BASIC

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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", it should be noted that:

- The contract is governed by the 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 421331.
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.

BENEFITS VALID FOR THE PERIOD
01/06/2021 - 30/09/2022

BASIC

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to the **Healthcare Plan**

WELCOME

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

PERSONS COVERED
BY THE HEALTHCARE PLANCOVERAGE

The Healthcare Plan is provided to **employees who are Sanedil Fund members** and are employed under one of the National Collective Labour Agreements pursuant to article 1 of the Fund's articles of association or that are employees of companies that are members of the Construction Workers' Funds set up by the founding parties of the same Fund and their family members who are fiscally dependent, meaning **the fiscally dependent spouse as per the official family status declaration and fiscally dependent children**.

BENEFITS COVERED
BY THE HEALTHCARE PLAN

BASIC

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

- **HOSPITALISATION FOR MAJOR SURGERY;**
- **HIGHLY-SPECIALISED SERVICES;**
- **SPECIALIST EXAMINATIONS;**
- **CO-PAYMENT FOR DIAGNOSTIC INVESTIGATIONS AND ACCIDENT & EMERGENCY CARE;**
- **REHABILITATION PHYSIOTHERAPY TREATMENTS;**
- **SPECIAL DENTAL TREATMENT;**
- **IMPLANTOLOGY;**
- **ORTHODONTICS;**
- **NON-HOSPITAL 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

Coverage only valid for Members

Hospitalisation means an overnight stay at a healthcare facility. A&E management alone does not constitute hospitalisation. Members who are hospitalised for surgery, as listed in point List of surgical procedures 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.
This coverage is provided exclusively via reimbursement with an annual sub-limit of **€ 1,000.00**, to be shared with the Post-hospitalisation point.

SURGERY

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, MEDICINAL PRODUCTS AND TREATMENTS

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

HOSPITALISATION FEES

Coverage 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, coverage is limited to **€ 50.00** per day for no more than **30 days per hospitalisation**.

PRIVATE INDIVIDUAL NURSING CARE

Individual private nursing care is granted with a limit of **€ 60.00** per day for no more than **30 days per hospitalisation**. This coverage is provided exclusively via reimbursement.

POST-HOSPITALISATION

Tests and procedures and diagnostic investigations, medication, 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), carried out during the **50 days** following the end of hospitalisation, provided they are made necessary by the illness or accident resulting in hospitalisation. Medicines prescribed by the treating physician upon discharge from the medical institution are included in the guarantee. There is an annual sub-limit of **€ 1,000.00** to be shared with the Pre-hospitalisation point.

a1) Services at private or public healthcare facilities affiliated with UniSalute on behalf of the Sanedil Fund and provided by affiliated physicians.
In this case, expenses related to the services provided are paid directly by the Sanedil Fund, through UniSalute, to the affiliated facilities without the application of any excess or fixed excess, with the exception of the following:
- point "Hospitalisation for major surgery after illness or injury":
  - letter "Pre-hospitalisation";
  - letter "Private individual nursing care";
- point "Medical transport";

which are reimbursed to the Insured within the limits of the points specified, and the following:
- point "New-borns"

which is 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 on behalf of the Sanedil Fund and provided by 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 "New-borns", the Member is reimbursed the expenses for the benefits provided with a limit of **€ 8,000.00** 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 after illness or injury":
  - letter "Hospitalisation fees";
  - letter e) "Accompanying person";
  - letter "Private individual nursing care";
- point "Medical transport";

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

c) Benefits provided by the National Health Service
In case of hospitalisation at facilities of the National Healthcare Service or accredited by the same in the form of direct assistance, and therefore with costs entirely borne by the National Healthcare Service, the coverage listed under point "Allowance in lieu" will be activated.
If during hospitalisation the Insured incurs expenses for accommodation or prescription charges, the Fund will fully reimburse any amounts paid in advance by the Insured within the limits of the various points; in addition to the total amount for allowance in lieu. If hospitalisation occurs in external private practice with costs charged to the Insured, the expenses incurred are reimbursed pursuant to the provisions of letter a) "Services at private or public healthcare facilities affiliated with UniSalute for the Sanedil Fund and provided by affiliated physicians" or b) "Services at non-affiliated public and private healthcare facilities".

MEDICAL TRANSPORT

The Fund reimburses expenses for the transport of the Insured in ambulance, with mobile coronary unit and air ambulance to the healthcare facility, transfer from one healthcare facility to another and return to home within a maximum limit of **€ 300.00** 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 tests;
- medical and nursing care;
- surgery;
- treatments;
- medications;
- hospitalisation fees.

NEW-BORNS

The Sanedil Fund, through UniSalute, will pay the expenses for surgical procedures performed in the first 3 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 **€ 6,000.00** 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 **€ 90.00** for each day of hospitalisation for a period of no more than 90 days for each hospitalisation.
NB: 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" coverage in this case are provided without the application of the limits in the section "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 SPENDING LIMIT FOR HOSPITALISATION

The Healthcare Plan sets an annual spending limit of **€ 55,000.00** per insurance year and per Insured. This means that if this amount 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-SPE ALISED SERVICES
Coverage only valid for Members

As an exception to point 18 of the "Non-validity of the Plan" chapter, the Fund will cover the expenses for the following out-of-hospital services:

Conventional radiology (without contrast)
- 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
- Total vertebral column radiography
- Organ or Apparatus radiography
- Intraoral x-rays
- Oesophagus x-ray
- X-ray of the oesophagus, direct examination
- Small bowel series
- 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
- Simple and double-contrast opaque 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 sonohysterography
- Lymphography
- Myelography
- Pneumoencephalography
- Any contrast examination in 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

Ultrasounds
- 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

High-quality diagnostic imaging Computerised Tomography (CT)
- CT-angiography
- Exo- and endocranial CT-angiography
- Multi-slice helical CT (64-slices)
- CT with or without contrast medium

Magnetic Resonance (MR)
- Cardiac cine MRI
- MR angiography with contrast
- NMR with or without contrast medium

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

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

Instrumental diagnostics
- Campimetry
- Dynamic electrocardiogram (ECG) using analogue 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 coverage, a medical prescription containing the working diagnosis or pathology making the service itself necessary is required.

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 **€ 45.00** 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. At the facility, the Insured must present the prescription issued by his/her treating physician describing the medical condition or the 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.
In case of use of non-affiliated healthcare facilities, the expenses incurred are reimbursed with the application of a minimum non-refundable amount of **€ 45.00** for each diagnostic test or treatment cycle.
In order to receive reimbursement from the Fund, the Insured must attach to the copy of the invoice a copy of the request by the treating physician describing the medical condition or the working diagnosis.

In case of use of the National Healthcare Service, the Fund reimburses any fees paid by the Insured with the application of a minimum non-refundable amount of **€ 20.00** for each diagnostic test or treatment cycle.

The annual limit for this coverage is **€ 3,000.00** per Insured.
For "Diagnostic and interventional endoscopy" benefits,
there is an annual sublimit of **€ 300.00** per Member.

SPECIALIST EXAMINATIONS

Coverage applies for both the Member and his/her family

The Sandel Fund, through UniSalute, covers the payment of expenses for specialist consultations resulting from illness or injury, with the exception of dental and orthodontic consultations. Only a preliminary psychiatric examination required in order to ascertain the presence of any medical condition is covered.
To activate coverage, a medical prescription containing the working diagnosis or pathology making the service itself necessary is required.

Expense documentation (invoices and receipts) must show the specialisation of the physician, which, for the purposes of reimbursement, must correspond to the pathology reported.

When **healthcare facilities** and **staff affiliated with UniSalute on behalf of the Sanedil Fund are used**, the expenses for the services provided to the Insured will be paid directly by the Sanedil Fund to the facilities applying a non-refundable minimum of € 35.00 for each specialist examination.
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 uses the **services of a facility or staff that are not affiliated**, **the expenses incurred are reimbursed with the application of a minimum non-refundable amount equal to € 35.00 for each specialist examination.**

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 **€ 20.00** per specialist consultation.

The annual limit for this coverage is **€ 450.00** per family unit.

CO-PAYMENT FOR DIAGNOSTIC INVESTIGATIONS AND ACCIDENT & EMERGENCY TREATMENT

Coverage only valid for Members

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 **€ 20.00** per co-payment:

- for diagnostic investigations (not included under point 4. "Highly-specialised services";
- for Accident and Emergency treatment;

The annual limit for this coverage is **€ 300.00** per Insured.

REHABILITATION PHYSIOTHERAPY TREATMENTS
Coverage only valid for Members

The annual limit for the set of benefits listed below under the points "Rehabilitation physiotherapy treatments following an injury" and "Rehabilitation physiotherapy treatments following temporarily-invalidating illnesses" is **€ 150.00** per Member.

In case healthcare facilities and staff affiliated with UniSalute on behalf of the Sanedil Fund are used, the expenses for the services provided to the Insured will be paid directly by Unisalute to the facilities applying a non-refundable minimum of **€ 35.00** per 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 **€ 35.00** 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 € 20.00 per treatment cycle**.

REHABILITATIVE PHYSICAL THERAPY FOLLOWING INJURY

Notwithstanding the provisions of the section "Non-validity of the Plan" under point 18, the Fund provides for the payment of expenses for physiotherapy after injury, exclusively for rehabilitation purposes, in the presence of an A&E certificate, provided that treatment is prescribed by a primary care physician or specialist whose specialisation is pertinent to the reported medical condition, and is provided by a medical or healthcare professional qualified in rehabilitation therapy, whose qualification must be indicated on the expense documentation.
This coverage 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

Notwithstanding the provisions of the section "Non-validity of the Plan" under point 18, the Fund provides for the payment of expenses for physiotherapy after a temporarily-invalidating illness as per the list below, exclusively for rehabilitation purposes, provided that treatment is prescribed by a primary care physician or specialist whose specialisation is pertinent to the reported medical condition, and is provided by a medical or healthcare professional qualified in rehabilitation therapy, whose qualification must be indicated on the expense documentation.
This coverage 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
Coverage applies for both the Member and his/her family

Notwithstanding the provisions of 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 for the whole family** at healthcare facilities affiliated with UniSalute on behalf of the Sanedil Fund, and which must be booked in advance. The services described below, comprising the aforementioned "package", are designed to monitor any existence of pathological conditions, although not yet manifested, and are particularly recommended in case of familial occurrence.

Tartar removal (with or without a check-up) using ultrasound, or alternatively, if necessary, other types of oral hygiene treatment.

If, due to particular clinical and/or medical conditions of the Insured, the practitioner finds, in agreement with the Fund, it is necessary 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 planning, fissure sealing, etc., shall be at the Insured's expense.

If **healthcare facilities** and **staff affiliated with UniSalute on behalf of the Sanedil Fund** are used, the expenses for the services provided to the Insured will be directly paid by then Sanedil Fund to the facilities themselves with the application of a co-payment of **40%**, which must be paid by the Insured to the healthcare facility at the time of invoicing.

IMPLANTOLOGY
Coverage applies to the Member and fiscally dependant spouse as shown on the Family Status Declaration

Notwithstanding the provisions of the section "Non-validity of the Plan" under point 3, the Fund will cover the expenses for the benefits listed under the points:

The annual limit to be shared between the Member and the fiscally dependant spouse for the dental implantology benefit is **€ 1,680.00**.

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 corresponding reports.

PLACEMENT OF THREE OR MORE IMPLANTS

This benefit applies in case of placement of three or more implants indicated in 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 **€ 1,050.00**.
The benefit includes the placement of the implant, the definitive restoration, the provisional restoration and the dental post/abutment for the 2 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 **€ 1,050.00** provided for by this cover, minus any sums that have already been authorised or paid.

PLACEMENT OF ONE IMPLANT

For the placement of an implant indicated in the treatment plan, there is an annual expense sublimit of **€ 525.00**.
Coverage includes the placement of the implant, the definitive element, the provisional element and the dental post related to 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

Coverage applies for both the Member and his/her family

The benefit applies for the extraction of 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.

ORTHODONTICS
Coverage valid for fiscally dependent minors

Notwithstanding the provisions of the section "Non-validity of the Plan" under point 3, the Fund will cover the expenses for the benefits listed below.:
If **healthcare facilities** and **staff affiliated with UniSalute on behalf of the Sanedil Fund** are used, the expenses for the services provided to the Insured will be directly paid by the Sanedil Fund to the facilities themselves with the application of a co-payment of **40%**, which must be paid by the Insured to the healthcare facility at the time of invoicing.

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

The annual limit for this coverage is **€ 1,200.00** per family unit.

NON-HOSPITAL DENTAL SURGERY
Coverage applies for both the Member and his/her family

Notwithstanding the provisions of the section "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
- odontoma
- removal of displaced implant in the maxillary sinus.

To activate coverage, a medical prescription containing the working diagnosis or pathology making the service itself necessary is required.

The healthcare documentation required in order to obtain the reimbursement of the expenses incurred consists of:
- 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 coverage is **€ 2,000.00** per family unit.

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
Coverage applies for both the Member and his/her family

Notwithstanding the provisions of the section "Non-validity of the Plan" under point 3, the Fund for the payment of services for conservative dental care.

If **healthcare facilities** and **staff affiliated with UniSalute on behalf of the Sanedil Fund** are used, the expenses for the services provided to the Insured will be directly paid by the Sanedil Fund to the facilities themselves with the application of a co-payment of 40%, which must be paid by the Insured to the healthcare facility at the time of invoicing.
If the Insured makes use of the **National Health Service**, the Company fully reimburses the subsidised medical expenses incurred by the Insured.

The annual limit for this coverage is **€ 120.00** per family unit.

SPECIAL DIAGNOSTIC SERVICES
Coverage only valid for Members

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 above
- Alanine transaminase ALT
- Aspartate transaminase AST
- HDL cholesterol
- total cholesterol
- Creatinine test
- Complete blood count and morphological examination
- Gamma GT test
- Blood glucose
- Triglyceride level test
- Partial thromboplastin time (PTT)
- Prothrombin time (PT)
- Blood urea nitrogen
- ESR
- Urine; chemical, physical and microscopic examination

For women 18 years of age and over: Smear test

ORTHOPAEDIC AND ACOUSTIC IMPLANTS
Coverage only valid for Members

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

The expenses incurred are reimbursed with a co-payment of 20% and a minimum non-refundable amount of **€ 100.00** per invoice/person.

The annual limit for this coverage is **€ 300.00** per Insured.

LENSES
Coverage applies for both the Member and his/her family

The Fund will reimburse expenses incurred for corrective 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 or an optometrist whose qualification is indicated on the documentation certifying the change in vision is required to use the benefit.

The annual limit for this coverage is **€ 50.00** per family unit.

SEVERE IMPAIRMENT RESULTING FROM PERMANENT DISABILITY FOLLOWING OCCUPATIONAL ACCIDENTS OR SEVERE MEDICAL CONDITIONS
Coverage only valid for Members

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 coverage is **€ 4,200.00** per Insured.
This limit can be used for the first three years of this Healthcare Plan.

MONITOR SALUTE SERVICE
Coverage only valid for Members

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 (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.
To activate coverage, a medical prescription containing the working diagnosis or pathology making the service itself necessary is required.
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 Insured makes use of the National Health Service, the Fund fully reimburses the subsidised medical expenses incurred by the Insured.

The annual limit for this coverage is **€ 300.00** per Insured.

MATERNITY/PREGNANCY
Coverage only valid for Members

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 Insured makes use of the National Health Service, the Fund fully reimburses the subsidised medical expenses incurred by the Insured.

COVID-19 SECTION
Coverage only valid for Members

DAILY HOSPITALISATION ALLOWANCE IN THE CAS 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** within the membership year for each Member.
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 a maximum of **30 days**.

THE DAILY HOSPITALISATION ALLOWANCE AND THE POST-HOSPITALISATION ALLOWANCE ARE NON-ACCUMULABLE.

SERVICES AT UNISALUTE DISCOUNTED RATES
Coverage applies to the entire family

If any service is not covered because Healthcare Plan cover does not apply or 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 coverage provided; in this case, 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 for the elimination or correction of physical defects* or malformations** already existing at the time the Plan is concluded, unless indicated under the point "New-borns".
2. the treatment of mental illness and psychological disorders in general, including neurotic behaviour;
3. dental prosthetics, 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 accidents 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 need of the Insured 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 the member's physical conditions for which recovery with medical treatment is no longer possible, requiring admission to a healthcare facility 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. injuries 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. injuries caused by malicious acts committed by the Member;
14. consequences of attempted suicide, self-harm and criminal acts committed by the insured 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:

- aesthetic implants;
- treatment 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", the Healthcare Plan is not valid for the consequences:
- 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 policyholder reaches the age of 70; the plan is automatically discontinued upon the first annual expiry after the Insured turns 71.

MANAGEMENT OF EXPENSE DOCUMENTATION (INVOICES AND RECEIPTS)

A) Benefits provided by healthcare facilities affiliated with UniSalute for the Sanedil Fund

Expense documentation for healthcare benefits provided at affiliated healthcare facilities is directly delivered to the Insured 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 requests the Insured to provide original documentation, on a monthly basis the original documentation only will be returned.

The documentation attached to the claim form (invoices, receipts, doctor's prescriptions, medical records, etc.) must be submitted as copies. The Fund may, at its unchallengeable discretion, at any time, request the submission of the original documentation, in order to carry out the appropriate checks. 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.

ATTENTION:
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-medullar)
- Anterior or posterior surgery for disc herniation and/or other cervical myelopathy
- Brachial plexus surgery

OPHTHAMOLOGY
- 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 SYSTEM
- Bronchopleural fistula surgery
- Pulmonary echinococcosis surgery
- Total or partial pneumonectomy
- Nasal polyp procedures

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

DIGESTIVE SYSTEM
- Sleeve Gastrectomy bariatric surgery for BMI >40
- Esophagectomy (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
- Surgery for acute or chronic pancreatitis by laparotomy
- Surgery for cysts, pseudo cysts or pancreatic fistulas by laparotomy

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

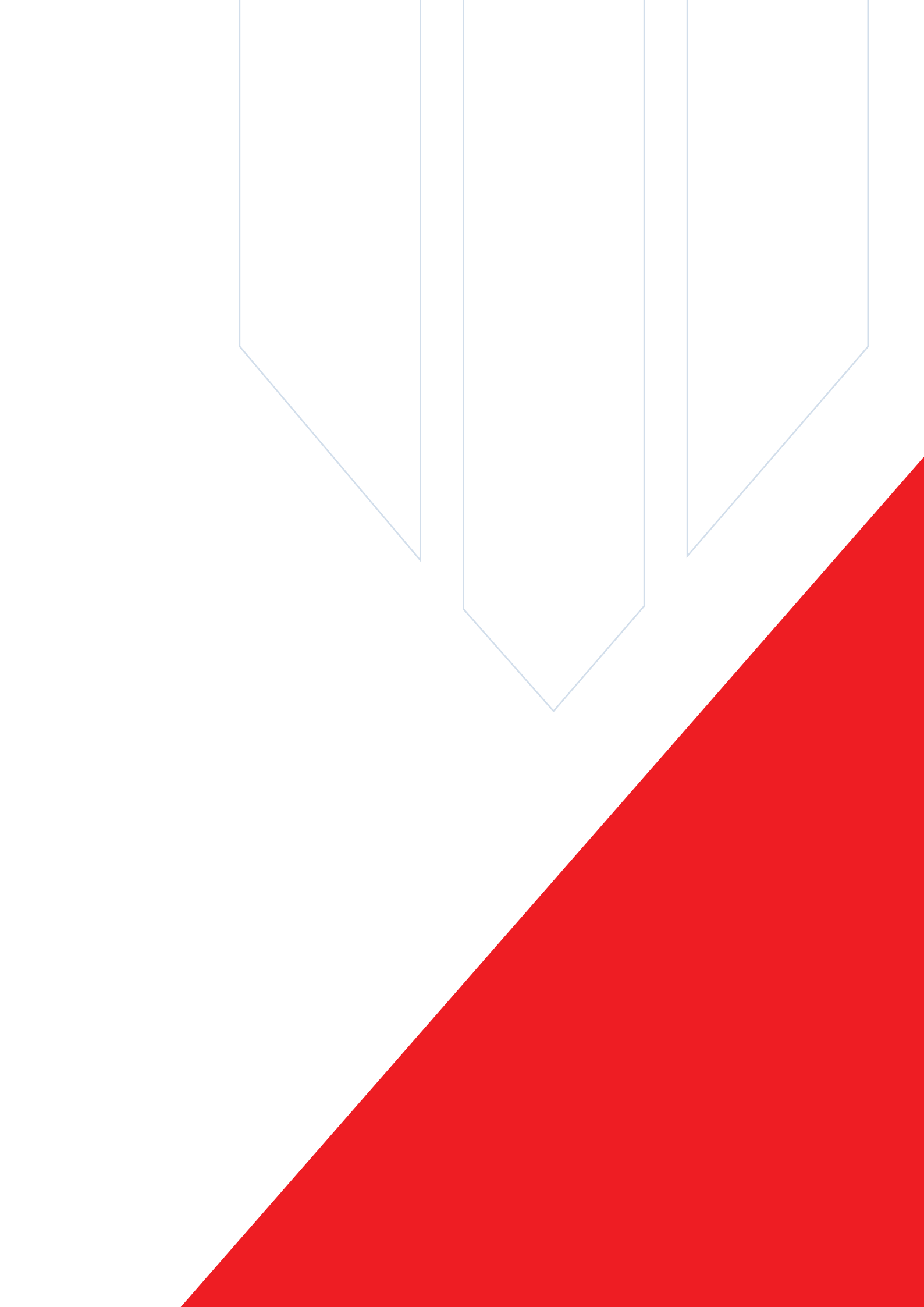
- Resection of vertebral bodies
- Treatment of dissymmetry and/or deviation of the lower limbs with external devices
- Radical surgery for the removal of bone tumours
- Surgical replacement of shoulder, elbow, hip or knee
- Carpal tunnel and trigger finger procedures

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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