements indicated in article 1 of the Fund's articles of association or employees of businesses that are members of the construction workers' healthcare fund(s) that comprise the Sanedil Fund.

BENEFITS COVERED
BY THE HEALTHCARE PLAN

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The **Healthcare Plan** is valid in case of illness or injury during the validity of the Healthcare Plan for the provision of the following benefits:

- **HOSPITALISATION FOR MAJOR SURGERY;**
- **HIGHLY-SPECIALISED SERVICES;**
- **SPECIALIST APPOINTMENTS;**
- **CO-PAYMENT FOR DIAGNOSTIC INVESTIGATIONS AND ACCIDENT & EMERGENCY CARE;**
- **REHABILITATION PHYSIOTHERAPY TREATMENTS;**
- **SPECIAL DENTAL TREATMENT;**
- **IMPLANTOLOGY;**
- **OUTPATIENT DENTAL SURGERY;**
- **CONSERVATIVE DENTAL CARE;**
- **SPECIAL DIAGNOSTIC SERVICES;**
- **ORTHOPAEDIC AND ACOUSTIC IMPLANTS;**
- **LENSES;**
- **SEVERE IMPAIRMENT RESULTING FROM PERMANENT DISABILITY FOLLOWING OCCUPATIONAL ACCIDENTS OR SEVERE MEDICAL CONDITIONS;**
- **MONITOR SALUTE;**
- **MATERNITY/PREGNANCY.**

COVID-19 SECTION:

THE HEALTHCARE PLAN IS VALID IN CASES OF HOSPITALISATION FOLLOWING A DIAGNOSIS OF COVID-19 INFECTION:

- **DAILY HOSPITALISATION ALLOWANCE IN CASE OF POSITIVITY FOR COVID-19 (CORONAVIRUS);**
- **POST-HOSPITALISATION DAILY ALLOWANCE FOLLOWING INTENSIVE CARE FOR COVID-19 (CORONAVIRUS).**

HOSPITALISATION, FOR MAJOR SURGERY AS PER THE APPENDED LIST, FOLLOWING ILLNESS AND INJURY

Hospitalisation means the overnight stay at a healthcare facility. A&E management alone does not constitute hospitalisation. Members who are hospitalised for surgery, as listed in point 9 below, may make use of the following benefits:

PRE-HOSPITALISATION
Tests and procedures, diagnostic investigations and specialist consultations provided during the **50 days** prior to hospitalisation, if made necessary by the illness or injury resulting in hospitalisation.
Coverage is exclusively given in the form of reimbursement with an annual sub-limit of **€ 1,000.00**, to be shared with the post-hospitalisation facility.
SURGICAL

PROCEDURE
Fees of the surgeon, aid, assistant, anaesthesiologist, and any other persons participating in the surgery (as shown on the surgical report); fees for the operating theatre and surgical equipment including endoprostheses.

MEDICAL CARE, MEDICINES, TREATMENT
Medical and nursing care, specialist consultations, medicinal products, tests and procedures, diagnostic investigations and physiotherapy and rehabilitation treatments **during the hospitalisation period**.

HOSPITALISATION FEE
The benefit does not include unnecessary expenses.
In case of hospitalisation at a healthcare facility not affiliated with UniSalute on behalf of the Sanedil Fund, expenses incurred are reimbursed up to a limit of **€ 300.00 per day**.

ACCOMPANYING PERSON
Full board and accommodation of the accompanying person at the healthcare facility or in a hotel.
In case of hospitalisation in a medical institution not affiliated with UniSalute on behalf of the Sanedil Fund, the benefit is limited to **€50.00** per day for no more than **30 days** per hospitalisation.

INDIVIDUAL PRIVATE NURSING CARE
Individual private nursing care is granted with a limit of **€ 60.00** a day for a maximum hospitalisation period of 30 days.
This benefit is provided exclusively via reimbursement.

POST-HOSPITALISATION
Tests and procedures and diagnostic investigations, medication and medical, surgical and nursing services (the latter if the request is certified at the time of discharge from the healthcare facility), physiotherapy or rehabilitation treatments and thermal treatments (excluding in any case any hotel expenses), provided in the **50 days** following the end of hospitalisation, if necessary by the illness or injury resulting in hospitalisation. Medicines prescribed by the treating physician upon discharge from the medical institution are included in the guarantee.
The annual sub-limit is **€ 1,000.00**, to be shared with the pre-hospitalisation facility. .

a1) Services at private or public healthcare facilities affiliated with UniSalute for the Sanedil Fund and provided by affiliated physicians.
In this case, the expenses for the benefits provided are paid directly by the Sanedil

Fund, through UniSalute, to the affiliated healthcare facilities, without applying any non-refundable amount, with the exception of the following:
- point "Hospitalisation for major surgery following illness or injury":
  - sub-point "Pre-hospitalisation";
  - sub-point "Individual private nursing care",
- point "Medical transport";

which are reimbursed to the Member within the limits of the points specified, and the following:
- point "Infants";

which are paid to the affiliated healthcare facility within the limits of the point specified.

a2) Services at private or public healthcare facilities affiliated with UniSalute for the Sanedil Fund and provided by non-affiliated physicians.
If a surgical procedure is performed by a non-affiliated physician in an affiliated facility, all the expenses of the hospitalisation are reimbursed according to the same terms and conditions envisaged for hospitalisation in non-affiliated facilities (point b).

b) Services at non-affiliated private or public healthcare facilities.
If the Member lives in a province with no affiliated healthcare facilities, with the exclusion of the provisions set forth in the points "Transplants" and "Infants", the Member is reimbursed for the expenses for the benefits provided with a limit of **€ 10,000.00** per procedure, with the application of a **20% excess** and a minimum non-refundable amount of **€ 2,000.00** per procedure. The following items are not taken into consideration when calculating the excess:
- point "Hospitalisation for major surgery following illness or injury":
  - sub-point "Hospitalisation fee"
  - sub-point "Accompanying person";
  - sub-point "Individual private nursing care",
- point "Medical transport";

which are reimbursed to the Member within the limits of the points specified.

c) Benefits provided in National Health Service facilities
In case of hospitalisation at facilities of the National Healthcare Service or that are accredited by the same in the form of direct assistance, and therefore with costs entirely borne by the NHS, the benefit described under the point "Allowance in lieu" will be provided.
If, during hospitalisation, the Member incurs expenses for overnight accommodation or healthcare co-payments, the Fund will reimburse all the expenses paid in advance by the Member, within the limits envisaged in the various points, in addition to the entire allowance in lieu.
If hospitalisation is provided on an external private practice basis with costs charged to the Member, the expenses incurred are reimbursed pursuant to the provisions of letter a) "Services at private or public healthcare facilities affiliated with UniSalute on behalf of the Sanedil Fund and provided by affiliated physicians" or b) "Services at non-affiliated private or public healthcare facilities".

MEDICAL TRANSPORT

The Fund will reimburse the cost for the Member's medical transport by ambulance with a mobile coronary care unit and by air ambulance to the healthcare facility, transfer expenses from one healthcare facility to another and return to his/her home with a maximum limit of **€ 500.00** per hospitalisation.

TRANSPLANTS

In case of transplantation of organs or parts thereof, the Fund pays for the expenses listed under the points "Hospitalisation for major surgery following illness or injury" and "Medical transport" within the relative limits listed, as well as the expenses necessary for harvesting from the donor, including those for organ transport.
Pharmacological treatments aimed at preventing rejection during pre-hospitalisation are also included.
In the case of a live donor, the benefit guarantees the expenses incurred for the services provided during the hospitalisation of the donor for:

- diagnostic investigations;
- medical and nursing care;
- surgery;
- treatments;
- medicinal products;
- hospitalisation fees.

INFANTS

The Sanedil fund, through UniSalute, will pay the expenses for surgical procedures performed in the first three years of the infant's life to correct congenital malformations*, including consultations, pre- and post-operative diagnostic interventions, and the expenses for the board and lodgings of the accompanying person at the healthcare facility or in a hotel for the hospitalisation period, with an annual limit of **€ 10,000.00** per infant.

ALLOWANCE IN LIEU FOR PRE- AND POST-HOSPITALISATION

If the Member does not claim any reimbursement from the Fund, either for hospitalisation (as per the appended list) or for other related benefits (with the exception of any expenses incurred during hospitalisation for accommodation services or medical co-payment), he/she shall be entitled to **€ 150.00** for each day of hospitalisation for a period of no more than **90 days** for each hospitalisation.
N.B.: The first and the last day of hospitalisation are considered a single day, regardless of the times of admission and discharge.
The expenses relating to "pre-" and "post-hospitalisation" guarantees in this case are provided without the application of any of the limits pursuant to the point "Hospitalisation for major surgery as per the appended list following illness or injury" and are subject to an annual expense limit of **€ 1,000.00**.

ANNUAL EXPENSE LIMIT FOR HOSPITALISATION

The Healthcare Plan sets an annual expense limit of **€ 90,000.00** per insurance year, per Member. This means that if this figure is reached during the year, it is not possible to use any further benefits. Cover will recommence the following year for any events that occur in the new period. However, it will no longer be possible to reimburse events that occurred in the previous year.

HIGHLY-SPECIALISED SERVICES

As an exception to the provisions set forth in the Chapter "Non-validity of the plan" under point 18, the Fund will cover the expenses for the following out-of-hospital services:

Conventional radiology (without contrast medium)

- Imaging of the skeletal system and joints
- Mammogram (a doctor's prescription is required for this benefit, which is provided even when there is no disease present)
- Bilateral mammogram (a doctor's prescription is required for this benefit, which is provided even when there is no disease present)
- Orthopantomogram
- X-ray of whole spine
- X-ray of an organ/system
- Intraoral x-rays
- X-ray of the oesophagus
- X-ray of the oesophagus, direct examination
- Small bowel series x-ray
- Digestive tract x-ray
- Upper digestive tract x-ray
- Lower digestive tract x-ray

Conventional radiology (with contrast medium)

- Arthrography
- Bronchography
- Cavernosography
- Cisternography
- Cystography/double-contrast
- Micturition cystourethrography
- Opaque and double-contrast enema
- Cholangiography/percutaneous cholangiography
- Retrograde cholangiopancreatography
- Cholecystography
- Colpography
- Coronary angiogram
- Dacryocystography
- Defecography
- Discography
- Urodynamic test
- Fistulography
- Phlebography
- Fluorescein angiography
- Galactography
- Hysterosalpingography and/or sonohysterosalpingography and/or sonohysterography and/or sonosalpingography
- Lymphography
- Myelography
- Pneumoencephalography
- Any contrast-enhanced study for interventional radiology
- Opaque-/ double-contrast x-ray of oesophagus;
- Double-contrast x-ray of small intestine
- Double-contrast x-ray of stomach
- Double-contrast x-ray of small intestine with selective study;
- Contrast-enhanced x-ray of the entire digestive tract including the oesophagus
- Contrast-enhanced sialography

- Splenoportography
- Urethrocystography
- Urography
- Vasography
- Pancreatography

Diagnostic imaging

Ultrasound scans
- Breast ultrasound
- Pelvic ultrasound including transvaginal examination;
- Prostate ultrasound including transrectal examination;

Colour Doppler US
- Doppler echocardiography including colour study
- Color Doppler ultrasound of upper and lower limbs
- Color Doppler ultrasound of abdominal aorta
- Color Doppler ultrasound of supra-aortic vessels;

Highly-specialised diagnostic imaging

Computed tomography (CT)
- CT-angiography
- Exo- and endocranial CT-angiography
- Multi-slice helical CT (64-slices);
- CT with and without contrast;

MRI
- Cardiac cine MRI;
- MR angiography with contrast
- NMR with and without contrast.

PET
- Positron emission tomography (PET) per organ/ compartment/ system.

Scintigraphy (in vivo nuclear medicine)
- Scintigraphy of any system or organ (including myocardial perfusion scintigraphy)
- In vivo nuclear medicine
- SPET myocardial tomoscintigraphy
- Whole-body scintigraphy with radiolabelled autologous white blood cells

Instrumental diagnostics
- Campimetry
- Dynamic electrocardiogram (ECG) using analogical devices (Holter)
- Electroencephalography
- Sleep-deprived electroencephalogram (EEG)
- Dynamic 24-hour electroencephalogram (EEG)
- Electromyography (EMG)
- Electroretinogram
- Continuous (24-hour) blood pressure monitoring
- Gastric oesophageal pH test
- Evoked potentials
- Spirometry
- Corneal topography

Biopsies
- All

Diagnostic and interventional endoscopy
- Diagnostic endoscopic retrograde cholangiopancreatography (ERCP)
- Diagnostic cystoscopy
- Oesophagogastroduodenoscopy
- Diagnostic pancolonoscopy
- Diagnostic rectoscopy
- Diagnostic rectosigmoidoscopy
- Diagnostic tracheobronchoscopy

Miscellaneous
- Sentinel lymph node biopsy
- Arterial blood gas analysis
- Laser therapy for physical therapy purposes
- Endoscopic bronchoalveolar lavage
- Sentinel lymph node dissection and landmark

Treatments
- Chemotherapy
- Radiotherapy
- Dialysis

To activate the benefit, the medical prescription must indicate the working diagnosis or medical condition that necessitated the service.

In the case of use of healthcare facilities and physicians affiliated with UniSalute on behalf of the Sanedil Fund the expenses for the services provided to the Member will be paid directly by the Sanedil Fund, through UniSalute, to the facilities, with an amount of **€ 35.00** to be paid by the Member for each diagnostic investigation or treatment cycle, which the Member must pay to the facility when using the benefit. The Member must also present the facility with a prescription from the treating physician indicating the medical condition or working diagnosis.

The use of non-affiliated healthcare facilities or staff is only permitted if the Member lives or has his/her official residence in a province with no affiliated healthcare facilities. For the use of non-affiliated facilities, the expenses incurred are reimbursed with the application of a minimum non-refundable amount of **€ 35.00** for each diagnostic investigation or treatment cycle. In order to receive reimbursement from the Fund, the Member must attach to the copy of the invoice a copy of the request by the treating physician indicating the medical condition or working diagnosis.

If the Member uses the National Health Service, the Fund will reimburse the co-payment incurred by the Member with a minimum non-refundable amount of **€ 10.00** per service or treatment cycle.

The annual limit for this benefit is **€ 5,000.00** per Member.
For "Diagnostic and interventional endoscopy" benefits,
there is an annual sublimit of **€ 500.00** per Member.

SPECIALIST APPOINTMENTS

The Sanedil Fund, through UniSalute, covers the payment of expenses for specialist consultations resulting from illness or injury, with the exception of dental and orthodontic consultations. The benefit only includes a preliminary psychiatric examination to confirm the presence of a medical condition.
In order for the benefit to apply, the medical prescription must contain the working diagnosis or medical condition that necessitated the service itself.
Expense documentation (invoices and receipts) must show the specialisation of the physician, which, for the purposes of reimbursement, must be of relevance to the medical condition reported.

In the case of use of **healthcare facilities** and **staff affiliated with UniSalute for the Sanedil** Fund, the expenses for the services provided to the Member are paid directly by the Sanedil Fund to the facilities with the application of a minimum non-refundable amount of **€ 25.00** for each specialist consultation.

The use of non-affiliated healthcare facilities or staff is only permitted if the Member lives or has his/her official residence in a province with no affiliated healthcare facilities. If the Member makes use of **healthcare facilities or staff not affiliated with the Company**, the expenses incurred are reimbursed with the application of a minimum non-refundable amount of **€ 25.00** for each specialist consultation.

If the Member uses the National Health Service, the Fund will reimburse the co-payment incurred by the Member with a minimum non-refundable amount of **€ 10.00** per specialist consultation.

The annual limit for this benefit is **€ 500.00** per Member.

CO-PAYMENT FOR DIAGNOSTIC INVESTIGATIONS AND ACCIDENT & EMERGENCY TREATMENT

The Fund reimburses co-payment incurred by the Member as a result of illness or injury for NHS services with a minimum non-refundable amount of **€ 10.00** per co-payment:
- for diagnostic investigations (not included under point 4. "Highly-specialised services");
- for A&E care.

The annual limit for this benefit is **€ 500.00** per Member.

REHABILITATION PHYSIOTHERAPY TREATMENTSI

The annual limit for the set of benefits listed below under the points "Rehabilitation physiotherapy treatments following injury" and "Rehabilitation physiotherapy treatments following a temporarily-invalidating illness" is **€ 250.00** per Member.o.

In the case of use of **healthcare facilities** and **staff affiliated with UniSalute on behalf of the Sanedil** Fund, the expenses for the services provided to the Member are paid directly by the Sanedil Fund to the facilities with the application of a minimum non-refundable amount of **€ 25.00** for each treatment cycle.

The use of non-affiliated healthcare facilities or staff is only permitted if the Member lives or has his/her official residence in a province with no affiliated healthcare facilities. If the Member makes use of healthcare facilities or staff not affiliated with the Company, the expenses incurred are reimbursed with the application of a minimum non-refundable amount of **€ 25.00** for each treatment cycle.
If the Member uses the National Health Service, the Fund will reimburse the co-payment incurred by the Member with a minimum non-refundable amount of **€ 10.00** per treatment cycle..

REHABILITATION PHYSIOTHERAPY TREATMENTS FOLLOWING INJURY

As an exception to the provisions set forth in the Chapter "Non-validity of the Plan" under point 18, the Fund provides for the payment of expenses for physical therapy after injury, exclusively for rehabilitation purposes, in the presence of an A&E certificate, provided the treatment is prescribed by a primary care physician or specialist whose specialisation is related to the reported medical condition, and is provided by a medical or healthcare professional qualified in rehabilitation therapy, whose qualification must be proven by the expense documentation.
This benefit does not include services provided at gyms, sports clubs, beauty centres, medical hotels or spas, even if these have adjoining medical centres.

REHABILITATION PHYSIOTHERAPY TREATMENTS FOLLOWING A TEMPORARILY-INVALIDATING ILLNESS

As an exception to the provisions set forth in the Chapter "Non-validity of the Plan" under point 18, the Fund provides for the payment of expenses for physical therapy after a temporarily-invalidating illness as per the list below, exclusively for rehabilitation purposes, provided the treatment is prescribed by a primary care physician or specialist whose specialisation is related to the reported medical condition, and is provided by a medical or healthcare professional qualified in rehabilitation therapy, whose qualification must be proven by the expense documentation.
This benefit does not include services provided at gyms, sports clubs, beauty centres, medical hotels or spas, even if these have adjoining medical centres.

List of medical conditions after which the benefit applies:
- Temporarily-invalidating cardiovascular diseases
- Temporarily-invalidating neurological diseases
- Temporary limb prosthetisation
- Temporarily-invalidating high-grade pathological fractures

SPECIAL DENTAL TREATMENT

As an exception to the provisions set forth in the Chapter "Non-validity of the Plan" under point 3, the Fund provides for the payment of the special dental treatment "package", available once a year at healthcare facilities affiliated with UniSalute on behalf of the Sanedil Fund, and which must be booked in advance. The below-listed services comprising the "package", are designed to monitor the existence of any pathological conditions, even when not clinically overt, and are particularly recommended in subjects with a family history.

Tartar removal, including any check-ups with the use of ultrasound, or alternatively, if necessary, with the use of other types of oral hygiene treatment.

If, due to particular clinical and/or medical conditions of the Member, the practitioner finds, in agreement with the Fund, the need to carry out a second session of tartar removal within the same insurance year, the Fund will also pay for this second session, according to the terms described below, as was done for the previous service. In case of use of healthcare facilities affiliated with UniSalute on behalf of the Sanedil Fund, UniSalute must be notified in advance of the second session.

Any other services requested, such as fluoride therapy, root planing, fissure sealing, etc., shall be at the Member's expense.

In the case of use of **healthcare facilities** and **staff affiliated with UniSalute on behalf of the Sanedil** Fund, the expenses for the benefits provided to the Member are paid directly by the Sanedil Fund to the facilities with a **25%** excess to be paid by the Member to the healthcare facility when the invoice is issued.

IMPLANTOLOGY

As an exception to the provisions set forth in the Chapter "Non-validity of the plan" under point 3, the Fund will cover the expenses for the services indicated below.

The annual limit for dental implantology services is **€ 2,000.00**.

In the case of use of **healthcare facilities** and **staff affiliated with UniSalute on behalf of the Sanedil** Fund, the expenses for the services provided to the Member are paid directly by the Fund to the facilities without applying any non-refundable amount.

If the Member uses the National Health Service, the Fund reimburses the co-payment incurred by the Member without applying any non-refundable amount.

N.B.:
- for payment purposes it is necessary to present the pre- and post-implantation x-rays and the related reports.

PLACEMENT OF THREE OR MORE IMPLANTS

This benefit applies in case of placement of three or more implants, provided for under the same treatment plan.
The benefit includes the placement of the implant, the definitive restoration, the provisional restoration and the dental post/abutment for the 3 or more implants.

› If the total cost of services indicated in the treatment plan exceeds the expense limit indicated above, any excess amounts must be paid directly by the Member to the affiliated facility..

PLACEMENT OF TWO IMPLANTS

For the placement of two implants indicated in the same treatment plan, there is an annual expense sublimit of **€ 1,250.00**.
The benefit includes the placement of the implant, the definitive restoration, the provisional restoration and the dental post/abutment for the two implants.
If the total cost of services indicated in the treatment plan exceeds the expense limit indicated above, any excess amounts must be paid directly by the Member to the affiliated facility.

› If, during the same insurance year, after activating the benefit provided for in the point "Placement of an implant", it becomes necessary to place a second implant, the latter will be paid within the sub-limit of **€ 1,250.00** provided for by this cover, minus any sums that have already been authorised or paid..

PLACEMENT OF AN IMPLANT

For the placement of an implant indicated in the treatment plan, there is an annual expense sublimit of **€ 625.00**.
The benefit includes the placement of the implant, the definitive restoration, the provisional restoration and the dental post/abutment for the implant.

› If the total cost of services indicated in the treatment plan exceeds the expense limit indicated above, any excess amounts must be paid directly by the Member to the affiliated facility.

EXTRACTION OF UP TO 4 TEETH
(ONLY IF NECESSARY FOR IMPLANT TREATMENT)

The benefit applies for extractions made necessary by an implant treatment, for up to 4 teeth per year.

When affiliated facilities are used:

› If the total number of services indicated in the treatment plan exceeds the number indicated above, the corresponding costs must be paid directly by the Member to the affiliated facility.

OUTPATIENT DENTAL SURGERY

As an exception to the provisions set forth in the Chapter "Non-validity of the Plan" under point 3, the Fund covers the payment of the expenses incurred for surgical procedures required as a consequence of the following medical conditions, including dental implant procedures, even when performed following surgical procedures outside the cover provided by the Healthcare Plan, provided they are also a consequence of the following medical conditions:

- adamantinomas
- dental abscess in the presence of root canal filling
- follicular cysts
- radicular cysts
- odontomas
- removal of displaced implant in the maxillary sinus

In order for the benefit to apply, the medical prescription must indicate the working diagnosis or medical condition that necessitated the service.

The healthcare documentation required in order to obtain the payment of the expenses incurred consists in:

- x-rays and radiology reports for the removal of displaced implants in the maxillary sinus and tooth abscess in the presence of an endodontic instrument in the root canal, performed/compiled by a radiodiagnostics specialist;
- x-rays and radiology reports performed/compiled by a radiodiagnostics specialist and histology reports compiled by a pathology specialist, for follicular cysts and radicular cysts, adamantinomas and odontomas

The annual limit for this benefit is **€ 2,000.00** per Member.

In the case of use of **healthcare facilities** and **staff affiliated with UniSalute on behalf of the Sanedil** Fund, the expenses for the services provided to the Member are paid directly by the Fund to the facilities without applying any non-refundable amount.

If the Member uses the National Health Service, the Fund reimburses the co-payment incurred by the Member without applying any non-refundable amount.

CONSERVATIVE DENTAL CARE

As an exception to the provisions set forth in the Chapter "Non-validity of the plan" under point 3, the Fund will cover the expenses for conservative dental care.

In the case of use of **healthcare facilities** and **staff affiliated with UniSalute on behalf of the Sanedil** Fund, the expenses for the benefits provided to the Member are paid directly by the Fund to the facilities with a **25%** excess to be paid by the Member to the healthcare facility when the invoice is issued.

If the Member uses the National Health Service, the Fund provides full reimbursement for the co-payment incurred by the Member.

The annual limit for this benefit is **€ 100.00** per Member.

SPECIAL DIAGNOSTIC SERVICES

The Fund provides for payment of the benefits listed below performed once a year in **healthcare facilities** and by **staff affiliated with UniSalute on behalf of the Sanedil Fund**.
The services provided, which are intended to monitor the existence of any pathological conditions, despite not yet being clinically overt, are particularly appropriate for subjects with a family history of the condition.
All benefits must be provided on a single occasion.

Basic package for women and men 18 years of age and over
- Alanine transaminase ALT
- Aspartate transaminase AST
- HDL cholesterol
- Total cholesterol
- Creatinine
- Complete blood count and morphological examination
- Gamma-GT
- Blood glucose
- Triglycerides
- Partial thromboplastin time (PTT)
- Prothrombin time (PT)
- Urea
- ESR
- Urine; chemical, physical and microscopic examination

For women 18 years of age and over
- Smear test

A - Cardiovascular prevention
Women/men 40 years of age and over
Authorised expense limit € 150.00 for Members of both sexes and all ages who have the following investigations:
a) diagnostic blood chemistry tests characterised by:
- Complete blood count
- ESR
- Blood glucose
- BUN
- Creatinine
- Total and HDL cholesterol
- Triglycerides
- Total and fractionated bilirubin
- ALT and AST

b) specific investigations:
- Specialist cardiology consultation
- Baseline and stress ECG

B - Prevention of female reproductive system and breast cancers
For women over 50 years of age
Authorised expense limit € 120.00 for the following investigations:
a) common basic diagnostic blood chemistry panel characterised by
- Complete blood count
- ESR
- Blood glucose
- BUN

- Creatinine
- Total and HDL cholesterol
- Total and fractionated bilirubin
- ALT and AST

b) specific investigations:
- Gynaecology consultation and smear test

– Prevention of prostate cancers
For men over 50 years of age
Authorised expense limit € 120.00 for the following investigations:
a) common basic diagnostic and blood chemistry tests based on:
- Complete blood count
- ESR
- Blood glucose
- BUN
- Creatinine
- Total and HDL cholesterol
- Total and fractionated bilirubin
- ALT and AST

b) specific investigations:
- Specialist urology consultation
- Ultrasound scan of the prostate and bladder
- PSA test

ORTHOPAEDIC PROSTHETICS AND HEARING AIDS

The Fund reimburses expenses for the purchase of orthopaedic prostheses and hearing aids. A prescription providing justification is required.

The expenses incurred are reimbursed with the application of a **20%** excess with a minimum non-refundable amount of **€ 100.00** per invoice, per person.

The annual limit for this benefit is **€ 500.00** per Member.

LENSES

The Fund reimburses expenses incurred for corrective eyeglass lenses or contact lenses.

The Fund reimburses the expenses incurred with the application of a minimum non-refundable amount of **€ 50.00** per invoice/person.

Certification from an NHS or private ophthalmologist certifying the change in vision is required to use the benefit.

The annual limit for this benefit is **€ 90.00** per Member..

SEVERE IMPAIRMENT RESULTING FROM PERMANENT DISABILITY FOLLOWING AN OCCUPATIONAL ACCIDENT OR SEVERE MEDICAL CONDITION

The Fund reimburses healthcare expenses and/or care services for conditions of severe impairment caused by an occupational accident resulting in more than 50% permanent invalidity (according to the INAIL table) or caused by one of the following medical conditions:

- Stroke;
- Multiple sclerosis;
- Paralysis;
- Heart, liver, lung, kidney, bone marrow or pancreas transplant;
- Cystic fibrosis;
- Vertebral artery ischaemia.

The benefit only applies if:

- **the occupational accident is substantiated by an Accident & Emergency report and occurred during the validity of the Healthcare Plan;**
- **the severe medical condition occurred during the validity of the Healthcare Plan.**

The degree of permanent invalidity is calculated considering only the direct consequences of the accident, without taking into account the greater impairment resulting from concomitant impairments.

The annual limit for this benefit is **€ 7,000.00** per Member.
This annual limit can be used for the first three years
of this Healthcare Plan..

MONITOR SALUTE SERVICE

UniSalute, through the Fund, provides Members over 40 years of age with a clinical parameter monitoring service for the following chronic diseases: chronic respiratory diseases (bronchial asthma and COPD), hypertension and diabetes.
UniSalute, through the Fund provides Members with an advanced technology system that allows the measurement of their clinical parameters in the comfort of their own home.
Once a questionnaire has been filled out, the patient is provided with a medical device that performs measurements in his/her own home, completely free of charge.
The patient's values are constantly monitored by a Helpline staffed by specialised nurses who intervene in the presence of clinical alerts and provide coaching and training to favour patient empowerment.
The benefit for the patient consists in improving the management of the medical condition through better compliance with his/her treatment plan and a better awareness of their health conditions.

SPECIALIST CONSULTATIONS AND DIAGNOSTIC INVESTIGATIONS FOR CHRONIC MEDICAL CONDITIONS

For Members participating in the chronic diseases monitoring programme, the Fund provides payment for expenses for specialist consultations and diagnostic investigations closely related to the Members' chronic medical conditions, according to the terms described below.
In order for the benefit to apply, the Member must present a medical prescription indicating the working diagnosis or medical condition that necessitated the service.

In the case of use of healthcare facilities and **staff affiliated with UniSalute on behalf of the Sanedil** Fund, the expenses for the services provided to the Member are paid directly by the Fund to the facilities without applying any non-refundable amount.

If the Member lives in a province in which there are no healthcare facilities affiliated with UniSalute, he/she may make use healthcare facilities or professionals that are not affiliated with UniSalute and the expenses will be fully reimbursed without the application of any excess or fixed excess.

If the Member uses the National Health Service, the Fund provides full reimbursement for the co-payment incurred by the Member.

The annual limit for this benefit is **€ 300.00** per Member.

MATERNITY/PREGNANCY

The Fund provides payment for the following ante-natal monitoring expenses:
- ultrasound scans, for a maximum of 2.

In the case of use of healthcare facilities and **staff affiliated with UniSalute on behalf of the Sanedil** Fund, the expenses for the services provided to the Member are paid directly by the Fund to the facilities without applying any non-refundable amount.

If the Member uses the National Health Service, the Fund provides full reimbursement for the co-payment incurred by the Member.

COVID-19 SECTION

DAILY HOSPITALISATION ALLOWANCE IN CASE OF POSITIVITY FOR COVID-19 (CORONAVIRUS)

For each day of hospitalisation following an event occurring during the validity of the Healthcare Plan in which the Member tests positive for COVID-19 virus (positive Coronavirus swab test), the Fund undertakes to pay a daily allowance of **€ 40.00** for a maximum of **30 days** for each Member's membership year.
The days of admission and discharge are considered a single day.

POST-HOSPITALISATION DAILY ALLOWANCE FOLLOWING INTENSIVE CARE FOR COVID-19 (CORONAVIRUS)

Following discharge, and only if during hospitalisation the Member required intensive care and intubation, the Member is entitled to a daily convalescence allowance of **€ 40.00** for **30 days**.

THE ALLOWANCES INDICATED IN POINTS 6.16.1 AND 6.16.2 ABOVE CANNOT BE ACCUMULATED.

SERVICES AT UNISALUTE DISCOUNTED RATES

If for any benefit pertaining to one of the guarantees indicated above, Healthcare Plan cover does not apply due to the reaching of the annual expense limit or because the benefit costs less than the minimum non-refundable amount and remains at the full expense of the Member, it is in any case possible to ask the Helpline to book the service and to send a fax to the facility chosen from its network making it possible to apply special rates to UniSalute Members, who will therefore be able to obtain a discount on the rates usually applied.

NON-VALIDITY OF THE PLAN

The Healthcare Plan does not include all events attributable to the type of benefit provided; not all expenses incurred for the healthcare services guaranteed are covered by the Plan.

The Healthcare Plan is not valid for:

1. treatment and/or surgery to eliminate or correct physical defects* or malformations** already existing at the time the Plan is concluded, with the exception of the point "Infants".
2. the treatment of mental illness and psychological disorders in general, including neurotic behaviour;
3. dentures, treatment of periodontal disease, dental care and dental checks;
4. medical treatments for cosmetic purposes (with the exception of reconstructive plastic surgery made necessary by injury or demolitive surgery taking place during the validity period of the Healthcare Plan);
5. hospitalisation and day hospital services during which treatments (including physical therapies or the administration of medicines) or diagnostic investigations are performed that, by their technical nature, can also be administered on an outpatient basis;
6. infertility tests and medical practices for the purpose of artificial insemination;
7. hospitalisation arising from the Member's need to receive third-party assistance in order to perform basic activities of daily living, as well as admission to long-term care.
8. admission to long-term care is understood as that arising from physical conditions of the Member for which recovery with medical treatment is no longer possible, requiring admission to a medical establishment for care or physical therapy maintenance;
9. surgery for the replacement of orthopaedic implants of any kind;
10. treatment of illness resulting from alcohol or psychoactive drug abuse, as well as the non-therapeutic use of drugs or hallucinogens;
11. injury resulting from alcohol or psychoactive drug abuse, as well as the non-therapeutic use of drugs or hallucinogens;
12. injury arising from the practice of extreme and dangerous sports, such as, for example, air sports, motor sports, automotive sports, free climbing, rafting and extreme mountaineering, as well as participation in the related competitions or practice sessions, whether official or otherwise;
13. injury caused by malicious acts committed by the Member;
14. consequences of attempted suicide, self-harm and criminal acts committed by the Member with intent or gross negligence;
15. direct or indirect consequences of the transmutation of atomic nuclei of radiation caused by the artificial acceleration of atomic particles or exposure to ionising radiation;
16. consequences of war, riots, earthquakes, volcanic eruptions and atmospheric events;
17. services not recognised by official medicine, and experimental treatments and biological medicinal products;
18. all medical therapies, including intravitreal injections;
19. the direct or indirect consequences of pandemics.

Only with regard to the services provided for under the points regarding "Dental care" benefits, the Healthcare Plan is not valid for:
- cosmetic prostheses
- treatments arising from the consequences of psychiatric disorders.

Only for the benefits described under the point "Severe impairment caused by permanent invalidity resulting from an occupational accident or a severe medical condition", as well as the exclusions listed above, the Healthcare Plan is not valid for the consequences of:

- Permanent invalidity caused by mental illness, mental health and behaviour disorders in general, including neurotic behaviour, psychosis, depression and the consequences thereof;
- Previous accidents and illnesses that occurred prior to the validity of the Healthcare Plan.

* Physical defect is understood as a deviation from the normal morphological order of an organism or parts of its organs due to acquired medical conditions or injuries.
**Malformation is understood as a deviation from the normal morphological order of an organism or part of its organs due to congenital medical conditions.

IMPORTANT CLARIFICATIONS

TERRITORIAL SCOPE

The Healthcare Plan is valid worldwide with the same terms that apply in Italy.

AGE LIMITS

The Healthcare Plan may be concluded or renewed until the Member reaches the age of **70**; the Plan automatically expires at the first annual expiry after the Member turns **71**.

MANAGEMENT OF EXPENSE DOCUMENTATION (INVOICES AND RECEIPTS)

A) Benefits provided by healthcare facilities affiliated with UniSalute on behalf of the Sanedil fund

Expense documentation for healthcare benefits provided at affiliated healthcare facilities is directly delivered to the Member by the facility.

B) Benefits provided by non-affiliated healthcare facilities

Copies of the expense documentation received must be kept and attached to reimbursement claims pursuant to law. If the Fund asks the Member to provide original documentation, on a monthly basis the original documentation only will be returned.

The documentation accompanying the reimbursement claim (invoices, receipts, doctor's prescriptions, medical record, etc.) must be submitted as co-

pies. The Fund may, at its discretion and at any time, ask for the original documentation to be submitted for the necessary verifications. It should be noted that in the event of submission of false or forged documents, the Fund will immediately notify the competent judicial authorities for the appropriate investigations and confirmation of possible criminal responsibilities.

N.B.:
Reimbursement claims must be submitted within two years of the date on the invoice or expense documentation relating to the benefit used. For hospitalisations, this term is calculated from the date of discharge. No reimbursement will be provided for invoices and expense documentation submitted after the end of the two-year term.

LIST OF SURGICAL PROCEDURES

Malignancies affecting any organ or system. The diagnosis for patient management and subsequent reimbursement must be confirmed by a histological or cytological biopsy report. It goes without say that procedures for which a diagnosis of malignancy is histologically confirmed after the surgery will also be accepted.

NEUROSURGERY
- Craniotomy or transoral neurosurgery
- Cranioplasty
- Transsphenoidal pituitary surgery
- Orbital tumour removal
- Removal of spinal cord tumours (intra and/or extra-medullary)
- Anterior or posterior surgery for disc herniation and/or other cervical myelopathy
- Brachial plexus surgery

OPHTHALMOLOGY
- Enucleation surgery
- Cataract and lens surgery, with or without vitrectomy

ENT
- Removal of parapharyngeal, uvula (uvulectomy) and vocal cord (cordectomy) tumours
- Ossicular chain reconstruction
- Surgery for neuroma of the vestibulocochlear nerve

NECK SURGERY
- Total thyroidectomy

RESPIRATORY TRACT SURGERY
- Bronchopleural fistula surgery
- Pulmonary echinococcosis surgery
- Total or partial pneumonectomy
- Nasal polyp procedures

CARDIOVASCULAR SURGERY
- Heart surgery by thoracotomy

- Major thoracic vessel surgery by thoracotomy
- Abdominal aortic surgery by laparotomy
- Endarterectomy of the carotid and vertebral arteries
- Decompression of the transverse foraminal segment of the vertebral artery
- Aneurysm surgery: resection and prosthetic grafting
- Removal of carotid glomus tumours
- Major vessel saphenectomy (great saphenous vein varices only)

DIGESTIVE TRACT SURGERY
- Sleeve Gastrectomy bariatric surgery for BMI >40
- Oesophagectomy (total or partial)
- Surgery with esophagoplasty
- Surgery for megaesophagus
- Gastrojejunocolic fistula surgery
- Total colectomy, hemicolectomy and anterior recto-colic resection (with or without colostomy)
- Rectum-anus amputation surgery
- Anterior or abdominal-perinea surgery for megacolon
- Removal of tumours of the retroperitoneal space
- Drainage of hepatic abscess
- Inguinal or femoral herniation (excluding all other abdominal wall hernias)
- Hepatic echinococcosis surgery
- Hepatectomies
- Gastric resection for ulcers that cannot be treated with pharmacological therapy
- Biliary tract reconstruction surgery
- Portal hypertension surgery
- Laparotic surgery for acute or chronic pancreatitis
- Laparotic surgery for cysts, pseudo-cysts or pancreatic fistulas

UROLOGY
- Adrenalectomy
- Bladder reconstruction with or without ureterosigmoidostomy
- Bladder stones

GYNAECOLOGY
- Hysterectomy with or without adnexectomy

ORTHOPAEDICS AND TRAUMATOLOGY
- Cervical rib surgery
- Vertebral stabilisation surgery
- Resection of vertebral bodies
- Treatment of dissymmetry and/or deviation of the lower limbs with external devices
- Radical surgery for the removal of bone tumours
- Surgical shoulder, elbow, hip or knee replacements
- Carpal tunnel and trigger finger procedures

MAXILLOFACIAL SURGERY
- Oromaxillofacial surgery for facial disfigurations caused by an accident that result in a >25% functional impairment

ORGAN TRANSPLANTS
- All

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SANEDIL FUND

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