Purple Health Plan

Guide for clients

+ Services
+ Well-Being
+ Welfare

FasiOpen

Open Fund for Supplementary Health Care

*Modern and efficient **Supplementary Health Care** for your company's employees and their families*

Fasi

V1.0.R5.23

A useful tool to make the best use of the **Purple Plan**

GUIDE FOR CLIENTS

FasiOpen has an extensive network of affiliations for "Direct Provision" care

This Guide sets out the Covers offered by the FasiOpen "PURPLE" Health Plan and therefore identifies, within the individual Covers, a series of services/treatments included in the cover, the financial conditions and any further information beyond that contained in the FasiOpen Basic Nomenclature.

The Guide is therefore a useful tool for making best use of the opportunities offered by the Health Plan.

We encourage you to carefully read the information in the FasiOpen Basic Nomenclature and that shown here to avoid making refund claims that are not in-line with the information provided in your chosen Health Plan (for example services that fall within FasiOpen's general area of activity but are not included in your Health Plan, non-refundable treatments, covers that are not included, etc.), delays in the assessment and refund process, and possible payments that do not meet with expectations.

Without prejudice to a people's right to a "freely choose" their healthcare facility and/or qualified professional in Medicine and Surgery and/or Dentistry and Dental Prosthetics (duly qualified and recognised by the competent Authorities) for the provision of services, and in order to fully satisfy the needs of its clients, FasiOpen has extended its offering for some Covers by also granting refunds for services via some previously excluded forms of access. We remind you that FasiOpen has an extensive network of direct affiliations with nursing homes, dental surgeries, hospital/university facilities, diagnostic polyclinics, physiotherapy centres, day hospitals and day surgeries.

At affiliated facilities belonging to the network recognised by the Fund, the health services provided - within the limits and ceilings set out in the respective Health Plans - are fully paid for by FasiOpen.

The "Direct Provision" care provided in these facilities allows clients to avoid paying in advance, with the exception of any excesses if specified and any normal incidental expenditure (e.g. phone calls, copies of medical records, extra services, etc.) and always within the financial limits specified in each individual Health Plan.

CONTENTS

FASIOPEN HEALTH CARE

FasiOpen has its own Basic Nomenclature, which is a list of services recognised as falling within its area of activity. A Health Plan is a set of Covers which themselves, in turn, contain a set of services. The services recognised as refundable by FasiOpen are, therefore, only and exclusively those explicitly set out in the Basic Nomenclature provided that they are simultaneously covered by the Cover/s in your Health Plan within the specified financial limits.

Each chapter regarding the individual Covers lists the services, methods and the amount of contribution towards the cost by the Fund, as well as the procedures that must be followed to request a refund. Useful information is thus provided on the correct way to follow the procedures, as well as a glossary of the terminology used (which can also be viewed in the Basic Nomenclature).

INFORMATION CENTRE FREEPHONE NUMBER

800 085 502

The FasiOpen Information Centre is available to clients for any information or clarification

WHO CAN SIGN UP

FasiOpen can be joined solely by Companies and Funds/Third-party Funds that decide, on the basis of regulations, company agreements or collective labour agreements, to benefit from the supplementary social-health care assistance provided by FasiOpen.

A company can sign up only for the benefit of a community of employees identified as belonging to one or more homogeneous employee categories and, in all cases, without any selection of the risk.

Companies, Funds and Third-party Funds that decide to benefit from the supplementary healthcare provided by FasiOpen

WHO IS COVERED

Eligible for cover by FasiOpen are communities of employees at companies that have fully signed up to FasiOpen.

Cover can be extended, upon request and for an additional premium, also to members of the employee's entire family unit.

Family unit eligible for cover

The family unit eligible for cover includes:

1. spouses;
2. de facto cohabiting partners of employees;
3. children up to 18 years of age, provided that they are dependent on the employee for tax purposes;
4. children up to 21 years of age, provided that they are dependent for tax purposes and currently carrying out pre-university or university faculty studies;
5. children up to 26 years of age, provided that they are dependent for tax purposes and for the duration of their university studies;
6. children, without restrictions of age, if totally disabled with a disability percentage of at least 67%, substantiated by a certificate issued by the relevant authorities.

Cover for the family unit formally registered with the Fund is provided for as long as the employee remains associated with FasiOpen.

With regard to this we remind you that the granting of refunds for healthcare services by the Fund also depends on the company, and therefore the employee that holds the healthcare cover, having its/his/her administrative position in order at the moment of invoicing the balance for the services/treatments (always if provided for by the Covers of his/her Healthcare Plan).

"INDIRECT PROVISION" SERVICES

How to request a refund

To obtain an indirect provision refund from FasiOpen of healthcare expenditure paid directly by yourself as a client (for services received, therefore, at a healthcare facility not belonging to the network recognised by FasiOpen), within the limits specified in your Health Plan, you must forward the expenditure documents directly from your private area. The Refund will be paid to the main client by bank transfer, using the account details communicated by the company belonged to (other methods are not available). It is therefore vitally important for clients to check the accuracy of the data communicated to and therefore held by FasiOpen by accessing their personal home page (via individual password and personal code). In limited cases in which a bank transfer is not possible, the refund will be paid by drawing cheque sent at the client's own risk. Alternatively, and again in limited cases, it is possible to submit refund requests on hard copy using the "Healthcare Expense Refund Request" form, attaching a photocopy of the expenditure documents and the healthcare documentation; the form can be downloaded from www.fasiopen.it, located in your private area/personal home page. In this case Refund requests should be sent, via recorded delivery, to the FasiOpen Operational Headquarters, Viale Europa, 175 – 00144 Roma.

We remind you that sending requests in non-physical form requires less time for processing and that, regardless of the despatch method, a request must be made for each person who has received treatment and that the expense documentation must be in the name of the person who has received the services/care (in the case of minors, even if the invoice is in the name of the FasiOpen membership holder, the name of the minor receiving treatment must be clearly indicated on the invoice, since the person for whom the expenditure receipt was issued must always be identifiable as required by the tax regulations).

It is therefore not possible to submit an expenditure receipt for services received by multiple family members/clients, regardless of the method of submission and regardless of the form of access (direct or indirect).

To avoid hindering payment procedures, we request that you do not send receipts for expenditure relating to "Direct Provision" services and/or documentation for services not covered by FasiOpen in general and/or not provided for in your Health Plan.

Terms of Presentation

Refund requests must be fully completed and sent to FasiOpen online via the client's home page - within and no later than three months after the issue date of the balance expenditure documents for which the refund is requested (art. 13 of the Regulations currently in force). For example: copies of invoices/receipts issued on 1 January must be sent no later than 1 April of the same year.

For refund requests for services that do not require documentation of expenditure, such as payment of an allowance/daily allowance (for major surgery or childbirth), the deadline for submission is three months from the date of discharge from hospital; in this

case, in addition to the request it is a mandatory requirement that you send a complete medical record legible in every part. Refund requests (with expenditure documentation or without it as in the case of allowances) sent after the above deadlines will be rejected.

Expenses relating to third party liability

In the event of a claim relating to third party liability, as referred to in article 13 of the Regulations currently in force, services are provided - if envisaged, and limited to the provisions of the individual Covers - subject to the client sending two certifications, the texts of which will be issued by FasiOpen when required (and are also downloadable on www.FasiOpen.it), in which the person concerned undertakes to pay the Fund, up to the sum due for the services themselves, any money received in compensation from any person, for whatever damages they have been held responsible for, within 30 days of receipt of the money.

Medical records and medical certifications

The explanatory documentation that must be sent, together with receipts for expenditure in order to proceed with payment, is set out in detail in each Cover (see following chapters).

In the event of hospitalisation, both with night-time stay and daytime stay (for Covers/Health Plans that provide for this), with or without surgery (for Covers/Health Plans that provide for this), it is essential, regardless of how the treatment is received, to send a complete copy of the relevant medical record, if possible in digital format.

The medical records must also show requests for consultations with specialisations other than that of the treating medical-surgical team, the diagnostic issue for which consultations are requested and the relevant medical reports/references of the specialists consulted.

Please note that in no cases will refunds be made for cosmetic services and/or anything else included in the exclusions or associable with them, regardless of whether they are received in the course of hospitalisation for another pathology included in the Covers of your Health Plan.

FasiOpen reserves the right to request a transcript of medical records if the documentation is not legible and/or to request a translation if the documentation is in a foreign language (particularly if produced in Oriental and/or Arab countries).

Services/treatments received in foreign countries

FasiOpen will also give financial support for costs incurred abroad at healthcare institutions and/or specialist physicians to the same extent and under the same conditions as for treatments carried out in Italy.

Reference should therefore be made to the FasiOpen Basic Nomenclature, without prejudice to the fact that any services/treatments must be included in the Covers of your Health Plan (therefore if a service is included in the Basic Nomenclature but not in the Covers of your Health Plan it will not be paid for by the Fund, even if it falls within the scope of the Fund's healthcare activities).

Procedures for submitting refund requests, all time and/or quantity and/or age and/or gender limits, deadlines for the submission of requests, and all medical documentation

therefore also remain applicable for treatments received abroad.

To enable the correct financial evaluation of services we suggest that you obtain the broadest possible documentation clarifying all the services carried out.

In addition to the expenditure documentation, the Fund reserves the right to also request submission of the payment/balance receipt for services received. In this event, since the Fund pays refunds in euro, the currency conversion will take place according to the date on the payment receipt.

Dentistry

From 1 January 2022 onwards FasiOpen will also recognise refunds for “Indirect Provision” dental services under the conditions and within the time and financial limits set out in the individual Cover. It will therefore also recognise as refundable services provided by a professional who is qualified by the competent Authorities and/or by a qualified healthcare facility not included in the network recognised by the Fund (always within the limits contained in the Cover).

No contribution towards costs is envisaged for dental services provided during hospitalisation (any type), regardless of the reason for hospitalisation. Dental services will be recognised as refundable only if they are carried out on an outpatient basis.

Please note that dental services, regardless of the Health Plan, are subject to time limits for refund, and that for certain items there is a mandatory requirement to submit pre- and post-treatment documentation as well as a preventive treatment plan (using the specific indirect provision form where applicable). There is no need to wait for the outcome of the preventive treatment plan assessment to begin any treatment that you need; the Fund's assessment procedure is purely administrative, and in no way enters into the merits of the treatment decision made by your dentist and/or the healthcare facility.

The outcome of the treatment plan assessment is intended to highlight any medical-administrative incompatibilities between the service codes identified, particularly with regard to “Services not included in the client's health plan”, “time limits for refund” and “mandatory requirements” specified for the individual services.

To clarify further, please note that dental services are attributed to the individual teeth/sites/arches/hemiarches based on the invoice date for the balance of the services themselves. Thus, for example only, if a filling is refundable once every 3 years on a certain tooth and is refunded with an invoice dated 3/03/2021, this will not be recognised as refundable again for the same tooth before 04/03/2024.

The evaluation of time limits and/or compatibility between service codes/items is made based on services being requested simultaneously (those already settled at the time of examining the “Treatment Plan” sent), and clearly cannot consider requests still being prepared and/or those that have not yet arrived at the Fund and/or those that are not shown in any obligatory healthcare documentation.

For this reason, in limited cases, even if a service has a positive outcome from the medical assessment of the treatment plan, it may come up as non-payable when the refund request is examined because it “exceeds the limits” or because the service shown on the treatment plan is different from that carried out or incompatible with the services paid for or those appearing in the medical documentation.

Please remember that refund requests must be fully completed and sent to FasiOpen within and no later than 3 months after the date of invoice for the balance of the services

that you wish to request from the Fund.

While reminding you that expenditure documentation must always be in the name of the client for whom the treatment has been carried out (in the case of minors, even if the invoice is in the name of the FasiOpen membership holder, the name of the minor receiving treatment must be clearly indicated on the invoice since the main person must always be identifiable as required by the tax regulations), and that it is not possible to submit an expenditure receipt for expenses relating to services received by more than one family member/client, we underline that invoices for payments on account are not refundable:

- ✓ An invoice on account is an invoice with no particular correlation between payments and the treatments carried out and completed, and must be sent together with that for the partial balance or balance of the treatments themselves. Example: the dentist issues a quotation to the member/client for 2 fillings at € 100.00 each. Total treatments quoted at € 200.00. The member/client pays an invoice of € 150.00. This latter invoice is a payment on account for the treatment plan agreed with the dentist because it is higher than the value of one filling but less than the value of both the treatments planned. In this example, therefore, the invoice for € 150.00 is for a payment on account which must be submitted together with the balancing invoice (of € 50.00).
- ✓ A partial balance invoice is an invoice that specifically refers to part of the treatment already carried out and completed, although others are still under way. We therefore call your attention to the fact that, although an invoice has “on account” in its description, it is considered to be a “partial balance” if an exact correlation between the amount and the completed services can be identified. Example (based on the previous example): the member/client pays an invoice on account of € 100.00 and the invoice includes the words “on account”. This, according to the previous example, appears to be a payment on account in the context of the relationship between the member/client and the dentist, but is actually a partial balance invoice because it is strictly associable with a completed treatment (a filling costing € 100.00). This invoice must therefore be submitted within 3 months from the date of issue.
- ✓ A balance invoice is an invoice that closes the accounts for treatments carried out and completed. Continuing with the examples given previously: a balance invoice of € 50.00 to be associated with the invoice on account (first example) of € 150.00, to be sent within 3 months from the date of issue of the balance invoice. Or another example: invoice for € 200.00 (total value of the 2 fillings) to be sent within 3 months from the date of issue.

Further information will be provided in the relevant Cover.

Diagnostic Tests

Diagnostic tests are recognised as refundable within the limits of whatever is provided for (if anything) by the Covers of the individual Health Plans.

To obtain the specified refunds, limited to what is provided for by the Covers, you must send - together with the relevant invoices - details of the services provided as well as the **prescription of the specialist physician and/or treating general practitioner indicating the type of pathology that made the tests themselves essential (further specifying pre-surgery and/or post-surgery tests where applicable)**.

FasiOpen reserves the right, however, to request a copy of the diagnostic reports should the need arise for further inspection

In view of the different Regional laws, in the event of the simultaneous payment of public healthcare charges and private services not recognised by the S.S.R. (Italian Regional Health Services), with both appearing on the same healthcare receipt, you must ask the healthcare facility to specify the amount (and therefore the services) relating solely to the public healthcare charges.

All tests are refunded, as set out and within the limits indicated in the Basic Nomenclature, if they are included in the Covers your Health Plan, including genetic analyses (only those indicated in the Nomenclature and included in the Health Plan within the limits set out by the Covers) carried out solely for diagnostic-therapeutic purposes and according to the diagnostic protocols sanctioned by conventional medicine.

Preventive (predictive) medicine, experimental and/or research and/or alternative services are strictly ineligible for refund.

For radiological tests and diagnostic tests using nuclear medicine, the items relate to complete examinations of projections and the number of x-rays needed for an exhaustive test to be provided.

The items also include the professional fees of radiologists or nuclear medicine specialists and other specialists/technicians, where involved, the contrast media, materials, medicines and other items except as expressly stated in the specific conditions of the branch displayed for each sub-section. Please note that, for Health Plans without refunds on a case-by-case basis, the contrast medium is considered to be a service in its own right; therefore any fixed and percentage excesses will also be applied to the “contrast medium” item, and this too will partly reduce the refund ceiling envisaged, if any, by the Cover.

Any anaesthesiological care for diagnostic and/or invasive tests, where necessary, is included in the item specified for the individual test, except as specifically described by FasiOpen.

For some diagnostic tests, if included in your Health Plan and in particular for the direct provision services regardless of the Health Plan, there is a 50% reduction on the second test (or the financially less expensive one).

Please note that the term “during the same session” means during the same access to the healthcare facility; thus, in the case of two tests carried out, the 50% reduction (where applicable) will be applied if a different moment of access is not unequivocally detectable (different day of the test being carried out).

Molecular genetic tests are included in the Diagnostic Tests section. With regard to this, please note that tests are refundable only and exclusively if included in your Health Plan

within the individual Covers (and limited to the contents of these). Only Molecular Genetics tests explicitly mentioned in the Basic Nomenclature (and if provided for by the Covers in your Health Plan) are refundable, and only if carried out for diagnostic-therapeutic purposes (thus excluding those relating to research and/or experimentation and/or prevention and/or prediction).

Molecular Genetics and/or cytogenetic tests pre- and post childbirth are refundable (if covered by the Cover in your Health Plan) only if prescribed by a Physician-Surgeon specialising in Medical Genetics (clinical genetics) or specialising in Oncology. No other possibilities are available.

The tests, even if of considerable importance and included in the Covers of the individual Health Plans, will not be recognised as refundable if prescribed by professionals, regardless of specialisation, other than those expressly specified.

Finally, please note that, since the results of many Molecular Genetics tests do not change over time, these will be recognised as refundable only once; we therefore recommend that a copy of these results is retained (the Fund cannot provide copies of any that it is sent in relation to refund requests).

Nursing Care

FasiOpen recognises refunds for Nursing Care during overnight hospitalisation if this is explicitly provided for in your Health Plan. By Nursing Care during overnight hospitalisation we mean private and individual assistance provided by nursing staff in addition to that regularly provided by the healthcare facility as a part of its nursing care in the ward (non-hospital activities). For the refund to be recognised it must be clear that the aforementioned nursing care does not overlap with other hospital activities and that it is unequivocally restricted to the individual member/client. Any refund, if envisaged by the Health Plan, is understood to be daily (24h) for a minimum number of 6 hours of care (whether daytime or night-time).

Public Healthcare Charges

Public Healthcare Charges, which must always display details of the services provided, are refundable - within the maximum limits specified by the individual Covers of the individual Health Plans - **only if they relate to the specialist services expressly included in the member's/client's Health Plan**, and are subject to the same quantity and/or time limitations as those envisaged for each service (as also specified in the Nomenclature).

It follows that a service, even if received through payment of Public Healthcare Charges and present in the FasiOpen Basic Nomenclature, cannot be recognised as refundable by FasiOpen if not included in the Covers of your Health Plan.

Please note that Public Healthcare Charges are a different item of expenditure to the Fixed Fee introduced in the 2011 Budget and the Additional Fixed Prescription Fee Contribution.

In view of the different Regional laws, in the event of the simultaneous payment of public healthcare charges and private services not recognised by the S.S.R., with both appearing on the same healthcare receipt, you must ask the healthcare facility to indicate which amount refers only to the public healthcare charges and/or which amount refers to privately received services.

Surgical Packages

In order to streamline procedures for sending refund requests on the part of clients and healthcare structures belonging to the network recognised by FasiOpen, surgical packages have been introduced for some procedures already included in the Fund's area of activities.

For Cover-based Health Plans nothing changes with respect to the previous valuation, since Packages still operate according to and within the limits of what - if anything - is provided for by the Covers that include them.

The Package approach, for direct provision services, enables access to surgical procedures at more financially favourable rates for the member/client.

“Package-based” services are treated as being related to a surgical operation as a single stage, i.e. the hospitalisation/surgical procedure is the only procedure carried out during a hospital stay.

If the operation/procedure is instead carried out during hospitalisation for another surgical operation (for which the package approach is not available), an additional item called a “concurrent operation” will be available in the Nomenclature that provides for a different monetary sum (ascribable, therefore, if the operation is not the main phase of the surgical procedure). In this case, and only for this type of operation, the valuation for refund purposes will be 100%.

Prevention

For Health Plans that have them, the Fund has expanded the range of Prevention Packages.

The member/client can freely choose 1 Prevention Package per year from those listed below (if included in his/her Health Plan), bearing in mind that 1 prevention package is refundable per year but that the same package is not refundable before another 2 years have elapsed.

The Prevention Packages are:

- ✓ Cardiovascular Prevention for Women - age 45 or over
- ✓ Cardiovascular Prevention for Men - age 45 or over
- ✓ Oncological Prevention for Women - age 45 or over
- ✓ Oncological Prevention for Men - age 45 or over
- ✓ Ophthalmic Prevention (Men/Women) - age 40 or older
- ✓ Thyroid Cancer Prevention (Men/Women) - age 45 or over
- ✓ Melanoma Prevention (Men/Women) - age 50 or over
- ✓ Dysmetabolic Syndrome Prevention (Men/Women) - age 50 or over
- ✓ Cancer of the Oral Cavity Prevention (only in the dental context, direct provision services - if envisaged by your Health Plan) - age 45 or over

For details of tests included in the individual packages, please refer to your Health Plan (if it envisages these).

Allowance for Childbirth Hospitalisation and/or allowance in lieu of overnight hospitalisation following Surgery

In a way limited to specific Health Plans, and wherever and within the limits individually provided for by them, FasiOpen recognises refunds exclusively in relation to indirect provision services for:

- ✓ Childbirth Hospitalisation Allowance
- ✓ Allowance in lieu of overnight hospitalisation following Surgery (specified by your Health Plan).

We underline that these refunds are recognised only when hospitalisation took place with the S.S.N (Italian National Health Service) and no refund is required and/or has not been requested from FasiOpen in relation to overnight hospitalisation and/or services connected with hospitalisation for surgery (diagnostics, specialist consultations, therapies, pre- and post-operation tests, transport by ambulance, etc.). The above allowance/daily allowance items will not be recognised as refundable in cases of surgical hospitalisation that is not included among the operations specified in Cover 1 and/or Cover 1.2 (if provided for) in your Health Plan.

To clarify further, please remember that a refund for an allowance (whatever type) is recognised only for the client receiving treatment, i.e. only and exclusively for the person directly receiving the treatment/therapy, if he/she belongs to the family unit registered with the Fund when hospitalisation began, regardless of the “patient's” age, i.e., no additional allowance is recognised for any family member staying in hospital to assist the patient.

The refund request for the allowance, where provided for in the Health Plan and without prejudice to the requirements for recognition of the request, must be received within and no later than 3 months after the date of discharge. With regard to this please remember that you must also attach with the application a copy of the medical record relating to surgery with overnight hospitalisation and/or relating to hospitalisation for childbirth.

Transportation by Ambulance

FasiOpen recognises a contribution towards the cost of “Transport by Ambulance”, limited to indirect provision services and exclusively within Italy.

Transportation by Ambulance is recognised as refundable only for serious pathologies in which clients/patients cannot be transported, with own means, from their home to the chosen healthcare facility for hospitalisation and vice versa. Hospitalisation means an overnight stay in a nursing home or hospital. Therefore, notwithstanding that the only recognised means of transport is an ambulance, no refund is recognised in the case of transport for ongoing therapies such as (but not limited to) chemotherapy, dialysis, physiokinesis therapy, etc. Please also note that the service recognised does not refer to emergency transport but only to planned hospitalisations.

No contribution to the cost of transport is recognised as refundable for transfers from one nursing home or hospital to another nursing home or hospital.

Non-refundable services

To avoid hindering payment procedures, we request that you do not send receipts for expenditure relating to services not covered by FasiOpen (for example: psychotherapy

if not specifically included in your Health Plan, beauty treatments and operations, etc.), as set out in the example list of "services not covered by FasiOpen". Likewise, do not send receipts for expenditure relating to services not included in the Health Plan chosen.

Services/treatments/operations not expressly mentioned and not included in your Health Plan must be deemed non-refundable, even if they are among the areas of activity of the Fund (FasiOpen Basic Nomenclature).

Photocopies of invoices/receipts

FasiOpen allows submission of refund requests for health services (those included in your Health Plan) only via the online channel. The Fund does not return expenditure receipts whether or not it receives these in their original paper form and/or as copies. Likewise, the Fund does not provide copies of expenditure receipts for direct provision services. If requested by the tax authorities during their assessment of income tax returns, FasiOpen undertakes to forward copies of documents it has been sent, with the related costs of doing so chargeable to the member/client receiving them (despatch charged to the recipient).

Information Centre

The FasiOpen Information Centre is available to clients on freephone 800 085 502, open Monday to Friday from 9 AM to 5 PM non-stop. If you contact the Information Centre:

- ✓ Option 1 Clients
  - Dial 1 Health information - Services - Care plans
  - Dial 2 Administrative information - Contributions
- ✓ Option 2 Companies
  - Dial 1 Registered companies or In the process of registration
  - Dial 2 Non-registered companies and general information.

Personal Home Page

You can access your own **personal home page** by going to www.fasiopen.it and entering your personal code and individual password. Through this page you can:

- ✓ Submit online dental treatment plans, where applicable;
- ✓ send online refund requests;
- ✓ check that FasiOpen has received a dental treatment plan request;
- ✓ check that FasiOpen has received a refund request;
- ✓ check the outcome of the dental treatment plans (being processed, processed, outcome available);
- ✓ check the outcome of refund requests (in assessment, paid);
- ✓ check your personal details;
- ✓ print the necessary forms (refund request form, change in personal details form, treatment plan form, etc.);
- ✓ change and/or renew your password;
- ✓ print the outcome of the dental treatment plans;
- ✓ print the payment details for your refund requests.

“DIRECT PROVISION” SERVICES

All ”Direct Provision” affiliated healthcare facilities (nursing homes, day hospitals, day surgeries, physiotherapy centres, diagnostic polyclinics, hospitals, university polyclinics, scientific institutes for hospitalisation and care, dental surgeries) are connected telematically. This connection enables these healthcare facilities to receive authorization for requested services **in real time 24 hours a day, 365 days a year**, always in compliance with the terms specified in the chosen Health Plan as well as with the specific and **more favourable tariffs** agreed with the healthcare facilities themselves for the benefit of clients.

This direct telematic connection is available for all “Direct Provision” services offered by the facilities and their physicians. For any services that cannot be carried out via “Direct Provision” within these affiliated healthcare facilities, the simultaneous and immediate authorisation of these services will not be possible.

In these cases only “Indirect Provision” services can be provided, i.e. upon payment of the relevant costs by clients, who must then request the relevant refund, if envisaged, from FasiOpen in accordance with the terms of the regulations and their chosen Health Plan.

In the latter case, the procedure is the same as for services provided at non-affiliated healthcare facilities: you must submit t**he expenditure documentation in the dedicated section on your personal page** accompanied by the **requested health documentation**.

INFORMATION CENTRE FREEPHONE NUMBER

800 085 502

The FasiOpen **Information Centre** (**Freephone 800 085 502**, open from 9 AM to 5 PM Monday to Friday) is available to clients for information on all the available types of affiliated healthcare facilities, on those branches of medical and surgical treatment available via “Direct Provision”, and on those without direct affiliation agreements.

"Direct Provision" services

Validity of "Direct Provision" refund authorisations for hospitalisation

IMPORTANT

Hospitalisations in direct affiliation agreements can be authorised subject to any limitations specified in your Health Plan:

- ✓ for a maximum of 12 days, if provided on medical wards;
- ✓ for a maximum of 8 days for those following surgery.

If, for purely medical reasons, it is necessary to extend a stay in a "Direct Provision" healthcare facility then the facility must request, through procedures known to the facility itself, an **extension** to the hospitalisation authorisation, explaining this on a **certificate** issued by the treating physician.

All such requests will be submitted to the Fund's medical consultants to verify their validity: should FasiOpen not accept a request for **extension** of the hospitalisation period, the medical costs of the "additional" period will be payable in full by the client.

"Direct Provision" services

Use of affiliated healthcare facilities

The procedures and rules that clients must observe to access affiliated healthcare facilities and to benefit from "Direct Provision" services are set out below.

Clients who wish to use the services of directly affiliated facilities must prove their membership of FasiOpen at the offices of affiliated healthcare facilities by presenting:

- ✓ their client code;
- ✓ a document for identification (for minors, the ID of a parent/guardian).

We recommend clients to request, from the same offices, all the information needed for the correct use of the affiliation, to avoid any possible misunderstandings. Once the applicability of "Direct Provision" services has been ascertained in real time via telematic connection (i.e. once the client's administrative status had been found to be in order, with the facility simply receiving an "Eligible" or "Non-Eligible" notification), healthcare facilities undertake to pay in advance any expenditure incurred by clients within the limits specified by their chosen Health Plan. FasiOpen, in the name of and on behalf of its clients, will settle the amount due if this is included in the Cover provided by the client's Health Plan and if recognised as refundable.

It should be remembered that not all physicians operating in the above-mentioned healthcare facilities have accepted the affiliation agreements. In these cases "Direct Provision" services are not applicable: clients will be obliged to pay the relevant expenditure in person and to subsequently request a refund from FasiOpen according to the procedures specified for "Indirect Provision" services. This could also occur in the event of medical or surgical hospitalisation: if, for example, all members of the medical team are affiliated except for the histologist, who has not accepted direct affiliation.

Some healthcare facilities are unable to provide "Direct Provision" services for specialist consultations and/or for certain diagnostic tests: also in this case, clients must personally pay their own costs. It is also possible that during certain periods some healthcare facilities may no longer offer certain "Direct Provision" services.

We invite clients, above all in the event of hospitalisation, to obtain a detailed estimate of costs from the affiliated healthcare facility to avoid misunderstandings through erroneous interpretation of the provisions of the Cover in their Health Plan.

Medical invoices/receipts issued for any "Direct Provision" services received at affiliated health facilities will be forwarded telematically by the healthcare facilities themselves. We therefore urge clients not to forward the same expenditure documentation and/or expenditure documentation relating to fees remaining payable by the client.

Clients, therefore, must always **ask healthcare facilities for the originals of invoices/receipts** relating to costs that the Fund will pay and to those paid personally by themselves, for use as permitted by the current tax regulations.

Upon discharge or upon the termination of any outpatient services, a specific form must be signed - prepared by FasiOpen and forwarded to the affiliated healthcare facility - in which a client who requested and received these services:

- ✓ confirms, by signing, that he/she has used the services indicated in the request in terms of both its type and quantity (since an advance request for services yet to be received is not eligible for refund);
- ✓ authorises the healthcare facility to recover the sum that it had paid in advance on his/her behalf, if due because they have been recognised as refundable by FasiOpen. Otherwise, he/she undertakes to pay for them personally;

- ✓ releases the physicians who have treated him/her from the obligation of professional secrecy (*vis a vis* FasiOpen and its collaborators);
- ✓ declares that he/she has paid any surplus amount for which, according to the terms of the chosen Health Plan, he/she is not entitled further refund by FasiOpen;
- ✓ undertakes, in compliance with article 13 of the Regulations, to refund FasiOpen, up to the amount paid by the Fund on his/her behalf, any sums received by third parties as compensation should the expenditure be for events connected with third party liability;
- ✓ undertakes to pay any amounts which, while assessing the refund request, FasiOpen detects as non-refundable and/or as not falling within the Cover of his/her Health Plan and/or as exceeding the limits;
- ✓ totally commits to paying for all services that, after they have been provided - regardless of whether relating to outpatient services and/or hospitalisation of any kind (daytime or night-time) - turn out to be not payable by the Fund due to loss of the right to assistance by FasiOpen;
- ✓ authorises the healthcare facility to forward to FasiOpen, Poste Welfare e Servizi S.r.l. and Pro.ge.sa S.r.l. a copy of the expenditure documentation and whatever else is needed to receive refunds from FasiOpen;
- ✓ grants his/her “consent” to the processing of personal, common and sensitive data, as required by Law 196/03 on Privacy and subsequent additions and/or modifications.

How to use the Servizio Sanitario Nazionale or Servizio Sanitario Regionale

The Italian National Health Service (S.S.N.) and Regional Health Services (S.S.R.) recognise the right of citizens to “free choice” of the healthcare facility at which they wish to receive health services. The law states that citizens, if in possession of a “prescription/request” from their general practitioner, can choose where the services will be provided without the need for authorisation from their AUSL (Local Health Authority). In concrete terms, they have the right to choose between a public healthcare facility and an accredited private healthcare facility (affiliated to the S.S.N./ S.S.R.).

This law applies to any type of medical service, both outpatient and in the event of hospitalisation. For example: in Italy nearly all analysis laboratories, radiology units, physiokinesis therapy centres and nuclear medicine (scintigraphy) centres are accredited by (affiliated to) the S.S.N./S.S.R. It is therefore possible to access these with a prescription from your general practitioner and to ask, for all recognised services, to use the Regional Health System or, **for unrecognised services**, to request the agreed tariff agreements or private tariffs of the healthcare facility, if lower at that time, to be applied.

IMPORTANT

Refund Ceilings

Ceilings for “Indirect Provision” and “Direct Provision” refunds cannot be added to each other.

The right to “free choice” via a prescription/request from your general practitioner can also be exercised at private nursing homes accredited by (affiliated to) the S.S.N./S.S.R., without any need for authorisation from the local health authority. The cost of private services, even if received within accredited public or private healthcare facilities, will be refunded within the limits specified by your chosen Health Plan and, whatever the case, outside Cover 7 - charges for healthcare services used at public or accredited private healthcare facilities.

If you simultaneously pay charges for public healthcare services and fees for private services and these costs appear on the same medical receipt, you must ask the healthcare facility to indicate the type of service and the amount relating to the charges for public healthcare services only.

"Direct Provision" services

Stamp Duty on Medical Receipts

Given that:

- ✓ pursuant to article 13 of Presidential Decree no. 642/72, every invoice, note, receipt or similar document, not subject to VAT, issued for an amount equal to or higher than that specified by the current legislation, must be subjected to stamp duty to the amount currently required by the application of stamps or perforated marks by the issuer of the expenditure document;
- ✓ in the event of non-compliance with the above obligation, an administrative fine will be charged of between 100% and 500% of the tax due;
- ✓ any parties who sign, receive, accept or negotiate records or documents not in compliance with payment of the tax due, or who attach them to other records or documents, are jointly and severally liable to pay the tax and any administrative fines.

Should FasiOpen receive from its clients, for the purposes of refunds, records or documents that do not bear a stamp or perforated mark, it will be obliged to present such documents to the Registrar's Office to exonerate itself from administrative responsibility.

In order for FasiOpen to accept the refund documentation, the client must present, via his/her personal home page, all invoices to FasiOpen with stamp duty paid wherever necessary.

Stamp duty is not refundable by FasiOpen.

"PURPLE" HEALTH PLAN
DETAILED DESCRIPTION OF COVERS INCLUDED

COVER 1 - Hospitalisations in healthcare institutions for major surgery following illness and injury

Hospitalisation

Refunds can be obtained for both "direct provision" and "indirect provision" services, and refer exclusively to overnight stays. Cover does not apply in the case of daytime hospitalisation or for operations carried out on an out-patient basis (as shown in the medical records and/or operating theatre report).

"Direct Provision" refunds are made at affiliated healthcare facilities belonging to the network recognised by FasiOpen, in which clients do not pay in advance any costs up to the refund limits specified in their Health Plan. This form of refund is possible only when both the healthcare facility and the chosen physician-surgeon-orthodontist are affiliated[1].

To obtain an "Indirect Provision" refund you must send FasiOpen the expenditure documentation (online procedure) unequivocally confirming payment in full of the medical services received. A complete and legible copy of the medical record relating to the subject of the refund must be attached.

Please remember to submit separate requests if these refer to different members of the family unit.

The Cover is applicable within the limitations and conditions specified in each chosen Health Plan, as illustrated in the following pages.

Refunds specified in Cover 1.2, Other Hospitalisations with or without surgical operation, and those specified in Cover 8 - Maternity and Refunds for preventive services/operations/treatments, and anything not included in the list of major surgical operations - are excluded.

Client means the employee and/or each member of his/her family unit duly registered with FasiOpen.

1 For more detailed information on "Direct Provision" refunds, clients are urged to carefully read the Chapter entitled "Direct Provision Services", and the Chapter entitled "Use of affiliated healthcare facilities".

Description	Refund ceilings
MAXIMUM REFUND PER YEAR AND PER CLIENT	€ 100,000
MAXIMUM REFUND PER EVENT	€ 100,000
REFUND AMOUNT (INCLUSIVE OF ALL COMPETENCIES INCLUDING MEDICAL TEAM)	100%
MINIMUM NON REFUNDABLE	None
Details	**Refund sub-ceilings**
HOSPITALISATION CHARGES	Up to €300 per night for “indirect provision”
ACCOMPANIMENT CHARGES	Up to €50 per day – maximum 30 days for “indirect provision” hospitalisation
NURSING CARE	Up to €60 per day – – maximum 30 days for “direct” or “indirect provision” hospitalisation
OPERATING THEATRE	Refundable up to a maximum ceiling
MEDICINES, MATERIALS AND PROSTHESES	
SPECIALIST INPATIENT CONSULTATIONS	
INPATIENT DIAGNOSTICS	

List of major surgical operations
Operations recognised as refundable solely for malignant oncological pathologies

- ✓ Axillary lymphadenectomy (as a single operation)
- ✓ Radical mastectomy, any technique, with associated lymphadenectomies
- ✓ Simple total mastectomy with any lymphadenectomies
- ✓ Subcutaneous mastectomy (complete treatment)
- ✓ Quadrantectomy with search for and removal of the sentinel lymph node and associated lymphadenectomies, any technique (including nuclear medicine/radiology)
- ✓ Quadrantectomy with search for and removal of the sentinel lymph node, any technique (including nuclear medicine/radiology), without other associated lymphadenectomies
- ✓ Quadrantectomy, including "NIPPLE-SPARING" technique, without associated lymphadenectomies
- ✓ Breast reconstruction after radical mastectomy with introduction of implants, including muscle flap if needed
- ✓ Breast reconstruction after simple total mastectomy with introduction of prosthesis, including muscle flap if needed
- ✓ Breast reconstruction after subcutaneous mastectomy or quadrantectomy with introduction of implants, including muscle flap if needed
- ✓ Removal and possible replacement of breast prosthesis implanted in previous mastectomy or quadrantectomy surgery (as a single operation)
- ✓ Tumourectomy with sentinel node resection (including nuclear medicine/radiology)
- ✓ Tumourectomy with sentinel node resection and associated lymphadenectomies (including nuclear medicine/radiology)
- ✓ Tumours of any type, exeresis or excision en bloc
- ✓ Unilateral cervical lymphadenectomy (as a single operation)
- ✓ Bilateral cervical lymphadenectomy (as a single operation)
- ✓ Supraclavicular lymphadenectomy (as a single operation)
- ✓ Parathyroids - complete treatment, intervention on the

- ✓ Parathyroids, reinterventions
- ✓ Thyroid, lobectomies
- ✓ Subtotal thyroidectomy
- ✓ Total thyroidectomy, or total thyroidectomy, any route of access, without laterocervical emptying
- ✓ Total thyroidectomy for malignant neoplasms with unilateral laterocervical emptying
- ✓ Total thyroidectomy for malignant neoplasms with bilateral laterocervical emptying
- ✓ Malignant tumour of the neck, removal of (excluding described cases)
- ✓ Total oesophagectomy with oesophagoplasty, in one session, including lymphadenectomy
- ✓ Cervical oesophagus, resection of, with oesophagostomy
- ✓ Oesophagus, partial resection of , with oesophagostomy
- ✓ Total oesophagus-gastrectomy, by thoracic-laparotomy and possible lymphadenectomy
- ✓ Endo-oesophageal prostheses, placement of
- ✓ Partial or subtotal gastrectomy (including possible lymphadenectomy)
- ✓ Total gastrectomy with lymphadenectomy, including extended
- ✓ Total gastrectomy with extended lymphadenectomy with associated left splenopancreasectomy
- ✓ Gastro duodenal resection
- ✓ Miles abdominoperineal amputation, complete treatment
- ✓ Gastrointestinal or intestinal bypasses for malignant diseases
- ✓ Segmental colectomy (including possible ostomy)
- ✓ Segmental colectomy with lymphadenectomy and possible colostomy
- ✓ Total colectomy (including possible ostomy)
- ✓ Total colectomy with lymphadenectomy (including possible ostomy)
- ✓ Right hemicolectomy with lymphadenectomies
- ✓ Left hemicolectomy with lymphadenectomies and possible colostomy (Hartmann and others)
- ✓ Colon prosthesis placement
- ✓ Rectal prosthesis placement
- ✓ Total procto-colectomy with ileal pouch
- ✓ Excision of the sigma-rectum for malignant pathology with possible associated lymphadenectomies
- ✓ Anterior recto-colic resection (also ultra-low) including lymphadenectomy and possible colostomy
- ✓ Rectum, amputation of, for neoplasm of the anus, including possible bilateral inguinal lymphadenectomy
- ✓ Malignant tumour of the rectum, by transanal or transanal endoscopic microsurgery (TEM), removal of
- ✓ Unilateral inguinal or crural lymphadenectomy (as a single operation)
- ✓ Bilateral inguinal or crural lymphadenectomy (as a single operation)
- ✓ Laparotomic lymphadenectomy (as a single operation)
- ✓ Exploratory laparotomy as main intervention for unresectable neoplasms or for staging of lymphadenopathies
- ✓ Retroperitoneal tumour or fibrosis (including ureterolysis and extensive viscerolysis), surgery for (complete treatment)
- ✓ Cholecystostomy for unresectable neoplasms
- ✓ Hepatic artery cannulation for antiblastic perfusion
- ✓ Papilla of Vater, ampullectomy for cancer with re-implantation of Wirsung duct and common bile duct
- ✓ Major hepatic resections
- ✓ Minor hepatic resections
- ✓ Radiofrequency thermoablation of primary hepatic tumours, any access route
- ✓ Biliary tract, palliative interventions
- ✓ Cephaloduodenum pancreasectomy including possible lymphadenectomy
- ✓ Endocrine pancreatic neoplasms, intervention for
- ✓ Left pancreatectomy including splenectomy and possible lymphadenectomy
- ✓ Total pancreatectomy (including possible lymphadenectomy)
- ✓ Splenectomy
- ✓ Exenteratio orbitae
- ✓ Submaxillary gland, removal for malignant neoplasms, including possible lymphadenectomy
- ✓ Tongue and oral floor, surgery for malignant tumours with functional or radical latero-cervical emptying
- ✓ Tongue and oral floor, surgery for malignant tumours without emptying the submaxillary lodge
- ✓ Mandible, partial resection for neoplasia of the, including possible radical or functional unilateral latero-cervical emptying
- ✓ Mandible, partial resection for neoplasia of the, including any bilateral radical or functional latero-cervical emptying
- ✓ Upper maxillary for neoplasms, including possible radical or functional unilateral latero-cervical emptying, resection of the
- ✓ Upper maxillary for neoplasms, including possible bilateral radical or functional latero-cervical emptying, resection of the
- ✓ Facial skeleton, tumour demolition surgery with orbital emptying
- ✓ Large endosseous neoplasms, exeresis of
- ✓ Malignant neoplasms of the lip/cheek with emptying of the submaxillary loggia, removal of
- ✓ Malignant neoplasms of the lip/cheek without emptying of the submaxillary loggia, removal of
- ✓ Total or subtotal parotidectomy
- ✓ Areola and nipple malformation, surgery for or reconstruction of the nipple after cancer surgery

- ✓ Breast reconstruction after simple total mastectomy with introduction of prosthesis, including muscle flap if needed
- ✓ Breast reconstruction after subcutaneous mastectomy or quadrantectomy with introduction of implants, including muscle flap if needed
- ✓ Removal and possible replacement of breast prosthesis implanted in previous mastectomy or quadrantectomy surgery (as a single operation)
- ✓ Bilobectomy surgery (including possible lymphadenectomy and/or biopsy)
- ✓ Mediastinal lymphadenectomy (as a single operation)
- ✓ Malignant neoplasms ribs and/or sternum (including possible lymphadenectomy and/or biopsy)
- ✓ Malignant neoplasms of the diaphragm (as main stage of intervention)
- ✓ Malignant neoplasms of the trachea (including plastic surgery and possible lymphadenectomy and/or biopsy)
- ✓ Malignant neoplasms and/or cysts of the mediastinum (including possible lymphadenectomy and/or biopsy)
- ✓ Pleurectomies (including possible lymphadenectomy and/or biopsy)
- ✓ Pleuropneumectomy (including possible lymphadenectomy and/or biopsy)
- ✓ Pneumectomy surgery (including lymphadenectomy and/or biopsy)
- ✓ Pneumectomy with resection of trachea and tracheo-bronchial anastomosis
- ✓ Bronchial resection with reimplantation
- ✓ Segmental resection or lobectomy (including possible lymphadenectomies)
- ✓ Single or multiple atypical segmental lung resections (including possible lymphadenectomies)
- ✓ Typical segmental resections (including possible lymphadenectomies)
- ✓ Thymectomy
- ✓ Pelvic evisceration
- ✓ Radical laparotomic or vaginal hysterectomy with pelvic and/or lumbar/aortic lymphadenectomy, including anterior and/or posterior vaginal plastic surgery
- ✓ Radical hysterectomy by laparotomic or vaginal route without lymphadenectomy, including anterior and/or posterior vaginal plastic surgery
- ✓ Simple total hysterectomy with or without mono/bilateral adnexiectomy by laparotomic or vaginal route, including anterior and/or posterior vaginal plastic surgery
- ✓ Malignant vaginal tumours with lymphadenectomy, radical surgery for
- ✓ Malignant vaginal tumours without lymphadenectomy, radical surgery for
- ✓ Partial vulvectomy
- ✓ Partial vulvectomy with bilateral diagnostic lymphadenectomy of superficial inguinal lymph nodes, surgery for
- ✓ Wider radical vulvectomy with inguinal and pelvic lymphadenectomy, surgery for
- ✓ Simple vulvectomy (local or cutaneous), surgery for
- ✓ Total vulvectomy
- ✓ Craniotomy for cerebellar tumours, including basal tumours
- ✓ Laminectomy for extramedullary intra-dural tumours
- ✓ Laminectomy for intramedullary tumours
- ✓ Endocranial neoplasms, removal of
- ✓ Neoplasms, chordotomies, radicotomies and meningomideal affections, endorachid surgery
- ✓ Orbital tumour, endocranial excision
- ✓ Peripheral nerve tumours, removal of (excluding traumatic and non-traumatic nerve lesions of the hand and foot)
- ✓ Cranial base tumours, trans-oral surgery
- ✓ Orbital tumours, surgery for
- ✓ Deep cysts or neoplasms around the orbit, removal of
- ✓ Exenteratio orbitae
- ✓ Hemipelvectomy
- ✓ Internal" hemipelvectomies with salvage of the limb
- ✓ Resection of the sacrum (as a single operation)
- ✓ Emptying of metastatic foci and reinforcement with synthesis plus cement
- ✓ Bone tumours and pseudo-tumours, large segments or joints, removal of
- ✓ Bone tumours and pseudo-tumours, medium-sized segments or joints, removal of
- ✓ Bone tumours and pseudo-tumours, small segments or joints, removal of
- ✓ Bone tumours and pseudo-tumours, vertebral tumours, removal of
- ✓ Exploratory laparotomy with demolition surgery
- ✓ Duct neoplasms, exeresis
- ✓ Tumours of the middle ear, removal of
- ✓ Malignant tumours of the nose or sinuses, removal of
- ✓ Partial pharyngectomy
- ✓ Parapharyngeal neoplasms
- ✓ Malignant pharyngotonsillar tumour, removal of
- ✓ Cordectomy
- ✓ Laser Cordectomy

- ✓ Epiglottisectomy
- ✓ Partial laryngectomy with unilateral laterocervical emptying
- ✓ Total laryngectomy without laterocervical emptying
- ✓ Total laryngectomy with unilateral laterocervical emptying
- ✓ Total laryngectomy with bilateral laterocervical emptying
- ✓ Total laryngopharyngectomy
- ✓ Abdominal aorta arteriography plus simple embolization of tumours
- ✓ Embolization of malformations and/or aneurysms and/or cerebral vascular fistulas or endocranial tumours
- ✓ Thermoablation or Cryoablation of primary or metastatic neoplasms
- ✓ Bladder neoplasm, endoscopic resection of
- ✓ Prostate, endoscopic resection or vaporisation of (any technique and equipment, excluding cases described)
- ✓ Heminephrectomy
- ✓ Wider nephrectomy for cancer with possible treatment of caval thrombus (including adrenectomy)
- ✓ Polar nephrectomy
- ✓ Simple nephrectomy
- ✓ Radical nephroureterectomy with lymphadenectomy plus possible adrenectomy, surgery for
- ✓ Radical nephroureterectomy (including possible adrenectomy)
- ✓ Surrenectomy (complete treatment)
- ✓ Partial cystectomy with ureterocystoneostomy
- ✓ Simple partial cystectomy
- ✓ Total cystectomy including lymphadenectomy and prostatovesiculectomy or uteroannessiectomy with ileum or colobladder
- ✓ Total cystectomy including lymphadenectomy and prostatovesiculectomy or uteroannexectomy with rectal neobladder included
- ✓ Total cystectomy including lymphadenectomy and prostatovesiculectomy or uteroannessiectomy with bilateral ureterosigmoidostomy or ureterocutaneostomy
- ✓ Laparotomic lymphadenectomy (as a single operation)
- ✓ Radical prostatectomy for carcinoma with lymphadenectomies, including possible ligation of the vas deferens (any access and technique)
- ✓ Total haemasculatio and possible lymphadenectomy
- ✓ Wider orchidectomy with unilateral abdominal or retroperitoneal lymphadenectomy
- ✓ Wider orchidectomy with bilateral abdominal or retroperitoneal lymphadenectomy
- ✓ Bilateral subcapsular orchidectomy
- ✓ Penis, total amputation with lymphadenectomy
- ✓ Penis, total amputation of

Other major surgery for other pathologies

- ✓ Multiple coronary artery bypass (CEC)
- ✓ Single coronary artery bypass (CEC)
- ✓ Adult or neonatal open-heart cardiac surgery, including aneurysms or multiple valve replacements or aortic replacement or aortic plastic replacement (CEC), except for the interventions described
- ✓ Commissurotomy for mitral stenosis
- ✓ Wounds or foreign bodies or tumours of the heart or tamponade, surgery for
- ✓ Arteriovenous fistulas of the lung, surgery for
- ✓ Internal heart massage
- ✓ Partial pericardiectomy
- ✓ Total pericardiectomy
- ✓ Reintervention with restoration of CEC
- ✓ Section or ligation of the ductus arteriosus of Botallo
- ✓ Valve replacement with minimally invasive surgery (heart port)
- ✓ Single valve replacement (CEC)
- ✓ Valve replacements with coronary artery bypass (CEC)
- ✓ Cardiac transplantation (inclusive of all services and medical explantation and implantation operations)
- ✓ Cardiac valvuloplasty
- ✓ Total thyroidectomy for mediastinal goiter, surgery for
- ✓ Cervical oesophageal diverticula (including myotomy), surgery for
- ✓ Diverticula of the thoracic oesophagus, surgery for
- ✓ Megaoesophagus, surgery for
- ✓ Megaoesophagus, reintervention for
- ✓ Oesophageal varices: transthoracic or abdominal surgery

- ✓ Gastro-digiunal-colic fistula, surgery for
- ✓ Total gastrectomy for benign pathology
- ✓ Gastro-digiunal resection for anastomotic peptic ulcer
- ✓ Gastric varices (surgical haemostasis)
- ✓ Preternatural anus, closure, continuity reconstruction
- ✓ Anoplasty and perineoplasty (as a single operation)
- ✓ Appendectomy with diffuse peritonitis
- ✓ Construction of artificial anus (as a single operation)
- ✓ Megacolon, surgery for
- ✓ Megacolon: colostomy
- ✓ Extended viscerolysis (enteroplication), surgery for (as a single operation)
- ✓ Extended viscerolysis (enteroplication), surgery for (as the main operation stage)
- ✓ Intestinal obstruction with resection
- ✓ Portocaval or splenic-renal or mesenteric-cava anastomosis
- ✓ Simple laparoscopic cholecystectomy (including lysis of adhesions)
- ✓ Laparoscopic cholecystectomy with intraoperative cholangiography and exploration of the biliary tract and possible stone extraction (including radiologist assistance) (including lysis of adhesions)
- ✓ Laparoscopic cholecystectomy with choledocholithotomy and stone extraction (including cholangiography and radiologist assistance) (including lysis of adhesions)
- ✓ Laparotomic cholecystectomy (including lysis of adhesions)
- ✓ Cholecystogastrostomy or cholecystenterostomy
- ✓ Choledocal/hepatic/digiunal/duodenostomy with or without cholecystectomy
- ✓ Choledocal-hepatic jejunostomy with or without cholecystectomy
- ✓ Choledocal-hepatic duodenostomy with or without cholecystectomy
- ✓ Choledochotomy and choledocholithotomy (as a single operation)
- ✓ Hepatic dearterialisation, with or without chemotherapy
- ✓ Azygos-portal deconnection by abdominal route
- ✓ Intra-hepatic digestive bile drainage
- ✓ Papilla of Vater, exeresis
- ✓ Papillostomy, via transduodenal route and possible removal of stones (as a single operation)
- ✓ Liver transplant (all-inclusive of services and medical explantation and implantation operations)
- ✓ Biliary tract, reinterventions
- ✓ Pancreatic-Wirsung Digestive Derivatives
- ✓ Spleen, conservative surgery (splenorrhaphy, splenic resections)
- ✓ Pancreas transplantation (inclusive of all services and medical explantation and implantation operations)
- ✓ Zygomatic fracture, orbit, surgical therapy for
- ✓ Maxillary fractures, surgical therapy for
- ✓ Frontal sinus fractures, surgical therapy for
- ✓ Fractures of the mandible and condyle, surgical therapy for (including possible fixation with ferrules)
- ✓ Mandibular fractures, reduction with ferrules
- ✓ Tongue, partial amputation for benign tumours, angiomas, macroglossia
- ✓ Dento-maxillofacial malformations of the mandible and maxilla (progenism, microgenia, prognathism, micrognathia, mandibular lateral deviation, etc.), including mentoplasty on the upper maxillary or mandible (full treatment)
- ✓ Small endosseous neoplasms (osteomas, cementomas, odontomas, palatine and mandibular torus), excisions of
- ✓ Limited malignant neoplasms of the lip or soft tissues of the oral cavity, removal of
- ✓ Dynamic or static facial nerve palsy, plastic surgery for
- ✓ Partial parotidectomy with possible sparing of the facial nerve
- ✓ Vaginal aplasia, reconstruction for
- ✓ Push-back surgery and pharyngoplasty
- ✓ Complex deformities of the hands or feet (complete treatment)
- ✓ Breast reconstruction after radical mastectomy with introduction of implants, including muscle flap if needed
- ✓ Intersexual states, surgery for
- ✓ Microvascular free flap transfer
- ✓ Pulmonary pleural decortication, surgery for
- ✓ Thoraco-abdominal wound with visceral damage
- ✓ Wounds with visceral damage to the chest
- ✓ Bronchial stump fistulas after exeresis or similar surgery, surgery for

- ✓ Bronchoesophageal and/or tracheoesophageal fistulas, operations for
- ✓ Thoracoplasty, first stage
- ✓ Thoracoplasty, second stage
- ✓ Lung transplant (inclusive of all services and medical explantation and implantation operations)
- ✓ Abdominal or thoracic aorta aneurysms plus dissection: resection and prosthetic graft (open)
- ✓ Distal limb artery aneurysms, resection and/or prosthetic graft (open)
- ✓ Aneurysms, resection and prosthetic grafting: iliac, femoral, popliteal, humeral, axillary, gluteal arteries, visceral arteries and supra-aortic trunks (open)
- ✓ Aorto-anonimous bypass, aorto-carotid, carotid-subclavian
- ✓ Aorto-iliac or aorto-femoral bypass
- ✓ Aorto-renal or aorto-mesenteric or celiac bypass and possible TEA and vascular plastic surgery
- ✓ Endovascular treatment of aneurysms or dissecting aneurysms of the thoracic aorta
- ✓ Thromboendarterectomy and bypass and/or embolectomy of supra-aortic trunks
- ✓ Thromboendarterectomy and patching and/or embolectomy of supra-aortic trunks
- ✓ Thromboendarterectomy and prosthetic grafting and/or embolectomy of supra-aortic trunks (any technique)
- ✓ Intra-extra cranial vessel anastomosis
- ✓ Atlanto-occipital joint, surgery for anterior or posterior malformations
- ✓ Chordotomy, rhizotomy and various myeloradicular affections, surgery on
- ✓ Cranioplasty - including possible removal of synthetic material
- ✓ Craniotomy for extradural haematoma
- ✓ Craniotomy for traumatic intracerebral lesions
- ✓ Encephalomeningocele, surgery for
- ✓ Focal epilepsy, surgery for
- ✓ Cervical intervertebral disc herniation, myelopathies, radiculopathies including uncoforaminotomy, vertebrotomy and removal of osteophytes
- ✓ Pituitary gland, transsphenoidal adenoma surgery
- ✓ Intracranial aneurysmal malformation (saccular aneurysms, carotid aneurysms, other aneurysms)
- ✓ Aneurysmal or angiomatous malformation with root and/or spinal cord compression
- ✓ Brachial plexus, surgery on
- ✓ Transplants, grafts and other plastic surgery operations (as a single operation)
- ✓ Anterior vertebro-medullary trauma, surgery for
- ✓ Full thickness corneal transplant
- ✓ Lamellar corneal transplant
- ✓ Limbal stem cell transplant
- ✓ Limbal stem cell transplant combined with amniotic membrane apposition
- ✓ Upper and/or lower limb stretching (per segment, complete treatment)
- ✓ Large segment amputation (full treatment)
- ✓ Anterior vertebral arthrodesis also for spondylolisthesis including possible lumbar stenosis (as a single operation)
- ✓ Posterior vertebral arthrodesis also for spondylolisthesis including possible lumbar stenosis (as a single operation)
- ✓ Anterior and posterior vertebral arthrodesis also for spondylolisthesis including possible lumbar stenosis (as a single operation)
- ✓ Arthrodesis: large joints
- ✓ Arthrodesis: medium joints
- ✓ Arthrolysis: large
- ✓ Arthrolysis: medium
- ✓ Arthroplasty: large (any material)
- ✓ Arthroplasty: medium (any material)
- ✓ Arthroplasty: small (any material)
- ✓ Arthroplasty: shoulder, partial
- ✓ Arthroplasty; shoulder, total
- ✓ Arthroplasty: partial hip (complete treatment)
- ✓ Arthroplasty: knee
- ✓ Arthroplasty: elbow
- ✓ Arthroplasty: removal and replacement of septic arthroplasty subsequently to the first operation (partial or total) as a single operation, except in the cases described
- ✓ Total hip arthroplasty (total hip arthroplasty - any technique - concurrent operation) refundable in the same operating session or hospitalisation not connected with the total hip prosthesis package)
- ✓ Arthroplasty: total hip revision carried out in the same hospital in which the first operation was carried out (total hip revision arthroplasty

- any technique - concurrent operation, refundable in the same operating session or hospitalisation not connected with the total hip revision package)

- ✓ Total hip arthroplasty (complete treatment - concurrent with another main operation): for removal and repositioning carried out subsequently to the first hospitalisation
- ✓ Surgical package (Traditional Technique) total hip prosthesis (arthroplasty: total hip - complete treatment). refund includes: medical team, operating theatre, hospital stay, materials, medicines, joint prosthesis, in-patient diagnostic tests
- ✓ Surgical package (Traditional Technique) total hip revision prosthesis (arthroplasty: total hip revision - complete treatment) surgery for removal and replacement or repositioning carried out in the same hospital in which the first surgery was carried out. refund includes: medical team, operating theatre, hospital stay, materials, medicines, joint prosthesis, in-patient diagnostic tests
- ✓ Surgical package (Traditional Technique) removal and repositioning of hip prosthesis carried out after the first hospitalisation (complete treatment). Refund includes: medical team, operating theatre, hospital stay, materials, medicines, joint prosthesis, in-patient diagnostic tests
- ✓ Surgical package (Robotic Surgery - RAS) total hip prosthesis (arthroplasty: total hip - complete treatment). Refund includes: medical team, operating theatre, use of computer-assisted surgery equipment (any), hospital stay, materials, medicines, joint prosthesis, in-patient diagnostic tests
- ✓ Surgical package (Robotic Surgery - RAS) total hip revision prosthesis (arthroplasty: total hip revision - complete treatment) surgery for removal and replacement or repositioning carried out in the same hospital in which the first surgery was carried out. Refund includes: medical team, operating theatre, use of computer-assisted surgery equipment (any), hospital stay, materials, medicines, joint prosthesis, in-patient diagnostic tests
- ✓ Surgical package (Robotic Surgery - RAS) removal and repositioning of hip prosthesis performed after the first hospitalisation (complete treatment). Refund includes: medical team, operating theatre, use of computer-assisted surgery equipment (any), hospital stay, materials, medicines, joint prosthesis, in-patient diagnostic tests
- ✓ Cervical rib and "outlet syndrome", surgery for
- ✓ Thoracic interscapular disarticulation
- ✓ Disarticulations, large
- ✓ Osteomyelitis (complete treatment), surgery for
- ✓ Vertebral osteosynthesis
- ✓ Complex osteotomy (pelvis, vertebral) including ablation of spinal osteophytes (by section)
- ✓ Re-implantation of a limb or its segment
- ✓ Surgical reduction and constriction of traumatic spinal dislocation
- ✓ Shoulder, complete resections according to Tickhor-Limberg
- ✓ Bone marrow transplant (all-inclusive of services and medical explantation and implantation operations)
- ✓ Uncoforaminotomy or vertebrotomy (complete treatment)
- ✓ Tendon and muscle or nerve transplants (complete treatment)
- ✓ Brain abscess, opening via transmastoid
- ✓ Vestibular nerve, section of
- ✓ Eighth nerve neuroma
- ✓ Tympanoplasty with mastoidectomy
- ✓ Tympanoplasty without mastoidectomy
- ✓ Tympanoplasty, second time of
- ✓ Velopharyngoplasty or hyoid bone advancement
- ✓ Laryngeal diaphragm, excision with plastic surgery reconstruction
- ✓ Partial laryngectomy
- ✓ Carotid stent placement with cerebral protection system for carotid stenosis treatment
- ✓ TIPS (port-superhepatic shunt)
- ✓ Kidney transplant (inclusive of all services and medical removal and implantation operations)
- ✓ Megaureter, remodelling surgery
- ✓ Bladder, plastic surgery for enlargement (colon/ileum)
- ✓ Bilateral antireflux bladderoplasty
- ✓ Unilateral antireflux vesicoplasty
- ✓ Total urethrectomy

COVER 1.2 Other hospitalisations with or without surgical operation

This Cover applies to both "indirect" and "direct-provision" services in documented cases of illness and/or injury with overnight or daytime hospitalisation (the latter with a minimum stay of 4 hours), with or without a surgical operation. The Cover does not apply in the case of services/procedures carried out on an out-patient basis, even if the services/procedures are included in this Cover and/or the Fund's area of activity (but not in the Health Plan).

Refunds specified in Cover 1, Hospitalisations for major surgical operation, and those specified in Cover 8 - Maternity and Refunds for preventive services/operations/treatments, and anything not included in the list below - are excluded.

Please note that this Cover does not include hospitalisation for diagnostic tests and/or check-ups alone, i.e. day hospitalisation is recognised as refundable only for chemotherapy, cancer treatment and pain therapy (day hospital) or for surgical operations (day surgery) with a stay of no less than 4 hours.

"Direct Provision" refunds are made at affiliated healthcare facilities belonging to the network recognised by FasiOpen, in which clients do not pay in advance any costs up to the refund limits specified in their Health Plan. This form of refund is possible only when both the healthcare facility and the chosen physician-surgeon-orthodontist are affiliated[2].

To obtain an "Indirect Provision" refund you must send FasiOpen the expenditure documentation (online procedure) unequivocally confirming payment in full of the medical services received. A complete and legible copy of the medical record relating to the subject of the refund must be attached.

Please remember to submit separate requests if these refer to different members of the family unit.

The Cover is applicable within the limitations and conditions specified.

Client means the employee and/or each member of his/her family unit duly registered with FasiOpen.

[2] For more detailed information on "Direct Provision" refunds, clients are urged to carefully read the Chapter entitled "Direct Provision Services", and the Chapter entitled "Use of affiliated healthcare facilities".

Description	Refund ceilings
MAXIMUM REFUND PER YEAR AND PER CLIENT	€ 100,000
MAXIMUM REFUND PER EVENT	DIRECT PROVISION: € 100,000 INDIRECT PROVISION: € 8,000
REFUND AMOUNT (INCLUSIVE OF ALL COMPETENCIES INCLUDING MEDICAL TEAM)	100%
MINIMUM NON REFUNDABLE	DIRECT PROVISION: € 1,700 INDIRECT PROVISION: € 2,000
Details	**Refund sub-ceilings**
HOSPITALISATION CHARGES	Up to €300 per night for “indirect provision”
ACCOMPANIMENT CHARGES	Up to €50 per day – maximum 30 days for “indirect provision” hospitalisation
NURSING CARE	Up to €60 per day – maximum 30 days per hospitalisation
OPERATING THEATRE	Refundable up to a maximum ceiling
MEDICINES, MATERIALS AND PROSTHESES	
SPECIALIST INPATIENT CONSULTATIONS	
INPATIENT DIAGNOSTICS	

List of branches and sections of the FasiOpen Basic Nomenclature to refer to for this Cover

Considering the large amount of data to be included in any list, please note that only branches and sub-branches will be shown, without prejudice to the information given in the introduction on “Exclusions” (in the Basic Nomenclature), the “Services not covered by FasiOpen” paragraph and the services recognised.

The information set out case by case in the FasiOpen Basic Nomenclature (the branches and sub-branches of which are referred to in this document) must be seen in context within the terms of this Cover (e.g.: service X falls within a branch/sub-branch shown in the list below but is performed as a check-up in the day hospital - service X, therefore, although shown, will not be recognised for refund since it is performed as a day hospital test that is flagged as excluded from the services/treatments of the day hospital itself).

To verify coverage of the individual procedures that the client must undergo, the Health Information Centre is available (Option 1 Clients - Health Care Information Dial 1 Healthcare Information) on the days and at the times indicated in the relevant paragraph. In this case, before contacting the operators we recommend that you gather all possible information to help them provide you with feedback as quickly as possible.

Finally, please note that to be recognised as refundable by FasiOpen, information that you provide in advance (by telephone) must match the medical records and/or the operative report. It could happen, for example, that a procedure envisaged by the

professional and then verified by the client with the FasiOpen operator differs from that actually carried out in the operating theatre and recorded in the medical records/operative report (therefore not included in Cover 1.2 but perhaps included in Cover 1, or even not included in any Cover at all).

- ✓ Medical Oncology - Chemotherapy
- ✓ Lithotripsy
- ✓ Antalgic therapy
- ✓ Radionuclide therapies
- ✓ Radiotherapy
- ✓ Heart surgery
- ✓ Interventional cardiology
- ✓ Breast surgery
- ✓ Hand surgery
- ✓ Foot surgery
- ✓ Dermatological surgery, cryotherapy, laser therapy
- ✓ General surgery
  - Minor surgical operations
  - Neck
  - Oesophagus
  - Stomach, Duodenum
  - Intestine: Jejunum, Ileum, Colon, Rectum, Anus
  - Abdominal wall
  - Peritoneum
  - Liver and biliary tract
  - Pancreas, Spleen
- ✓ Oral, maxillofacial surgery
- ✓ Paediatric surgery
- ✓ Reconstructive plastic surgery
- ✓ Thoracic-pulmonary surgery
- ✓ Vascular surgery
- ✓ Gastroenterology (diagnostics, invasive activities)
- ✓ Gynaecology
- ✓ Neurosurgery
- ✓ Ophthalmology
  - Orbit
  - Eyebrow
  - Eyelids
  - Tear ducts
  - Conjunctiva
  - Cornea
  - Crystalline lens
  - Sclera
  - Operation for glaucoma
  - Iris
  - Retina
  - Muscles
  - Eyeball
  - Laser treatments
- ✓ Orthopaedics and traumatology
  - Bandages
  - Plastered appliances
  - Dislocations and fractures
  - Non-invasive surgery
  - Invasive surgery
  - Tendons, muscles, aponeuroses, peripheral nerves
- ✓ Obstetrics
- ✓ Otolaryngology
  - Ear
  - Nose and paranasal sinuses
  - Pharynx, oral cavity, oropharynx
  - Larynx and hypopharynx
- ✓ Interventional radiology
- ✓ Urology
  - Small operations and urological diagnostics
  - Diagnostic endoscopy
  - Operative endoscopy
  - Kidney
  - Ureter
  - Bladder
  - Prostate
  - Urethra
  - Male genital system

COVER 2 - Pre-hospitalisation diagnostic tests and specialist consultations for major surgery

This cover only applies in the context of diagnostic tests and specialist consultations, carried out on an out-patient basis, preliminary to subsequent overnight hospitalisation/s for major surgery (see list under Cover 1) and only if carried out within 120 days prior to overnight hospitalisation for the above-mentioned operations.

The Cover does not include:

- ✓ diagnostic tests and/or specialist consultations received in the 120 days prior to daytime or outpatient hospitalisation, even if the operation is included in the list under Cover 1;
- ✓ tests and/or specialist consultations received in the 120 days prior to daytime or outpatient hospitalisation but not related to it (e.g.: hospitalisation for hip replacement - ophthalmology consultation carried out in the 120 days prior to hospitalisation. In this case, the ophthalmology consultation is not referable to the hospitalisation and, although carried out within the indicated time period, will not be recognised as refundable by the Fund);
- ✓ diagnostic tests and/or specialist consultations received in the 120 days prior to hospitalisation for major surgery which, in the final analysis, are not included in the list under Cover 1.
- ✓ diagnostic tests and/or specialist consultations that, while meeting the above requirements, are not among the areas of activity of the Fund (FasiOpen Basic Nomenclature).

To request a refund for diagnostic tests you must attach - in addition to detailed expenditure documentation - a physician's prescription with diagnosis (by a specialist physician qualified to make diagnoses - diagnosis not to be confused with symptomatology) and a medical request with a description of the operation to be carried out (the tests must, therefore, be relevant to the operation) specifying the expected date of hospitalisation/surgery.

To request refund for specialist tests you must attach an invoice from the specialist physician which must unequivocally show his/her specialist title (duly registered with and traceable at the Italian Board of Physicians, Surgeons and Orthodontists) and a description of the operation to be carried out (the tests must, therefore, be relevant to the operation). The above-mentioned services, which are therefore included in this Cover, can only be recognised as refundable for "indirect provision" services (refunds to the client) whether or not they are used at a healthcare facility belonging to the network recognised by the Fund. Please pay attention, therefore, when using these services, since affiliated healthcare facilities are not in possession of the details of individual policies.

Excluded from refund are dental consultations, psychotherapy, cosmetic medicine and everything specified in the "Exclusions" paragraph (of the Basic Nomenclature) and the "Services not covered by FasiOpen" paragraph and/or everything related to these.

Please note that the use of this Cover precludes recognition of any type of allowance/daily allowance provided for by your Health Plan.

Client means the employee and/or each member of his/her family unit duly registered with FasiOpen.

Description	Refund ceilings
MAXIMUM REFUND PER YEAR AND PER CLIENT	€ 1,000
Details	**Sub-ceilings/Conditions of refund**
Diagnostic tests and specialist consultations relevant to the operation (major surgery)	Services must be received in the 120 days prior to the beginning of hospitalisation for major surgery (see list).

The cover does not apply if the planned surgery does not take place upon hospitalisation.

"Purple" Health Plan

Detailed description of covers included

COVER 3 - Post-hospitalisation diagnostic tests, specialist consultations and therapies for major surgery

This cover only applies in the context of diagnostic tests and specialist consultations, carried out on an out-patient basis, following overnight hospitalisation/s for major surgery (see list under Cover 1) and only if carried out within 120 days subsequent to overnight hospitalisation for the above-mentioned operations. The Cover does not include:

- ✓ diagnostic tests and/or specialist consultations received in the 120 days following daytime or outpatient hospitalisation, even if the operation is included in the list under Cover 1;
- ✓ tests and/or specialist consultations received in the 120 days following hospitalisation but not related to it (e.g.: hospitalisation for hip replacement - ophthalmology consultation carried out in the 120 days following hospitalisation. In this case, the ophthalmology consultation is not referable to the hospitalisation and, although carried out within the indicated time period, will not be recognised as refundable by the Fund);
- ✓ diagnostic tests and/or specialist consultations received in the 120 days following hospitalisation for major surgery which, in the final analysis (examination of the healthcare documentation), are not included in the list under Cover 1;
- ✓ diagnostic tests and/or specialist consultations that, while meeting the above requirements, are not among the areas of activity of the Fund (FasiOpen Basic Nomenclature).

To request a refund for diagnostic tests you must attach - in addition to detailed expenditure documentation - a physician's prescription with certain or presumed diagnosis (by a specialist physician qualified to make diagnoses - diagnosis not to be confused with symptomatology) and a complete copy of the medical record relating to the overnight hospitalisation for major surgery. To request a refund for specialist tests you must attach an invoice from the specialist physician which must unequivocally show his/her specialist title (duly registered with and traceable at the Italian Board of Physicians), which must be relevant to the operation carried out (major surgery).

The above-mentioned services, which are therefore included in this Cover, can only be recognised as refundable for "indirect provision" services (refunds to the client) and must be relevant to the operation carried out, whether or not they are used at a healthcare facility belonging to the network recognised by the Fund. Please pay attention, therefore, when using these services, since affiliated healthcare facilities are not in possession of the details of individual policies. Excluded from refund, since not related to hospitalisation for major surgery (even if carried out during the period covered by the conditions), are dental consultations, psychotherapy, cosmetic medicine and everything specified in the "Exclusions" paragraph (of the Basic Nomenclature) and the "Services not covered by FasiOpen" paragraph and/or everything related to these.

Client means the employee and/or each member of his/her family unit duly registered with FasiOpen.

Description	Refund ceilings
MAXIMUM REFUND PER YEAR AND PER CLIENT	€ 1,500
Details	**Sub-ceilings/Conditions of refund**
Diagnostic tests and specialist consultations relevant to the operation carried out (major surgery), therapies and physiotherapy or rehabilitation treatments on an outpatient basis	Services must be received in the 120 days following the beginning of hospitalisation for major surgery (see list) and always relevant to the operation carried out.

"Purple" Health Plan

Detailed description of covers included

COVER 4 - Ultrasound Diagnostics

This Cover applies exclusively to ultrasound diagnostics performed on an outpatient basis, using any technique, method and equipment and, when specified by the test, is inclusive of medicines/drugs, anaesthesiological assistance, arterial and venous examination (double charges are therefore not recognised as refundable).

The Cover does not include:

- ✓ ultrasound tests in pregnancy and/or related to this;
- ✓ ultrasound tests carried out as a preliminary examination relating to overnight hospitalisation for major surgery, even if carried out in the 120 days prior to hospitalisation;
- ✓ ultrasound tests carried out as a post-overnight hospitalisation check-up examination following major surgery, even if carried out in the 120 days after hospitalisation;
- ✓ ultrasound tests, even if deemed necessary, that do not fall within the Fund's area of activities (FasiOpen Basic Nomenclature) and that are not specifically included in the list below.
- ✓ any contrast medium used in addition to the basic test since, under this Cover, it is included in the examination itself.

To request a refund for ultrasound tests you must attach - in addition to detailed expenditure documentation - a physician's prescription with certain or presumed diagnosis (by a specialist physician qualified to make diagnoses - diagnosis must not be confused with symptomatology) for which the tests were necessary, a copy of the report for the examination/s carried out.

This Cover applies to both indirect and direct-provision services at affiliated healthcare facilities belonging to the network recognised by the Fund. For direct-provision services, in the case of examinations (included in this Cover) carried out during the same session, the fees for examinations subsequent to the first one are reduced by/charged at 50% (always applied to the least expensive examination/s).

Client means the employee and/or each member of his/her family unit duly registered with FasiOpen.

Description	**Refund ceilings**
MAXIMUM REFUND PER YEAR AND PER CLIENT	€ 200
Details	**Sub-ceilings/Conditions of refund**
ULTRASOUND DIAGNOSTICS (See list)	DIRECT PROVISION: Refund Amount 30% INDIRECT PROVISION: Refund percentage 25%

Please note that:

- ✓ upper abdomen is defined as: liver, pancreas, spleen, abdominal vessels:
- ✓ lower abdomen-pelvis is defined as: kidneys, bladder, prostate and seminal vesicles (for men); kidneys, uterus, appendages and bladder (for women);
- ✓ for lymph node ultrasound scans, 1 examination per lymph node district is recognised as refundable regardless of whether the examination is unilateral or bilateral;
- ✓ bilateral upper limb ultrasonographic tests (Doppler, Echo Doppler, Echo Colour Doppler) carried out in the same session/access as bilateral tests on lower limbs, correspond to a single four-limb test.

List of ultrasound tests

- ✓ Upper abdominal (complete examination)
- ✓ Lower abdomen-pelvis and upper abdomen with bowel evaluation (complete examination)
- ✓ Doppler echocardiogram or transesophageal Colour Doppler
- ✓ M Mode 2D Echocardiogram
- ✓ M MODE 2D Doppler and Colour Doppler echocardiogram, with possible pharmacological or stress tests (echocardiostress)
- ✓ M MODE 2D and Doppler echocardiogram, with possible pharmacological or stress tests (echocardiostress)
- ✓ Endobronchial ultrasound
- ✓ Liver and biliary tract - Bilateral salivary glands - Large vessels - Intestinal - Mono/bilateral lymph nodes - Unilateral or bilateral breast - Mediastinal or hemithoracic - Spleen - Muscular, tendinous or articular - Ocular and Orbital - Pancreatic - Soft tissue - Pelvic (uterus, adnexa and bladder) - Penis - Prostate and bladder, suprapubic - Renal and adrenal bilateral - Testicular (bilateral) - Thyroid and parathyroid - Bladder (including possible use of contrast medium)
- ✓ Prostatic and bladder or anal and rectal, transrectal
- ✓ Renal, bilateral adrenal and bladder
- ✓ Scrotal and inguinal for detecting undescended testicle
- ✓ Transesophageal for gastroenterology
- ✓ Transvaginal with possible Colour Doppler
- ✓ Perminational bladder or transurethral intracavitary
- ✓ Upper or lower limbs (bilateral): Doppler
- ✓ Upper or lower limbs (bilateral): Echo Doppler
- ✓ Upper or lower limbs (bilateral): Echo Colour Doppler
- ✓ Upper and lower limbs (four limbs): Doppler
- ✓ Upper and lower limbs (four limbs): Echo Doppler
- ✓ Upper and lower limbs (four limbs): Echo Colour Doppler
- ✓ Echo Colour Doppler of any other non-described arterial-venous district or vascular segment
- ✓ Penile or testicular: Doppler
- ✓ Penile or testicular: Echo Doppler
- ✓ Penile or testicular: Echo Colour Doppler
- ✓ Complete Transcranial: Echo Doppler
- ✓ Complete Transcranial: Echo Colour Doppler
- ✓ Complete transcranial with spectral analysis
- ✓ Supra-aortic trunks: Doppler
- ✓ Supra-aortic trunks: Echo Doppler
- ✓ Supra-aortic trunks: Echo Colour Doppler
- ✓ Visceral: Doppler
- ✓ Visceral: Echo Doppler
- ✓ Visceral: Echo Colour Doppler
- ✓ Lower abdominal-pelvis (complete examination)

"Purple" Health Plan

Detailed description of covers included

COVER 5 – Highly specialist Diagnostics and Therapies

This Cover applies exclusively to high-specialisation diagnostics performed on an outpatient basis, using any technique, method and equipment and, when specified by the test, is inclusive of medicines/drugs, anaesthesiological assistance, arterial and venous examination (double charges are therefore not recognised as refundable).

The Cover does not include:

- ✓ high-specialisation diagnostic tests carried out as preliminary examinations relating to overnight hospitalisation for major surgery, even if carried out in the 120 days prior to hospitalisation;
- ✓ high-specialisation diagnostic tests carried out as post-overnight hospitalisation check-up examinations following major surgery, even if carried out in the 120 days after hospitalisation;
- ✓ high-specialisation diagnostic tests, even if deemed necessary, that do not fall within the Fund's area of activities (FasiOpen Basic Nomenclature) and/or are not included this Cover.

To request a refund for all included in this Cover you must attach - in addition to detailed expenditure documentation (online procedure) - a physician's prescription with certain or presumed diagnosis (by a specialist physician qualified to make diagnoses - diagnosis must not be confused with symptomatology) for which the tests were necessary, a copy of the report for the examination/s carried out.

This Cover applies to both indirect and direct-provision services at affiliated healthcare facilities belonging to the network recognised by the Fund. For direct-provision services, in the case of examinations (included in this Cover) carried out during the same session, the fees for examinations subsequent to the first one are reduced by/charged at 50% (always applied to the least expensive examination/s).

Note that a "contrast medium" should be regarded as a "single service" (and is in any case not recognised as refundable in the absence of the main test), so that the refund conditions set out below also apply to the aforementioned item/charge (i.e. the minimum non-refundable amount is calculated also for the "contrast medium" item/service).

Client means the employee and/or each member of his/her family unit duly registered with FasiOpen.

Description	Refund ceilings

MAXIMUM REFUND PER YEAR AND PER CLIENT	€ 10,000
MINIMUM NON-REFUNDABLE, for each item/service	€ 60
Details	**Sub-ceilings/Conditions of refund**
NUCLEAR MAGNETIC RESONANCE	DIRECT PROVISION: Refund percentage 75% INDIRECT PROVISION: Refund percentage 75%
COMPUTERISED AXIAL TOMOGRAPHY	
NUCLEAR MEDICINE (SCINTIGRAPHY)	
ANGIOGRAPHY (ALSO WITH CONTRAST)	
TOMOGRAPHY (STRATIGRAPHY) OF ORGANS OR SYSTEMS	
TRADITIONAL RADIOLOGY	
OUTPATIENT CHEMOTHERAPY	
OUTPATIENT RADIOTHERAPY	
NEUROLOGICAL DIAGNOSTICS (EEG AND/OR EMG)	
ANY TEST USING CONTRAST IN INTERVENTIONAL RADIOLOGY	

"Purple" Health Plan

Detailed description of covers included

COVER 6 - Specialist outpatient consultations

Only specialist consultations for diagnostic purposes are eligible for refund, excluding those needed to resolve the pathological event (check-ups).

The Cover does not include:

- ✓ specialist consultations carried out in the 120 days prior to/following overnight hospitalisation for major surgery and related to the hospitalisation/surgery itself;
- ✓ medical consultations not carried out by a professional with specialisation registered and traceable at the Italian Board of Physicians;
- ✓ specialist consultations listed in "Exclusions" (of the Basic Nomenclature) and everything specified in the "Services not covered by FasiOpen" paragraph and/or everything related to these and/or everything related to services not included in the Fund's area of activities (FasiOpen Basic Nomenclature).

To request a Refund you must attach the expenditure documentation. Please note that the specialist qualification of the physician must be clearly stated in the expenditure documentation (duly registered and traceable at the Italian Board of Physicians). The service carried out must not relate to another Cover within this Health Plan. This Cover applies to both indirect and direct-provision services at affiliated healthcare facilities belonging to the network recognised by the Fund. Here too, any check-up and/or prevention services beyond those expressly provided for in the Health Plan are not eligible for refund.

Client means the employee and/or each member of his/her family unit duly registered with FasiOpen.

Description	Refund ceilings
MAXIMUM REFUND PER YEAR AND PER CLIENT	€ 1,000
MAXIMUM REFUND PER EVENT (SINGLE SPECIALIST CONSULTATION)	DIRECT PROVISION: € 200 INDIRECT PROVISION: € 180
MINIMUM NON REFUNDABLE	None
Details	**Sub-ceilings/Conditions of refund**
Specialist outpatient consultations (received outside 120 days pre or post hospitalisation for major surgery)	DIRECT PROVISION: Refund Amount 100% INDIRECT PROVISION: Refund percentage 80%

COVER 7 - Public healthcare charges for health services received at public or accredited private healthcare facilities

This Cover operates within the context of public healthcare charges for diagnostic tests, specialist consultations and therapies.

Please note that, within the limits specified in the conditions, refunds are available for all public healthcare charges relating exclusively to services included in the Health Plan; this therefore excludes those relating to services not included therein, even if connected with diagnostic tests, specialist consultations, therapies and/or other services included in the Fund’s area of activities.

Please also remember that public healthcare charges must always show details of the services received and that, in view of the different Regional laws, in the event of the simultaneous payment of public healthcare charges and private services not recognised by the S.S.R., with both appearing on the same healthcare receipt, you must ask the healthcare facility to indicate which amount refers only to the public healthcare charges and/or which amount refers to privately received services. With regard to this please note that, in the case of laboratory tests, there is no additional refund for samples since these are included in the services themselves (samples cannot, therefore, be regarded as a private service and/or payable over and above the prescription ceiling). In the case of samples taken at home that constitute an additional fee to the service itself, these are only included within the ceiling set by the Cover if specifically indicated in the medical prescription (the request must always be in-line with the pathology indicated in the prescription and with the critical clinical profile that necessitated the sample being taken at home).

This Cover applies to both “indirect provision” and “direct provision” services.

To request a refund you must attach expenditure documentation clearly showing the application of the public healthcare charges, of any private healthcare fees, and details of the services. The contents of the expenditure documentation must match the contents of the medical prescriptions with diagnosis, which must be attached. Please note that any laboratory tests referable/related to pregnancy and paid for through public healthcare charges are a criterion for excluding refunds for ultrasounds during pregnancy (and vice versa) provided for by Cover 8 - Maternity Package.

Excluded from this Cover are all private services, all services mentioned in the "Exclusions" (in the Basic Nomenclature) and everything in the "Services not covered by FasiOpen paragraph and/or anything related to these, as well as spa treatments, medicines, dental services and anything else listed in the Basic Nomenclature as not falling within the Fund's area of activities.

We underline once again that FasiOpen does not refund additional fees (introduced by the law of 15/07/2011 n.11 and/or Financial Fixed Fee 2011 and/or by the "Fixed Fee Budget 2011" and/or any other additional fees, in addition to public healthcare charges).

Client means the employee and/or each member of his/her family unit duly registered with FasiOpen.

Description	Refund ceilings
MAXIMUM REFUND PER YEAR AND PER CLIENT	€ 500
MAXIMUM REFUND PER EVENT (single prescription)	€ 36.15
Details	**Sub-ceilings/Conditions of refund**
PUBLIC HEALTHCARE CHARGE FOR HEALTH SERVICES	DIRECT PROVISION: Refund Amount 100% INDIRECT PROVISION: Refund percentage 100%

COVER 8 - Maternity Package

This Cover is subdivided into 2 Sub-Covers in which the Fund's intervention differs by phase.

Sub-Cover 8.1 - Maternity Package TESTS

This Sub-Cover applies to both "indirect" and "direct-provision" services at affiliated healthcare facilities belonging to the network recognised by the Fund. It provides for the refund, within its own stated limits, for Clinical Laboratory Analyses or, alternatively, for a maximum of 5 ultrasounds during pregnancy. Please note that:

- Any clinical laboratory tests recognised as refundable by this Sub-Cover:
  - ✓ are exclusively those referable/related to pregnancy;
  - ✓ are exclusively those falling within the Fund's area of activities (again referable/relevant to pregnancy);
  - ✓ do not include prenatal diagnostic tests (PrenatalSafe, Harmony, NIPT and similar);
  - ✓ are recognised as refundable, within the limits of this Sub-Cover, only and exclusively if "ultrasounds in pregnancy" are not refunded, whether the latter are received privately and/or through payment of public healthcare charges;
  - ✓ rule out recognition of the allowance/daily allowance for Hospitalisation for Childbirth (whether received via public healthcare charges or privately);

- Non-invasive pre-natal diagnostic tests included in this Cover only include the tests indicated and are recognised as refundable only as an alternative to clinical analyses (i.e. ultrasounds during pregnancy). Should the test reveal the need for further investigations, refunds for Amniocentesis or Chorionic villus sampling may be recognised (upon submission of the Bi-Test or Tri-Test report).

- Any pregnancy ultrasounds recognised as refundable by this Sub-Cover:
  - ✓ are exclusively those referable/related to pregnancy;
  - ✓ are exclusively those falling within the Fund's area of activities (again referable/relevant to pregnancy);
  - ✓ are not covered under Cover 4 "Ultrasound Diagnostics" (and vice versa);
  - ✓ are recognised as refundable, within the limits of this Sub-Cover, only and exclusively if "clinical laboratory analyses" are not refunded, whether the latter are received privately and/or through payment of public healthcare charges;
  - ✓ rule out recognition of the allowance/daily allowance for Hospitalisation for Childbirth (whether received via public healthcare charges or privately).

To receive Refunds you must always attach, in addition to the expenditure documentation, a medical prescription for tests showing the "up-to-date" state of pregnancy in the diagnosis (i.e. it is not possible, in the case of services carried out privately, to submit for refund medical prescriptions that have already been forwarded

to the Fund even though there are no variations in the tests themselves). Should a non-invasive prenatal diagnostic test be carried out as an alternative to clinical laboratory analyses, the medical prescription and the test report must be submitted in addition to the expenditure documentation. Only if the test reveals well-founded reasons for further investigation, refunds for Amniocentesis or Chorionic villus sampling may be recognised upon submission of the expenditure documentation, the Bi-Test/Tri-Test report and the medical prescription for the Amniocentesis or Chorionic villus sampling. Please note that Amniocentesis or Chorionic villus sampling can be recognised as refundable only and exclusively if a refund for a Bi-Test or Tri-Test (no Public Healthcare Charges) with a positive report has been previously requested from (and therefore paid by) FasiOpen.

This Cover/Sub-Cover does not extend to tests/(any) investigations/services other than those expressly stated, or to anything set out in the "exclusions" paragraph (of the Basic Nomenclature), in the "Services not covered by FasiOpen paragraph" and/or to anything not falling within the Fund's area of activities.

Check-up	Description	Refund ceilings
CLINICAL LABORATORY ANALYSES	MAXIMUM REFUND PER PREGNANCY	€ 300
	MAXIMUM REFUND PER EVENT	€ 300
	Sub-ceilings/Conditions of refund	
	DIRECT PROVISION: Refund Amount 100% INDIRECT PROVISION: Refund percentage 80%	
ALTERNATIVELY TO CLINICAL ANALYSES		
NON-INVASIVE PRENATAL DIAGNOSTICS (Bi-Test or Tri-Test)	MAXIMUM REFUND PER PREGNANCY	€ 200
	MAXIMUM REFUND PER EVENT	€ 200
IN THE EVENT OF POSITIVE Bi-Test or Tri-Test		
AMNIOCENTESIS or CHORIONIC VILLUS SAMPLING	MAXIMUM REFUND PER PREGNANCY	€ 200
	MAXIMUM REFUND PER EVENT	€ 200
AS AN ALTERNATIVE TO CLINICAL ANALYSES (i.e. as an alternative to non-invasive prenatal diagnostics)		
Check-up	Description	Refund ceilings
ULTRASOUNDS IN PREGNANCY	MAXIMUM REFUND PER PREGNANCY	Maximum 5 Ultrasounds in Pregnancy
	Sub-ceilings/Conditions of refund	
	DIRECT PROVISION: Refund Amount 100% INDIRECT PROVISION: Refund Amount € 75 per single Ultrasound in Pregnancy	

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Detailed description of covers included

Sub-Cover 8.2 - Maternity Package - HOSPITALISATION FOR CHILDBIRTH

This Sub-Cover provides for the recognition of:

- ✓ an allowance/daily allowance per night, only for indirect provision, in the case of hospitalisation for childbirth carried out through the S.S.N. Please note that this Allowance/Daily Allowance is recognised solely for the person receiving care, i.e. only and exclusively for the woman giving birth, provided that her administrative status is in order at the time of hospitalisation for childbirth. No allowance is therefore recognised for any accompanying family members and/or children (even if registered with the Fund). The allowance/daily allowance for hospitalisation for childbirth is recognised, within the limits set out in this Sub-Cover, upon explicit request of the client/woman giving birth, only and exclusively if no refund request has been submitted to FasiOpen for "Hospitalisation for Childbirth" (any type) or for "Pregnancy Check-Ups", whether received via public healthcare charges or privately (and regardless of whether indirect or direct provision). To request recognition of this allowance/daily allowance you must attach to your request a complete, legible copy of the medical record relating to the hospitalisation for childbirth within and not later than 3 months from the date of discharge from this hospitalisation.
- ✓ Hospitalisation for eutocic childbirth (natural childbirth), whether with indirect or direct provision. The amount specified by the ceiling/sub-ceiling/conditions of refund is inclusive of all fees (charges for the healthcare facility, the medical/obstetric team etc.). The amount specified by the sub-ceiling/conditions of refund cannot be summed with the allowance for hospitalisation for childbirth (regardless of the type of childbirth). Please note that, regardless of the form of access (indirect or direct), if a hospitalisation for natural childbirth is converted to one for caesarean section or therapeutic abortion, the maximum amounts specified cannot be summed and only the final procedure, and therefore the relevant ceiling (and vice versa) will be recognised as refundable. To request a refund you must send a complete and legible copy of the medical record, together with the expenditure documentation, within the specified maximum limits (3 months from the date of discharge).
- ✓ Hospitalisation for Caesarean Section, whether indirect or direct provision. The amount specified by the ceiling/sub-ceiling/conditions of refund is inclusive of all fees (charges for the healthcare facility, the medical/obstetric team etc.). The amount specified by the ceiling/sub-ceiling/conditions of refund cannot be summed with the allowance for hospitalisation for childbirth (regardless of the type of childbirth). Please note that, regardless of the form of access (indirect or direct), if a hospitalisation for caesarean section is converted to one for natural childbirth or therapeutic abortion, the maximum amounts specified cannot be summed and only the final procedure, and therefore the relevant ceiling (and vice versa) will be recognised as refundable. To request a refund you must send a complete and legible copy of the medical record, together with the expenditure documentation, within the specified maximum limits (3 months from the date of discharge).
- ✓ Hospitalisation for Therapeutic Abortion, whether indirect or direct provision. The amount specified by the ceiling/sub-ceiling/conditions of refund is inclusive of all fees (charges for the healthcare facility, the medical/obstetric team etc.). The amount specified by the ceiling/sub-ceiling/conditions of refund cannot be summed with the allowance for hospitalisation for childbirth (regardless of the type of childbirth). Please note that, regardless of the form of access (indirect or direct), if

a hospitalisation is converted (as described above), the maximum amounts specified cannot be summed and only the final procedure, and therefore the relevant ceiling (and vice versa) will be recognised as refundable. To request a refund you must send a complete and legible copy of the medical record, together with the expenditure documentation, within the specified maximum limits (3 months from the date of discharge).

- ✓ Psychological support sessions in the immediate post-natal period - for both indirect and direct-provision services - if carried out and invoiced (within 150 days following the birth) by a physician specialising in psychiatry or clinical psychology or if carried out by psychologists or psychotherapists duly registered with the board. These therapies must be given in a specialist clinical facility. To request a refund, within the maximum limits set by the Cover itself, you must send - in addition to the expenditure documentation clearly showing the academic qualification of the professional and his/her registration number - a copy of the clinical file relating to the hospitalisation for childbirth and the specific dates of the individual sessions. Here too, please remember that the time limit for the above-mentioned consultations/sessions (150 days after childbirth) starts from the date of discharge from hospital.

Description	Refund ceilings
MAXIMUM REFUND PER EUTOCIC CHILDBIRTH (natural childbirth)	DIRECT PROVISION: € 3,000 INDIRECT PROVISION: € 3,000
MAXIMUM REFUND PER CAESAREAN CHILDBIRTH	DIRECT PROVISION: € 5,000 INDIRECT PROVISION: € 5,000
MAXIMUM REFUND PER THERAPEUTIC ABORTION	DIRECT PROVISION: € 2,000 INDIRECT PROVISION: € 2,000
MAXIMUM REFUND OF ALLOWANCE PER NIGHT (indirect provision only)	€ 100
MAXIMUM REFUND FOR POSTNATAL PSYCHOLOGICAL SUPPORT FOR PREGNANCY	€ 360
Details	**Sub-ceilings/Conditions of refund**
EUTOCIC CHILDBIRTH (natural childbirth)	DIRECT PROVISION: Excess charged to the client € 500 INDIRECT PROVISION: Excess charged to the client € 500
CAESAREAN CHILDBIRTH	DIRECT PROVISION: Excess charged to the client € 1,000 INDIRECT PROVISION: Excess charged to the client € 1,000
THERAPEUTIC ABORTION	DIRECT PROVISION: Excess charged to the client € 500 INDIRECT PROVISION: Excess charged to the client € 500
CHILDBIRTH HOSPITALISATION ALLOWANCE (only indirect provision)	INDIRECT PROVISION: Maximum 10 nights of hospitalisation for childbirth through the S.S.N
POSTNATAL PSYCHOLOGICAL SUPPORT	DIRECT PROVISION: € 60 per consultation/session for a maximum of 6 consultations/sessions within 150 days after childbirth INDIRECT PROVISION: € 60 per consultation/session for a maximum of 6 consultations/sessions within 150 days after childbirth

“Purple” Health Plan

Detailed description of covers included

COVER 9 - Prevention Packages

This Sub-Cover applies to both “indirect” and “direct-provision” services at healthcare facilities belonging to the network recognised by the Fund that have adopted the Prevention Packages.

FasiOpen recognises 1 Prevention Package per year (regardless of whether received indirectly or directly) according to the invoice date of the first “Package”, but with the specific characteristic that the same Package can be repeated every 2 years (according to the invoice date). Example: the client receives Package X - invoice date 20/01/2022 - from 21/01/2023 he/she can receive Package Y - on 22/01/2024 he/she can receive Package X again or choose a different Package (while he/she will be able to repeat Package Y in 2025).

The tests included in each individual package must be received in one single solution (regardless of whether indirect or direct provision). Each package can be received only if the client falls within specific age/sex bands (see diagram below) specified by the package.

To request a refund for a Prevention Package you must forward the expenditure documentation, clearly showing all the tests contained in the Package itself and received in one single solution.

FasiOpen reserves the right to request a copy of the test reports included in the individual Prevention Packages should it need these when preparing the file.

Diagnostic tests other than those described in this Cover and appearing on expenditure receipts will not be included in the value of the individual prevention services (i.e. they cannot be regarded as substitutes for those provided for in the Package regardless of the expenditure incurred) but, if included in other Covers, may be recognised as refundable within the limits of the conditions specified by the latter.

Client means the employee and/or each member of his/her family unit duly registered with FasiOpen.

Description	Services Included	Refund ceilings	Sex	Age Band
CARDIOVASCULAR WOMEN	- Hemochromocytometric and Morphological - Erythrocyte sedimentation rate (ESR) - Glycaemia - Azotaemia - Creatininemia - HDL cholesterol - LDL cholesterol - Total cholesterol - Glutamic oxalacetic transaminase (GOT) and glutamate-pyruvate transaminase (GPT) - Urine, complete chemical and microscopic examination - ECG	DIRECT PROVISION: 100% INDIRECT PROVISION: € 90	WOMEN	Age 45 or over
Description	**Services Included**	**Refund ceilings**	**Sex**	**Age Band**

ONCOLOGICAL WOMEN	- Hemochromocytometric and Morphological - Erythrocyte sedimentation rate (ESR) - Glycaemia - Azotaemia - Creatininemia - HDL cholesterol - LDL cholesterol - Total cholesterol - Glutamic oxalacetic transaminase (GOT) and glutamate-pyruvate transaminase (GPT) - Urine, complete chemical and microscopic examination - Cytological for cancer diagnostics (pap test) or endocervical cytological - plus vaginal bacteriological smear - Bilateral mammography	DIRECT PROVISION: 100% INDIRECT PROVISION: € 200	WOMEN	Age 45 or over
CARDIOVASCULAR MEN	- Hemochromocytometric and Morphological - Erythrocyte sedimentation rate (ESR) - Glycaemia - Azotaemia - Creatininemia - HDL cholesterol - LDL cholesterol - Total cholesterol - Glutamic oxalacetic transaminase (GOT) and glutamate-pyruvate transaminase (GPT) - Urine, complete chemical and microscopic examination - ECG	DIRECT PROVISION: 100% INDIRECT PROVISION: € 90	MEN	Age 45 or over
ONCOLOGICAL MEN	- Hemochromocytometric and Morphological - Erythrocyte sedimentation rate (ESR) - Glycaemia - Azotaemia - Creatininemia - HDL cholesterol - LDL cholesterol - Total cholesterol - Glutamic oxalacetic transaminase (GOT) and glutamate-pyruvate transaminase (GPT) - Urine, complete chemical and microscopic examination - Prostate-specific antigen (PSA) - Suprapubic prostate and bladder ultrasound	DIRECT PROVISION: 100% INDIRECT PROVISION: € 150	MEN	Age 45 or over
OPHTHALMOLOGY	- O.C.T. – Optical coherence tomography - Corneal Pachymetry - Computerised Campimetry (VCP) - Delivery of the Report by the Ophthalmologist	DIRECT PROVISION: € 180 INDIRECT PROVISION: € 120	MEN/ WOMEN	Age 40 or over
THYROID CANCER	- TSH (Thyrotropic Hormone) - Thyroid Ultrasound	DIRECT PROVISION: 100% INDIRECT PROVISION: € 50	MEN/ WOMEN	Age 45 or over
MELANOMA	- Dermatological examination - Nerve Mapping - Epiluminescence - Delivery of test images/photos	DIRECT PROVISION: 100% INDIRECT PROVISION: € 70	MEN/ WOMEN	Age 50 or over
Description	**Services Included**	**Refund ceilings**	**Sex**	**Age Band**

DYSMETABOLIC SYNDROME	- Glycaemia - HDL cholesterol - LDL cholesterol - Total cholesterol - Triglycerides - Microalbuminuria - Uricemia	DIRECT PROVISION: € 30 INDIRECT PROVISION: € 30	MEN/ WOMEN	Age 50 or over

COVER 10 - Dentistry

The Cover applies to both “direct provision” and in “indirect provision” services, exclusively if carried out by a dentist qualified in Dentistry and Dental Prosthetics or by a physician qualified in Medicine and Surgery before January 1980, those covered by Legislative Decree 386/1998 and those specialised in one of the dental fields recognised in Ministerial Decree of 18 September 2000; in all cases, the title and relevant specialisation must be registered and traceable with the Italian Board of Physicians, Surgeons and Orthodontists.

Refunds for public healthcare charges relating to dental services are thus excluded.

Please note that dental services are subject to time limits for refund and that, for implants and prosthetic services (permanent fixed prostheses relating to osseointegrated implants) there is a mandatory requirement to submit pre- and post-treatment documentation as well as a preventive treatment plan (using the specific indirect provision form). There is no need to wait for the outcome of the preventive treatment plan assessment to begin any treatment that you need; the Fund's assessment procedure is purely administrative, and in no way enters into the merits of the treatment decision made by your dentist and/or the healthcare facility.

The outcome of the treatment plan assessment is intended to highlight any medical-administrative incompatibilities between the service codes identified, particularly with regard to what is specified in the Cover, time limits and mandatory requirements for individual services.

Please note that the time limit for eligibility for refund refers to the length of time before a service can again be recognised by the Fund on a particular tooth/site or arch/hemiarch (where applicable).

To clarify further, please note that dental services are attributed to the individual teeth/sites/arches/hemiarches (where applicable) based on the invoice date for the balance of the services themselves. For example, if a filling is refundable once every 3 years on a certain tooth and is refunded with an invoice dated 03/03/2022, this will not be recognised again for the same tooth before 04/03/2025.

The evaluation of time limits and/or compatibility between service codes/items is made based on services being requested simultaneously (those already settled at the time of examining the request), and cannot take into account services included in requests that are still being prepared and/or those that have not yet arrived at the Fund.

To send a claim for dental services you must submit a fully completed “Services Claim Form” (if you are only claiming for services without an obligatory treatment plan) or the form attached to the outcome of the treatment plan (if you are claiming for services with the obligation to submit a preventive treatment plan and/or services without this obligation simultaneously). The refund request for dental services must be submitted (correctly completed) to FasiOpen together with the balance invoice no later than 3 months from the date of the balance invoice itself.

We therefore urge clients to pay attention to the timetable for submitting the treatment plan (where necessary), since its submission does not constitute an exception to the maximum time limits for submitting a refund request. While reminding you that expenditure documentation must always be in the name of the client for whom the treatment has been carried out (in the case of minors, even if the invoice is in the name

of the FasiOpen membership holder, the name of the minor receiving treatment must be clearly indicated on the invoice since the main person must always be identifiable as required by the tax regulations), and that it is not possible to submit an expenditure receipt for expenses relating to services received by more than one family member/client, we underline that invoices for payments on account are not refundable. In particular, we urge you to read the contents of the "Dentistry" paragraph, particularly regarding the distinction between invoices on account, partial balance invoices and balance invoices.

For "direct provision" dental services received at a healthcare facility belonging to the network recognised by the Fund, we urge members/clients not to submit requests to the Fund for the refund of excess fees left payable by themselves, since FasiOpen (where the conditions are met) pays the relevant ceiling amount for cost-sharing directly to the healthcare facility. For direct-provision dental services, all administrative procedures for submitting refund request/s are the responsibility of the facility itself.

Implants and associated crowns

The cover is all-inclusive of implant surgery, osseointegrated screws, implant-supported mesostructure reconstruction and related permanent rehabilitation using prosthetic crowns (regardless of the material used to make the prosthesis by the dental laboratory), always within the specified annual limits.

It should be underlined that an osseointegrated screw is refundable only once in a lifetime, as is only one osseointegrated implant per tooth location, while the relevant definitive prosthetic crown (positioned on an implant paid for by the Fund) is refundable once every 5 years - always within the specified limits for the service within the refund ceiling bracket. No request for a permanent prosthetic crown can be made separately from the respective implant pillar, unless this involves the replacement (on the expiry of time limits) of a prosthesis previously refunded by the Fund.

Prosthetic services other than those specified - and according to the method specified - in the cover, and prosthetic operations performed on rehabilitated tooth locations with pre-existing implants and/or those not refunded by FasiOpen, are not eligible for refund. Likewise, no financial contribution is due from the Fund for temporary prosthetic crowns on osseointegrated implants even the latter are covered by this cover; mini-orthodontic implants; implants-prosthetic services carried out to replace supernumerary teeth or for the rehabilitation of diastemas or larger spaces existing between the dental locations; implant-supported mesostructure reconstructions and implant surgery not covered by the all-inclusive items - i.e. these services cannot be refunded as separate items.

Dental Treatments

Dental therapies, regardless of the type of treatment, are refundable for a maximum of 3 years, also not consecutive, regardless of the number of arches and always by the year (1 January-31 December) in which the client turns 18 years of age.

Please note that it is not possible to submit a refund claim for dental treatments with expenditure documentation that refers to multiple years of treatment. The sub-ceiling for dental treatments, within the annual ceiling specified by the Cover, applies regardless of the number of arches per year. Any unused annual sub-ceilings and/or residual unused annual sub-ceilings cannot be added to those of subsequent years (if remaining).

Please note that, in the context of dental treatment and therefore within the maximum period of 3 years (up to 18 years of age), maintenance therapy using a retainer (whether fixed or mobile) is refundable only once (according to the annual ceiling) regardless of the number of arches undergoing treatment. Please therefore take care when submitting refund requests, since dental retainer treatments are carried out at the end of therapy and their payment by the Fund prevents any subsequent recognition for refund of dental treatment (of any type regardless of the arch), even if all your available years of maximum refund have not been used.

Obligatory documentation to be submitted in order to obtain a refund

"Obligations" are diagnostic tests and/or certifications that must be produced provided to the Fund, without which services may not be recognised as being refundable by FasiOpen. You must attach, together with the treatment plan and expenditure documentation:

- ✓ The pre-treatment radiographic documentation (orthopanoramic - intrabuccal x-ray - bite wings - dentascan or conical beam tomography) - i.e. carried out, as specified by the medical-dental protocols, before positioning the fixture (in the case of "implants and crowns") and before extraction of the natural tooth (in the case of "extractions of bone-impacted tooth" and "extractions of the third molar in dysodontiasis" and "Germectomy"). The following are not considered to be valid pre-treatment documents: intraoral photographs; slides; radiographic documentation from before the year that coverage was activated.
- ✓ Post-treatment radiographic documentation (orthopanoramic - intrabuccal x-ray - bite wings - dentascan or conical beam tomography), i.e. radiographic documentation showing the rehabilitated osseointegrated implant with permanent prosthetic crown.

Alternatively, and only in the case of post-treatment documentation, one of the following options may be supplied:

- ✓ intrabuccal x-ray and/or bite wings showing the positioning of the fixture, and intraoral photograph, showing the permanent prosthetic crown cemented onto the relevant implant;
- ✓ intraoral photograph clearly showing the "healing screw" before fitting of the prosthesis, and intraoral photograph showing the successful cementing of the permanent prosthetic crown.

Client means the employee and/or each member of his/her family unit duly registered with FasiOpen.

Description		Refund ceilings	
MAXIMUM REFUND PER YEAR AND PER CLIENT		€ 2,400	
Service code	Details	Sub-ceilings/Conditions of refund	
6130	SPECIALIST DENTAL EXAMINATION WITH ANY TREATMENT PLAN	Refundable maximum once a year	DIRECT PROVISION CARE ONLY
6261	PREVENTION OF ORAL CAVITY CANCER	Refundable maximum once a year	DIRECT PROVISION CARE ONLY
6137	ORAL HYGIENE: DEBRIDEMENT	Refundable maximum twice a year	DIRECT PROVISION: Maximum excess charged to the client € 10 for Debridement INDIRECT PROVISION: Maximum Refund amount € 25
2583	GINGIVAL SURGERY PER ARCH (INCLUDING ANY TYPE OF FLAP - INCLUDING SUTURE) - FROM 17 YEARS OF AGE	Refundable once every 5 years regardless of age. Cannot overlap with other surgery on the same arch.	DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 77.50
30311	GINGIVAL SURGERY PER ARCH (INCLUDING ANY TYPE OF FLAP - INCLUDING SUTURE) - UP TO 16 YEARS OF AGE		DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 77.50
2584	MUCOGINGIVAL OR FORNIX LOWERING SURGERY, PER ARCH (INCLUDING ANY TYPE OF FLAP - INCLUDING SUTURE) - FROM 17 YEARS OF AGE		DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 117.50
30312	MUCOGINGIVAL OR FORNIX LOWERING SURGERY, PER ARCH (INCLUDING ANY TYPE OF FLAP - INCLUDING SUTURE) - UP TO 16 YEARS OF AGE		DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 117.50
2585	BONE SURGERY (INCLUDING ANY TYPE OF ACCESS FLAP - INCLUDING SUTURE) COMPLETE TREATMENT PER HEMIARCH - FROM 17 YEARS OF AGE	Refundable once every 5 years on the same hemiarch regardless of age. Cannot overlap with other surgery on the same hemiarch. OBLIGATORY: For code 2587, send preventive treatment plan at the same time as the osseointegrated implant/s	DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 130.00
30313	BONE SURGERY (INCLUDING ANY TYPE OF ACCESS FLAP - INCLUDING SUTURE) COMPLETE TREATMENT PER HEMIARCH - UP TO 16 YEARS OF AGE		DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 130.00
2586	GENGIVECTOMY AS A SINGLE SERVICE - PER HEMIARCH - FROM 17 YEARS OF AGE		DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 34.50
30314	GENGIVECTOMY AS A SINGLE SERVICE - PER HEMIARCH - UP TO 16 YEARS OF AGE		DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 34.50

Service code	Details	Sub-ceilings/Conditions of refund	
2587	INSERTION OF BIO-COMPATIBLE MATERIAL (INCLUDING ANY TYPE OF FLAP) - PER HEMIARCH - SERVICE REFUNDABLE ONLY IN THE EVENT OF IMPLANT SURGERY	Refundable once every 5 years on the same hemiarch regardless of age. Cannot overlap with other surgery on the same hemiarch. OBLIGATORY: For code 2587, send preventive treatment plan at the same time as the osseointegrated implant/s	DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 85.00
2589	INTERDENTAL SPLINTING - ANY MATERIAL USED - ONLY FOR PARODONTAL PROBLEMS FROM 25 YEARS OF AGE - PER HEMIARCH		DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 32.00
2602	DIRECT-INDIRECT PULP CAPPING - PER PERMANENT TOOTH - FROM 17 YEARS OF AGE	Refundable once every 3 years on the same tooth	DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 14.50
30322	DIRECT-INDIRECT - DECIDUOUS OR PERMANENT - PULP CAPPING - PER TOOTH - UP TO 16 YEARS OF AGE	Refundable once every 3 years on the same tooth. Not equatable with sealing	DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 14.50
2650	FILLING OF CAVITIES, CLASS 1 - 3 - 5 - ANY MATERIAL - PER PERMANENT TOOTH FROM 17 YEARS OF AGE	Refundable once every 3 years, on the same tooth, whether deciduous or permanent, and regardless of age	DIRECT PROVISION: Maximum excess charged to the client € 40 per single filling INDIRECT PROVISION: Maximum Refund amount € 10 per single filling
2667	FILLING OF CAVITIES, CLASS 2 - 4 - ANY MATERIAL - PER PERMANENT TOOTH FROM 17 YEARS OF AGE		
30324	FILLING OF ANY CAVITIES, CLASS 1 - 2 - 3 - 4 - 5 - ANY MATERIAL - PER PERMANENT TOOTH UP TO 16 YEARS OF AGE		
30325	FILLING OF DECIDUOUS TOOTH (ANY CLASS - ANY MATERIAL - REFUNDABLE ONCE EVERY 3 YEARS IN THE SAME TOOTH REGARDLESS OF WHETHER IT IS DECIDUOUS OR PERMANENT)		
2603	INLAY IN INTEGRAL PRECIOUS ALLOY (GOLD) OR CERAMIC INLAY OR ONLAY INCLUDING BUILD UP AND TEMPORARY - PER PERMANENT TOOTH - INDIRECT - FROM 17 YEARS OF AGE	Refundable once every 5 years on the same tooth/dental location, regardless of age or whether deciduous or permanent. Not refundable on the anterior teeth from canine to canine and cannot overlap with another type of inlay	DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 89.50
2632	INLAY IN RESIN OR CAD CAM COMPOSITE - INLAY OR ONLAY INCLUDING BUILD UP AND TEMPORARY - PER PERMANENT TOOTH - DIRECT/INDIRECT - FROM 17 YEARS OF AGE		DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 89.50

Service code	Details	Sub-ceilings/Conditions of refund	
30323	INLAY PER DECIDUOUS/PERMANENT TOOTH - REGARDLESS OF MATERIAL/METHOD/TECHNIQUE - INLAY OR ONLAY OR OVERLAY INCLUDING BUILD-UP AND TEMPORARY - PER DECIDUOUS/PERMANENT TOOTH - DIRECT/INDIRECT REGARDLESS OF THE NUMBER OF SURFACES - UP TO 16 YEARS OF AGE	Refundable once every 5 years on the same tooth/dental location, regardless of age or whether deciduous or permanent. Not refundable on the anterior teeth from canine to canine and cannot overlap with another type of inlay	DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 89.50
2609	TOOTH RECONSTRUCTION WITH SCREW OR PIN ANCHORING OF DECIDUOUS OR PERMANENT DEVITALIZED TEETH (AT THE SAME TIME OR PREVIOUSLY TREATED) - PER TOOTH - FROM 17 YEARS OF AGE	Refundable once every 3 years on the same tooth/dental location, regardless of age and/or whether deciduous or permanent	DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 27.50
30326	TOOTH RECONSTRUCTION WITH SCREW OR PIN ANCHORING OF DECIDUOUS OR PERMANENT DEVITALIZED TEETH (AT THE SAME TIME OR PREVIOUSLY TREATED) - PER TOOTH - UP TO 16 YEARS OF AGE		DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 27.50
2610	COMPLETE ROOT CANAL TREATMENT OF 1 CANAL (INCLUDING ANY TYPE OF FILLING) INCLUDING PRE-ENDODONTIC CORONAL RECONSTRUCTION - PER PERMANENT TOOTH - INCLUDING ENDORAL X-RAYS	Refundable once per tooth. Cannot overlap with other root canal treatment or endodontic re-treatment.	DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 47.50
30327	COMPLETE ROOT CANAL TREATMENT OF DECIDUOUS TOOTH 1 CANAL (INCLUDING ANY TYPE OF FILLING) INCLUDING PRE-ENDODONTIC CORONAL RECONSTRUCTION - PER TOOTH - INCLUDING ENDORAL X-RAYS		DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 47.50
2611	COMPLETE ROOT CANAL TREATMENT OF 2 CANALS (INCLUDING ANY TYPE OF FILLING) INCLUDING PRE-ENDODONTIC CORONAL RECONSTRUCTION - PER PERMANENT TOOTH - INCLUDING ENDORAL X-RAYS		DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 57.00
30328	COMPLETE ROOT CANAL TREATMENT OF MULTI-ROOT DECIDUOUS TOOTH - 2 OR MORE CANALS (REGARDLESS OF THE NUMBER OF CANALS) INCLUDING ANY TYPE OF FILLING AND INCLUDING PRE-ENDODONTIC CORONAL RECONSTRUCTION - PER TOOTH - INCLUDING ENDORAL X-RAYS		DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 57.00
2612	COMPLETE ROOT CANAL TREATMENT OF 3 OR MORE CANALS (INCLUDING ANY TYPE OF FILLING) INCLUDING PRE-ENDODONTIC CORONAL RECONSTRUCTION - PER PERMANENT TOOTH - INCLUDING ENDORAL X-RAYS		DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 78.50
2614	ENDODONTIC RETREATMENT OF TOOTH WITH 1 CANAL (INCLUDING ANY TYPE OF FILLING OF THE ACCESS CAVITY, INCLUDING ANY REMOVAL OF INTRACANAL PINS) PER PERMANENT TOOTH INCLUDING ENDORAL X-RAYS		DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 40.50

Service code	Details	Sub-ceilings/Conditions of refund	
30330	ENDODONTIC RE-TREATMENT OF DECIDUOUS TOOTH REGARDLESS OF THE NUMBER OF CANALS (INCLUDING ANY TYPE OF FILLING OF THE ACCESS CAVITY, INCLUDING ANY REMOVAL OF INTRACANAL PINS) PER TOOTH INCLUDING ENDORAL X-RAYS	Refundable once per tooth. Cannot overlap with other root canal treatment or endodontic re-treatment.	DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 40.50
2668	ENDODONTIC RETREATMENT OF TOOTH WITH 2 CANALS (INCLUDING ANY TYPE OF FILLING OF THE ACCESS CAVITY, INCLUDING ANY REMOVAL OF INTRACANAL PINS) PER PERMANENT TOOTH INCLUDING ENDORAL X-RAYS		DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 81.00
2669	ENDODONTIC RETREATMENT OF TOOTH WITH 3 OR MORE CANALS (INCLUDING ANY TYPE OF FILLING OF THE ACCESS CAVITY, INCLUDING ANY REMOVAL OF INTRACANAL PINS) PER PERMANENT TOOTH INCLUDING ENDORAL X-RAYS		DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 121.50
2613	PULPOTOMY AND FILLING OF THE PULP CHAMBER OR PULPECTOMY AND TEMPORARY FILLING FOR ANY NUMBER OF CANALS - PER PERMANENT TOOTH - INCLUDING ENDORAL X-RAYS	Refundable once per tooth. Cannot overlap with endodontic re-treatment.	DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 25.00
30329	PULPOTOMY AND FILLING OF THE PULP CHAMBER OR PULPECTOMY AND TEMPORARY FILLING FOR ANY NUMBER OF CANALS - PER DECIDUOUS TOOTH - INCLUDING ENDORAL X-RAYS		DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 25.00
2594	EXTRACTION OF TOOTH OR ROOT (SIMPLE OR COMPLEX) OF PERMANENT TOOTH INCLUDING ANY SUTURES - PER NATURAL TOOTH	Refundable only once for the same tooth. Not equatable with the extraction of implants and/or fragments.	DIRECT PROVISION: Maximum excess charged to the client € 20 per single extraction INDIRECT PROVISION: Maximum Refund amount € 17 per single extraction
30318	EXTRACTION OF A TOOTH OR A SIMPLE OR COMPLEX ROOT OF A DECIDUOUS TOOTH (INCLUDING ANY SUTURES AND SEDATION)		
2595	EXTRACTION OF TOTALLY BONE-IMPACTED TOOTH, INCLUDING 3RD MOLAR - ONLY FOR TEETH THAT HAVE NEVER ERUPTED IN THE DENTAL ARCH (EXCLUDING GERMECTOMY) - INCLUDING ANY SUTURES PER NATURAL TOOTH	Refundable only once for the same tooth. Not equatable with the extraction of implants and/or fragments. OBLIGATORY: preventive care plan to be sent with PRE-EXTRACTION (pre-treatment) radiography	DIRECT PROVISION: Maximum excess charged to the client € 40 per single extraction INDIRECT PROVISION: Maximum Refund amount € 69 per single extraction
2596	EXTRACTION OF PARTIALLY BONE-IMPACTED 3RD MOLAR - ONLY FOR TEETH THAT HAVE NEVER ERUPTED IN THE DENTAL ARCH - INCLUDING ANY SUTURES PER NATURAL TOOTH		DIRECT PROVISION: Maximum excess charged to the client € 40 per single extraction INDIRECT PROVISION: Maximum Refund amount € 63 per single extraction
30319	GERMECTOMY (INCLUDING ALL SURGICAL STAGES AND ACTIVITIES INCLUDING MUCOGINGIVAL FLAP AND/OR OSTEOTOMY AND/OR ODONTOTOMY - SUTURES AND SEDATION - EXCLUDING SEDATION WITH NITROUS OXIDE) UP TO 16 YEARS OF AGE		DIRECT PROVISION: Maximum excess charged to the client € 40 per single extraction INDIRECT PROVISION: Maximum Refund amount € 69 per single extraction

Service code	Details	Sub-ceilings/Conditions of refund	
2615	OSSEOINTEGRATED IMPLANTS (ANY TYPE INCLUDING ZYGOMATIC OR PTERYGOID IMPLANTS EXCLUDING MINI-ORTHODONTIC IMPLANTS OR IMPLANTS OTHER THAN OSSEOINTEGRATED) PER DENTAL LOCATION	Refundable only once per same tooth regardless of the number of roots and/or the space to be rehabilitated. OBLIGATORY: preventive care plan to be sent with PRE-IMPLANT (pre-treatment) radiography) Post-treatment radiography to be sent with the refund request	DIRECT PROVISION: Maximum refund per implant with crown € 650, of which: € 400 per osseointegrated implant € 250 per permanent prosthetic crown INDIRECT PROVISION: Maximum refund per implant with crown € 650, of which: € 400 per osseointegrated implant € 250 per permanent prosthetic crown
2671	POLYMER-COATED, METAL-FREE, CERAMIC-FREE PERMANENT CROWN, CERTIFIABLE AS PERMANENT MATERIAL - PER TOOTH/IMPLANT FROM 17 YEARS OF AGE	Refundable once every 5 years on the same implant. Not refundable on natural teeth and/or intermediate bridge locations and/or pre-existing implants or not paid by FasiOpen. OBLIGATORY: preventive care plan to be sent with PRE-REHABILITATION (pre-treatment) radiography Post-treatment radiography to be sent with the refund request (i.e. permanent crown on implant)	
2618	PERMANENT CROWN IN BIOMEDICAL ALLOY/RESIN/COMPOSITE CERTIFIABLE AS PERMANENT MATERIAL (ANY TYPE) - PER TOOTH/IMPLANT FROM 17 YEARS OF AGE	Refundable once every 5 years on the same implant. Not refundable on natural teeth and/or intermediate bridge locations and/or pre-existing implants or not paid by FasiOpen. OBLIGATORY: preventive care plan to be sent with PRE-REHABILITATION (pre-treatment) radiography Post-treatment radiography to be sent with the refund request (i.e. permanent crown on implant)	
2619	PRECIOUS ALLOY AND CERAMIC CROWN - METAL-FREE CROWN (CERAMIC OR INTEGRAL/MONOLITHIC CERAMIC MATERIALS - CAD CAM SYSTEMS) PER TOOTH/IMPLANT FROM 17 YEARS OF AGE	Refundable once every 5 years on the same implant. Not refundable on natural teeth and/or intermediate bridge locations and/or pre-existing implants or not paid by FasiOpen. OBLIGATORY: preventive care plan to be sent with PRE-REHABILITATION (pre-treatment) radiography Post-treatment radiography to be sent with the refund request (i.e. permanent crown on implant)	
2649	ENDORAL X-RAYS/BITE WINGS	A maximum of 1 pre-treatment endoral and 1 post-treatment endoral according to the codes relevant to them (implants and permanent crowns) up to a maximum of 6 endorals/bite wings per year (1 January - 31 December) OBLIGATORY: sending of the preventive treatment plan (since the request must be in the context of permanent implants/crowns) with obligation to submit the requested PRE-REHABILITATION (pre-treatment) endoral x-ray/bite wings with the refund request, obligation to send the requested post-treatment endoral x-ray/bite wings	DIRECT PROVISION: Maximum excess charged to the client € 10 per single endoral x-ray/bite wings INDIRECT PROVISION: Maximum Refund amount € 2.40 per single per single endoral x-ray/bite wings

Service code	Details	Sub-ceilings/Conditions of refund	
2637	ORTHOPANTOMOGRAPHY OF THE TWO ARCHES	Refundable maximum twice a year (1 January - 31 December)	DIRECT PROVISION: Maximum excess charged to the client € 20 INDIRECT PROVISION: Maximum Refund amount € 10.20 per orthopantomograph (performed at a dental facility)
2634	PARTIAL OR TOTAL SELECTIVE GRINDING, MAXIMUM 1 SESSION (REGARDLESS OF ARCH) - FROM 17 YEARS OF AGE	Refundable once per year regardless of arch	DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 19.00
30335	PARTIAL OR TOTAL SELECTIVE GRINDING, MAXIMUM 1 SESSION (REGARDLESS OF ARCH) - UP TO 16 YEARS OF AGE		DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 19.00
2635	DIAGNOSTIC PLATE OR ORTHOTIC OR BITE - INDIRECT SYSTEM - REGARDLESS OF ARCH AND NOT REFUNDABLE IN THE SAME YEAR AS THE DENTAL TREATMENT OR IN THE PRESENCE OF 2 TOTAL DENTURES IN THE 2 ARCHES - FROM 21 YEARS OF AGE	Refundable once every 2 years regardless of age and arch. Cannot overlap with any other plate or bite and not equatable with orthodontic retainer or template. Not refundable in the same year as the dental treatment.	DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 96.50
30336	BITE OR ORTHOTIC APPLIANCE - REGARDLESS OF ARCH - DIRECT OR INDIRECT SYSTEM - NOT REFUNDABLE IN ASSOCIATION WITH AND/OR IN THE SAME YEAR AS DENTAL TREATMENT (ANY TECHNIQUE AND/OR METHODOLOGY) OR RETAINER - UP TO 20 YEARS OF AGE		DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 96.50
2648	DIAGNOSTIC PLATE OR ORTHOTIC OR BITE - DIRECT SYSTEM - REGARDLESS OF ARCH AND NOT REFUNDABLE IN THE SAME YEAR AS THE DENTAL TREATMENT OR IN THE PRESENCE OF 2 TOTAL DENTURES IN THE 2 ARCHES - FROM 21 YEARS OF AGE		DIRECT PROVISION: Maximum excess charged to the client € 20 per service/arch INDIRECT PROVISION: Maximum Refund amount € 72.50
30307	DENTAL THERAPY WITH FIXED APPLIANCES PER ARCH PER YEAR, INCLUDING CEPHALOMETRIC ANALYSIS	Refundable once a year (1 January - 31 December), for a maximum of 3 years, also not consecutive, up to 18 years of age. Cannot overlap with other dental treatment items during the year. OBLIGATORY: TREATMENT PLAN PER YEAR OF TREATMENT with telecranium or photo of pre-treatment "bite/reverse bite" - Refund Phase per year of treatment - telecranium o photo of models in occlusion	DIRECT PROVISION: Maximum Refund amount € 200 per year regardless of number of arches treated INDIRECT PROVISION: Maximum Refund amount € 200 per year regardless of number of arches treated
30308	DENTAL THERAPY WITH MOBILE/FUNCTIONAL APPLIANCES PER ARCH PER YEAR, INCLUDING CEPHALOMETRIC ANALYSIS		
30309	DENTAL THERAPY WITH INVISIBLE APPLIANCES (ANY TYPE/MATERIAL) PER ARCH - PER YEAR - INCLUDING CEPHALOMETRIC ANALYSIS		
30310	DENTAL MAINTENANCE THERAPY WITH FIXED OR MOBILE RETAINER REGARDLESS OF THE NUMBER OF ARCHES	Refundable for maximum 1 year (1 January - 31 December) within a maximum of 3 years of treatment recognised for refund. Cannot overlap with other dental treatment items during the year. OBLIGATORY: TREATMENT PLAN FOR YEAR OF TREATMENT with intraoral photo of retainer in position - Refund Phase for 1 year of treatment - telecranium or intraoral photo of completed treatment (if completed) or intraoral photo of retainer in position (different from pre-treatment)	

"Purple" Health Plan

Detailed description of covers included

COVER 11 - Allowance/daily allowance in lieu for hospitalisation following major surgery with overnight stay

This Cover applies exclusively to "indirect provision" services.

Please note that recognition of the allowance/daily allowance can be issued only if explicitly requested by the member/client, and only when:

- ✓ The overnight hospitalisation for surgery was carried out with the S.S.R. (Italian regional health services);
- ✓ FasiOpen is not requested and/or was not requested to make any refund relating to/connected with overnight hospitalisation for surgery and/or services related to this (specialist consultations, therapies, tests, pre- and/or post-surgery, ambulance transport, etc.). The list of operations included in surgery is set out in Cover 1 and Cover 1.2.

The Cover does not apply in the case of daytime and/or overnight hospitalisation provided privately and/or for a difference in class. Likewise, no refund of allowance/daily allowance is available in the event of overnight hospitalisation for surgery not set out in the lists under Cover 1 and Cover 1.2 and/or for rehabilitation hospitalisation even if provided as a consequence of surgery (of those operations specified).

Please remember that any refund for an allowance/daily allowance is recognised for the client receiving treatment, i.e. only and exclusively for the person directly receiving the treatment/therapy (if he/she belongs to the family unit registered with the Fund when hospitalisation began), regardless of the "patient's" age, i.e., no additional allowance is recognised for any family member staying in hospital to assist the patient.

To request recognition of the allowance/daily allowance, a complete, legible copy of the medical record must be attached to the Refund Request Form, highlighting the intention to request only the relevant allowance. This refund request must be submitted within 3 months from the date of discharge.

Client means the employee and/or each member of his/her family unit duly registered with FasiOpen.

Description	Refund ceilings
MAXIMUM PER YEAR PER CLIENT	maximum 150 nights per year
Details	**Sub-ceilings/Conditions of refund**
ALLOWANCE IN LIEU FOR HOSPITALISATIONS FOLLOWING SURGERY	First 30 nights (regardless of department): € 80 Nights 31 to 150 (regardless of department): € 100

"Purple" Health Plan

Detailed description of covers included

COVER 12 - Newborn Protection

This Cover applies to both "indirect" and "direct-provision" services at healthcare facilities belonging to the network recognised by the Fund and is reserved for children up to 1 year of age maximum provided that they are members of the family unit assisted by FasiOpen at the time of hospitalisation.

The Cover includes major surgery for the correction of congenital malformations, a list of which is given below.

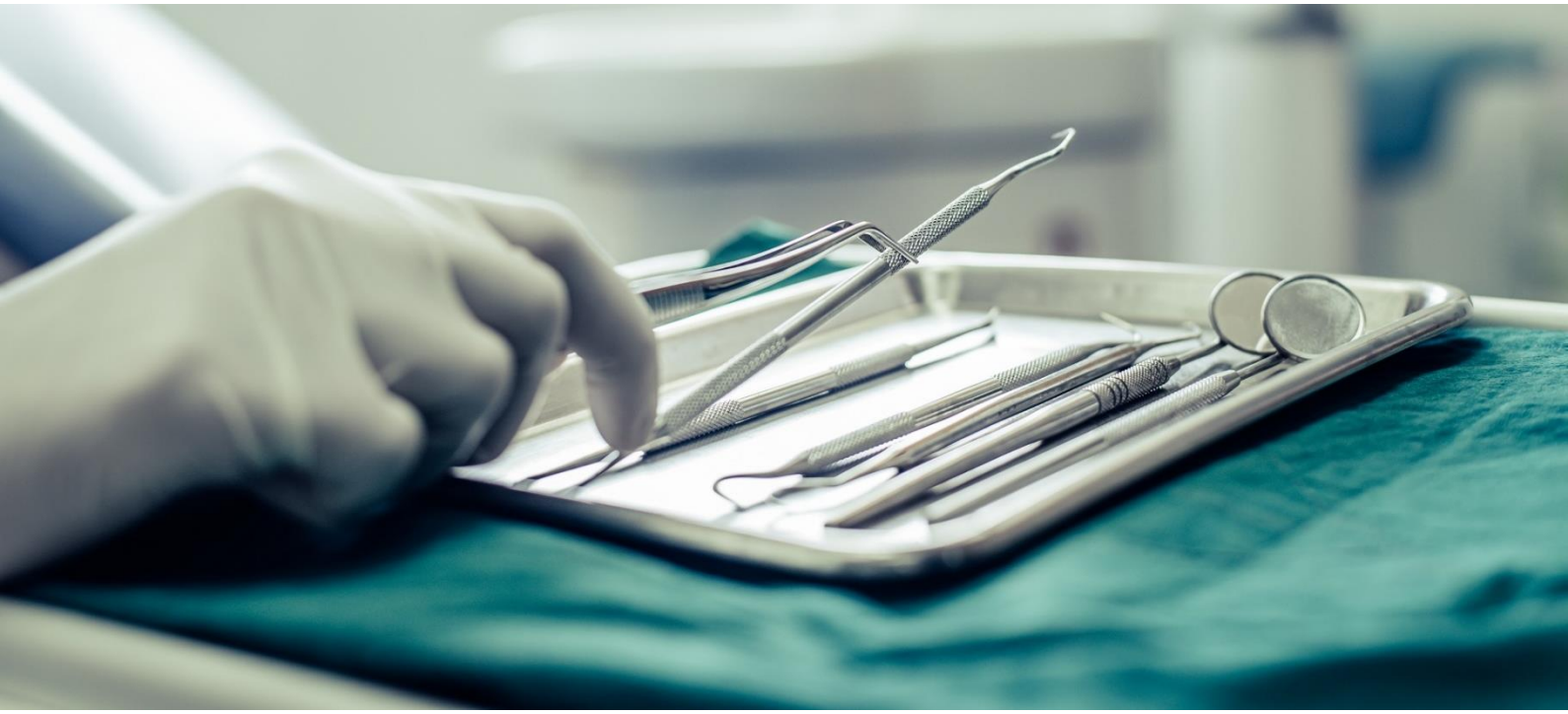
Client means the employee and/or each member of his/her family unit duly registered with FasiOpen.

Description	Refund ceilings
MAXIMUM REFUND PER YEAR PER CLIENT	€ 35,000
MAXIMUM AGE	1 year of age
Details	**Sub-ceilings/Conditions of refund**
LARGE SURGICAL OPERATIONS TO CORRECT CONGENITAL MALFORMATIONS	DIRECT PROVISION: Refund Amount 100% INDIRECT PROVISION: Refund percentage 100%

List of major surgical operations to correct congenital malformations

- ✓ Adult or neonatal open-heart cardiac surgery, including aneurysms or multiple valve replacements or aortic replacement or aortic plastic replacement (CEC), except for the interventions described
- ✓ Reintervention with restoration of CEC
- ✓ Section or ligation of the ductus arteriosus of Botallo
- ✓ Cardiac transplantation (inclusive of all services and medical explantation and implantation operations)
- ✓ Boutonniere deformity of the hand
- ✓ Correction of congenital clubfoot, soft and/or bone parts
- ✓ Boutonniere deformity of the toes
- ✓ Congenital cyst or fistula, removal of
- ✓ Oesophago-tracheal fistula, surgery for
- ✓ Megaoesophagus, surgery for
- ✓ Megaoesophagus, reintervention for
- ✓ Labial outcomes of cleft lip and palate
- ✓ Nasal outcomes of cleft lip and palate
- ✓ Unilateral cleft lip and palate
- ✓ Bilateral cleft lip and palate
- ✓ Anterior, posterior cleft palate of the soft palate
- ✓ Total cleft palate
- ✓ Wilms tumour removal
- ✓ Atresia of the anus with recto-urethral , recto-vulvar fistula: abdominal perineal descent
- ✓ Simple atresia of the anus: abdomino-perineal descent

- ✓ Atresia of the anus: perineal operation
- ✓ Biliary tract atresia, explorations
- ✓ Cephalohematoma, aspiration of
- ✓ Anterior bowel cysts (enterogenic and bronchogenic), surgery for
- ✓ Cranium bifidum with meningocele
- ✓ Cranium bifidum with meningoencephalocele
- ✓ Craniostenosis
- ✓ Dilatation due to congenital stenosis of the anus
- ✓ Bochdalek diaphragmatic hernia
- ✓ Morgagni diaphragmatic hernia
- ✓ Oesophagus (complete treatment), atresia or congenital fistulas of the
- ✓ Esonphalon or gastroschisis
- ✓ Umbilical fistula and cyst: from the omphalomesenteric canal with intestinal resection
- ✓ Umbilical granuloma, cauterisation
- ✓ Abdominal neuroblastoma
- ✓ Endothoracic neuroblastoma
- ✓ Pelvic neuroblastoma
- ✓ Newborn intestinal obstruction, atresia (need for anastomosis)
- ✓ Newborn intestinal obstruction with intestinal resection
- ✓ Newborn intestinal obstruction without intestinal resection
- ✓ Newborn intestinal obstruction-ileomeconeal: simple ileostomy
- ✓ Newborn intestinal obstruction-ileomeconial: resection with primitive anastomosis
- ✓ Newborn intestinal obstruction-ileomeconial: Mickulicz resection
- ✓ Pylorus, congenital stenosis of the
- ✓ Anal plastic surgery for congenital stenosis
- ✓ Brachial plexus, neurolysis for obstetrical paralysis of the
- ✓ Vein preparation for IV therapy and transfusion
- ✓ Rectum, prolapse with anal cerclage of the
- ✓ Rectum, prolapse with abdominal operation of the
- ✓ Spina bifida: meningocele
- ✓ Spina bifida: myelomeningocele
- ✓ Sacrococcygeal teratoma
- ✓ Obstetric lower limb trauma, treatment of
- ✓ Obstetric upper limb trauma, treatment of



COVER 13 – Transportation by ambulance

The Cover applies only to "indirect provision" services, and exclusively to transport within Italy.

Transportation by Ambulance is recognised as refundable - provided that the administrative status of clients is in order - only for serious pathologies in which they cannot be transported, with their own means, from their home to the chosen healthcare facility for hospitalisation and vice versa.

Within this Cover, hospitalisation means an overnight stay in a nursing home or hospital. Therefore, without prejudice to the fact that the only means of transport recognised as refundable for this Cover is an ambulance, no transport is recognised for ongoing therapies such as (though not limited to) chemotherapy, dialysis, physiokinesis therapy, etc.

The Cover does not include emergency private transport, even if in an ambulance, but is recognised as refundable only for planned hospitalisations.

The Cover does not apply to transfers from one nursing home or hospital to another nursing home or hospital.

To activate this Cover, the receipt/invoice issued by the ambulance service providing the transport (duly authorised by the competent Authorities) must be attached to the Refund Request Form, showing:

- ✓ medical certification specifying the client's critical clinical condition for which the service was activated, showing that it was impossible for him/her to use a different means of transport;
- ✓ the details of the person who provided the transportation;
- ✓ the name of the client who was transported;
- ✓ the date of transport;
- ✓ the place of departure and arrival.

Client means the employee and/or each member of his/her family unit duly registered with FasiOpen.

Description	Refund ceilings
MAXIMUM REFUND PER YEAR AND PER CLIENT	€ 1,500
MINIMUM NON REFUNDABLE	€ 50
Details	**Sub-ceilings/Conditions of refund**
TRANSPORTATION BY AMBULANCE FOR SERIOUS PATHOLOGIES	INDIRECT PROVISION: Refund percentage 100%

COVER 14 - LENSES

Ocular prostheses must be prescribed by the ophthalmologist for the correction of visual disturbances or ocular pathologies, sending the documentation regarding the visual correction to the Fund.

The ophthalmologist's prescription must not be dated more than 6 (six) months prior to the date of purchase of the aforementioned prostheses.

Refund requests must have attached a copy of the expenditure documentation valid for tax purposes, with details of the buyer (the client for whom the lenses are prescribed) and of the amounts relating to the individual items/services.

Requests must also be sent with a certificate of conformity with EU regulations (technical certifications issued by the optician and/or optometrist will not be accepted).

Refunds cannot be repeated, for the same client, within 12 (twelve) months following the date of the previous invoice, regardless of any residual ceiling.

Refunds for frames, eyeglasses, contact lenses for aesthetic purposes and single-use contact lenses (daily replacement) are excluded from this cover.

Refunds for corrective eyeglass lenses and contact lenses (not single-use) cannot overlap for the same patient.

Client means the employee and/or each member of his/her family unit duly registered with FasiOpen.

Description	Refund ceilings
MAXIMUM REFUND PER YEAR AND PER CLIENT	€ 100
MINIMUM NON REFUNDABLE	€ 65 per lens/pack of non-disposable contact lenses
Details	**Sub-ceilings/Conditions of refund**
LENSES	INDIRECT PROVISION: Maximum refund percentage 100%

COVER 15 - PHYSIOKINESIS THERAPY following injury

“Physiokinesis therapy” means treatments prescribed by the physician of choice and carried out in outpatient healthcare facilities authorised by the competent authorities, while “Accident” means an event owing to a chance, violent and external cause producing objectively observable injuries. Physiokinesis therapy services are “healthcare services” performed by physicians who are qualified in physiatrics or orthopaedics and traumatology, or by graduates in physiotherapy or with equivalent qualifications recognised by current regulations and the competent authorities (always duly registered with the respective professional registers). Please remember that the professional qualification of rehabilitation physiotherapist is not held, for example, by kinesiologists, aesthetic and/or sports masseurs, ISEF/IUSM graduates, shiatsu practitioners, chiropractic graduates, reflexologists, posturologists, naturopaths, etc.

Refunds for expenditure on physiokinesis therapy are available, only for outpatient treatment, for both “indirect” and “direct” provision within the maximum refund limit specified by the annual cover regardless of type, technique, instruments used and anatomical district. No exceptions, extensions and/or exemptions are available to the ceilings specified in this cover. The ceiling specified in the cover is all-inclusive (materials used, medications, medical fees, etc.).

Indirect-provision physiokinesis therapy services are refunded on a case-by-case basis (within the annual ceiling per patient), the rates of which are shown in the table below. In relation to this, please note that no refunds are available for in-patient rehabilitation and/or physiokinesis therapy services and that refunds are per service and not per session.

Therefore to obtain the refund you must send - together with the relevant invoices - detailed case by case information on the therapies/services carried out (types of therapies and number of services), the medical prescription with relevant definite diagnosis of the pathology (resulting from documented injury - not symptoms) that made the therapies necessary and indispensable, and any first aid report or copy of the medical record (if hospitalisation was needed as a result of the accident).

The cover applies, within the financial limits specified in the Health Plan, if the services are used and invoiced within 120 days following the day of the documented accident.

Description	Refund ceilings
MAXIMUM REFUND PER YEAR AND PER CLIENT (only following an accident, for services treated and invoiced within 120 days after the day of the documented accident)	€ 700
Details	**Sub-ceilings/Conditions of refund**
RADIAL SHOCK WAVES - DIATHERMY: SHORTWAVE/MICROWAVE/MARCONI/RADARTHERAPY	€ 6 per service
ANTALGIC ELECTROTHERAPY (DIADYNAMIC OR TENS)	€ 5 per service
ELECTROTHERAPY OF NORMAL OR DENERVATED MUSCLES (ELECTROSTIMULATION, FARADIC, GALVANIC, HYDROGALVANIC, INTERFERENTIAL)	€ 5 per service
INFRARED IRRADIATION	€ 5 per service
IONTOPHORESIS	€ 5 per service
SEGMENTAL HYPERTHERMIA	€ 7 per service
ANTALGIC LASER THERAPY	€ 9 per service
MAGNETOTHERAPY	€ 8 per service
PRESSOTHERAPY OR INTERMITTENT DEPRESSOTHERAPY OR MANUAL LYMPHODRAGE (limited to cases of lymphoedema, axillary/inguinal lymphadenectomy or in cases of hip prosthesis surgery in the context of post-hospitalisation therapy).	€ 7 per service
TECAR THERAPY	€ 8 per service
ULTRAVIOLET LIGHT OR PUVA THERAPY (PER SESSION)	€ 5 per service
ULTRASOUND THERAPY	€ 5 per service
ACUPUNCTURE (MANU MEDICA)	€ 14 per service maximum 10 services per year
ASSISTED EXERCISES IN WATER (PER SESSION)	€ 9 per service
EXERCISES WITH ISOKINETIC EQUIPMENT (PER SESSION)	€ 10 per service
POSTURAL EXERCISES	€ 5 per service
MOTOR AND PROPRIOCEPTIVE REHABILITATION	€ 6 per service
SPINAL MANIPULATIONS OR CHIROTHERAPY (MANU MEDICA)	€ 13 per service maximum 10 services per year
MASSAGE THERAPY	€ 5 per service
LOCALISED MASSAGE THERAPY - REFLEXOLOGY (MANU MEDICA)	€ 7 per service
JOINT MOBILISATIONS	€ 6 per service
SPINAL MOBILISATIONS	€ 7 per service
OCCUPATIONAL THERAPY (PER SESSION)	€ 9 per service
MECHANICAL SPINAL TRACTIONS (PER SESSION)	€ 6 per service

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Services not covered

SERVICES NOT COVERED BY FASIOPEN

Without prejudice to the fact that anything not explicitly set out in the FasiOpen Basic Nomenclature should be deemed to be excluded from the Fund's area of activities and that, on the other hand, anything set out in the same should be deemed refundable only and exclusively if it falls within the Covers included in your Health Plan (which also indicates its limits and conditions), the following is a brief list of services not covered by FasiOpen.

- ✓ Services/treatments beyond the stated limits of the services themselves (with no exceptions);
- ✓ Services/treatments for which the expenditure documentation (regardless of the amount) is submitted incorrectly and/or beyond the time limit;
- ✓ Diagnostic and/or surgical services/treatments/procedures not included in the individual Health Plan;
- ✓ Diagnostic and/or surgical services/treatments/therapies/procedures other than those expressly provided for in the individual Covers (even if generically provided for in the Health Plan);
- ✓ Diagnostic and/or surgical services/treatments/therapies/procedures not included in the individual member's Health Plan/Covers, even if among the areas of activity of the Fund;
- ✓ Invoices on account if not accompanied by the relevant partial balance/balance invoices (details of invoice types are set out in the introduction):
- ✓ Dental tests other than those provided for and if provided for by the specific Dental Cover of the Health Plan; hygiene and preventive medicine (even if carried out by a specialist physician); breast health consultations; those pertaining to occupational medicine; legal medicine; radiological consultations; those pertaining to nuclear medicine; sports medicine; aerospace medicine; applied pharmacology; medical hydrology; dietician and/or nutritionist consultations, regardless of whether carried out by a physician-surgeon specialised in food science; biologist; osteopathic and/or homeopathic and/or alternative and/or experimental medicine consultations and/or services; physiokinesis therapy consultations (other than physiatric tests); tests carried out by professionals without a degree medicine and surgery and/or without a specialisation duly registered with the Italian Board of Physicians and Surgeons;
- ✓ treatments and/or operations to eliminate or correct **physical defects*** or **malformations**** existing prior to joining FasiOpen, except as specified in Cover 12 - Newborn Protection;
- ✓ the treatment of **mental illness** and **psychiatric disorders** in general, including neurotic behaviour, psychiatrist or psychologist consultations and psychotherapy;
- ✓ **dentures** (fixed and mobile), **osteointegrated implants**, dental surgery (any type), maxillofacial surgery, **orthodontic therapy**, **removable partial dentures**, conservative, endodontic, gnathological treatments, dental radiology, pedodontic treatments in addition to those explicitly provided for and/or if not explicitly provided for and included in a specific Cover within the chosen Health Plan;
- ✓ **medical-surgical therapies for aesthetic purposes and/or related to these** (with the exception of reconstructive plastic surgery necessitated by accidents or destructive surgery occurring during the period of validity of the Health Plan), regardless of whether these are carried out by reconstructive plastic surgeons;
- ✓ surgical procedures and/or medical therapies and/or diagnostic tests and/or treatments related to male or female infertility and/or sterility and therapies and/or surgical procedures and/or tests for male impotence and female frigidity and/or related to all of these;
- ✓ services and/or treatments and/or medical therapies and/or tests and/or procedures and all activities for the purpose of assisted insemination and/or related to these;
- ✓ admissions to **healthcare homes**, to **long-term hospitalisation facilities**;
- ✓ the treatment of illnesses resulting from the **abuse of alcohol and psychotropic drugs**, as well as the non-therapeutic use of **narcotics or hallucinogens**;
- ✓ **spa treatments**;

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Services not covered

- ✓ accidents resulting from the practice of **airborne sports** in general or any **sport participated in professionally and/or any extreme sports and/or related to these**;
- ✓ accidents resulting from **participation in motor races or competitions** not on a pure regularity basis, **motorcycle** or **speedboat** competitions and related trials and training;
- ✓ accidents resulting from speleological activities
- ✓ accidents caused by **malicious actions of the client;**
- ✓ the direct and/or indirect consequences of transmutation by the nucleus of the atom of **radiation caused by the artificial acceleration of atomic particles and overexposure to ionizing radiation**, apart from radiation caused by radiotherapy;
- ✓ the consequences of **war, insurrections, political, football or sporting events, earthquakes and volcanic eruptions, electrical storms, pandemics, epidemics, floods, tidal waves and/or all related to these**;
- ✓ **therapies that are not recognised** in official medicine;
- ✓ **vaccines and medicines** and/or **substances** used for **allergy tests**;
- ✓ **certifications/medical examinations** for the **issue of licenses**, for **fitness to participate in sports**;
- ✓ **stamp duties, secretarial fees, administrative fees, medicine storage costs**, the issuing of **medical record copies**, copies of reports, of radiography results, **CDs** and **DVDs**, **travel expenditure, (any) expenditure for accompanying persons**;
- ✓ **haemodialysis;**
- ✓ **thermographic tests;**
- ✓ **sclerosing injections;**
- ✓ **frames for eyeglasses;**
- ✓ **medicines not administered during** hospitalisation in a Health Care Institution and shown on the invoice;
- ✓ **generic medical services including**, among others, examinations, injections, IV drips, vaccinations, various certifications, etc.;
- ✓ any medical therapy carried out in **day hospitals** and **outpatient contexts** excluding cancer therapies: chemotherapy, radiotherapy and pain therapy;
- ✓ admissions to **nursing homes** dedicated to personal **welfare** and/or to private **care homes** for self-sufficient elderly people;
- ✓ any surgical operation (regardless of method and/or equipment) for the **correction of visual acuity**, therefore any surgical operations/treatments/therapies and/or tests for the purposes of treating myopia, astigmatism, hypermetropia, presbyopia, correction of the cornea with any method and equipment; any laser treatment in ophthalmology;
- ✓ **Preventive medical services** and/or connected with these, unless expressly included in the chosen Health Plan; **check-ups** of whatever type and or for whatever reason;
- ✓ **Insoles, devices, prostheses** (for the latter, other than those required for major operations for malignant oncological pathologies within the chosen Health Plan);
- ✓ **DRG** (Diagnosis Related Group) costs.

* Physical defect means deviation from the normal morphological structure of a body or parts of its organs due to acquired morbidity or traumatic conditions.

** Malformation means deviation from the normal morphological structure of a body or parts of its organs due to congenital morbidity.

GENERAL GLOSSARY

DIRECT PROVISION CARE: the refund, by the Fund, directly to affiliated healthcare facilities (hereinafter "affiliated healthcare facilities"), of costs paid in advance by themselves on behalf of clients, within the maximum amounts and limits set out in the individual Health Plans. Direct provision services only occur when both the healthcare facility and the physician-surgeon-orthodontist (who, together with his/her team, has accepted the agreement through the healthcare facility itself) have entered into the agreement, without prejudice to the necessary requisites for the member to access the direct provision services.

INDIRECT PROVISION CARE: the refund, by FasiOpen, directly to the member, of costs incurred by him/her, within the limits of the maximum rates set out in the individual Health Plans at the time of invoicing the balance. Indirect provision care applies when services are provided at a healthcare facility that does not belong to the network recognised by FasiOpen or in cases in which, despite being an affiliated healthcare facility, it is not possible to carry out direct provision services (for example: problems with personal details/contributory status, services for which direct provision is not available, or cases in which the physician/surgeon has not entered into the affiliation).

CLIENT: person eligible for assistance from the Fund and registered with the Fund, according to the conditions set out in the Regulations, belonging to the family unit of a member who remains the sole effective holder of the relationship with the Fund.

CLINICAL MOLECULAR BIOLOGY: molecular biology studies and interprets biological phenomena at the molecular level, considering the structure, properties and reactions of the chemical molecules that make up living organisms. Clinical Molecular Biology is a disciplinary sector relating to laboratory medicine, which contains and indicates a set of tests to determine DNA, RNA, proteins or metabolites in order to detect the genotypes, mutations or biochemical variations that enable specific states of health to be identified.

PRIVATE NURSING HOME FOR ACUTE: Healthcare facility with beds for the medical care of acute illnesses and possessing due authorisation issued by the competent authorities.

ACCREDITED PRIVATE NURSING HOME FOR ACUTE: Healthcare facility with beds for the medical care of acute illnesses affiliated with the Italian National Health Service/Regional Health Service and possessing due authorisation issued by the competent authorities.

CONSULTATION: specialist consultation by a physician with a different specialisation to that of the treating physician during night-time or daytime stays, or with a different specialisation from that which made the hospitalisation necessary, in cases in which the treating physician considers it necessary and indispensable.

SPA TREATMENTS: therapies received at spa establishments in possession of due authorisation issued by the competent authorities.

DAY HOSPITAL (D.H.): method of providing services in which the patient remains at the healthcare facility with hospitalisation limited to daytime hours and without an overnight stay.

DAY SURGERY (D.S.): method of providing surgical operations or invasive diagnostic and/or therapeutic procedures (if provided for in the individual Health Plans/Covers), with hospitalisation limited to daytime hours.

HOSPITALISATION WITH OVERNIGHT STAY (O.S.): overnight stay in healthcare facilities authorised by the competent authorities to perform medical and surgical therapies.

REHABILITATION/PHYSIOTHERAPY DIARY: in the event of hospitalisation, a document included with the medical record in which the date, time and types of services received by the patient during hospitalisation are noted, including notes by the therapist; in the case of outpatient therapies, a document signed by the patient in which access occasions to the facility (dates) and

the typed of services given are noted.

• ***PHYSICAL DEFECTS***: these are deviation from the normal morphological form of a body or parts of its organs due to acquired pathological or traumatic conditions.

DOMICILE: place of residence of the member/client, even if temporary.

EXCLUSIONS: list of services excluded from cost-sharing by the Fund. Please remember that, as well as the exclusions stated in the current Basic Nomenclature, anything not explicitly provided for in the Nomenclature itself and anything not explicitly included in the Covers of your chosen Health Plan must be regarded as non-refundable.

EXTRA-MOENIA (OR EXTRAMURARY): self-employed professional activity at private healthcare facilities by physicians-surgeons-orthodontists who are employees of the Italian National Health Service/Regional Health Service.

INVOICE ON ACCOUNT: fiscal document issued by the physician-surgeon-orthodontist or the healthcare facility for only a part of the final fee when the services have not been completely received by the client. In the context of the relationship with FasiOpen, an invoice on account must always be accompanied by and therefore sent together with a partial or final balance invoice (within 3 months from the date of issue of the latter, as indicated in the Regulations). A stand-alone invoice on account is not refundable by the Fund.

PARTIAL BALANCE INVOICE: fiscal document issued by the physician-surgeon-orthodontist or the healthcare facility for payment of that part of the services already received by the member/client, when other services are yet to be received. In the context of the relationship with FasiOpen, the partial balance invoice must be sent (together with any invoice on account if present) within 3 months from the date of issue. Please note that, although an invoice has “on account” in its description, it can be considered to be a “partial balance” if the exact correlation between the amount and the completed services can be identified.

BALANCE INVOICE: fiscal document issued by the physician-surgeon-orthodontist or the healthcare facility when the entire fee has been paid and the services to which the invoice refers have been received. In the context of the relationship with FasiOpen, the balance invoice must be sent according to the timescales and conditions set out in the Regulations.

PHYSIOKINESIS THERAPY: physical treatments/care prescribed by one's physician of choice and used in duly authorised outpatient healthcare facilities (also see “Rehabilitation”). Since these are “healthcare services” they are always exempt from VAT regardless of invoicing, which may be issued by physical persons, companies, cooperatives, non-profit organisations or other organizations. Physiokinesis therapy services are “healthcare services” performed by physicians-surgeons who are qualified in physiatrics or orthopaedics and traumatology, or by graduates in physiotherapy or with equivalent qualifications recognised by current regulations and the competent authorities. Please remember that the professional qualification of rehabilitation physiotherapist is not held, for example, by kinesiologists, aesthetic and/or sports masseurs, ISEF/IUSM graduates, shiatsu practitioners, chiropractic graduates, reflexologists, posturologists, naturopaths, or masseurs and head attendants of hydrotherapy/spa establishments etc.

INJURY: an event due to a chance, violent and external cause that produces objectively ascertainable harm.

OUTPATIENT SURGICAL OPERATION: surgical operation carried out without daytime hospitalisation (therefore excluding recognition of day surgery hospitalisation) at a physician's surgery or at the outpatient clinic of a healthcare facility.

SURGICAL OPERATION: a therapeutic action carried out with manual and/or instrumental operations at healthcare facilities authorised to perform surgical procedures at a day surgery or with overnight hospitalisation.

INTRA-MOENIA (OR INTRA-MURARY): self-employed professional activity at public or private non-accredited healthcare facilities by physicians-surgeons-orthodontists who are employees of the Italian National Health Service/Regional Health Service.

MEMBER: holder of FasiOpen membership.

ILLNESS: any verifiable and objective alteration to health not resulting from injury. Must be proven in a specific medical certificate in which the “diagnosis” is shown.

MALFORMATIONS: means deviation from the normal morphological structure of a body or parts its organs due to congenital conditions.

MANU MEDICA: health services provided by graduates in medicine and surgery. Some physiokinesis therapy services, to be recognised by the Fund as refundable, must be performed by physicians with a specialist qualification in physiatry or orthopaedics and traumatology and not by personnel with a diploma or three-year degree in physiotherapy.

NUCLEAR MEDICINE: a medical speciality that uses radioisotopes to study any alterations in organ functionality for the diagnosis and/or treatment of various pathologies.

PHYSICIAN OF CHOICE OR TREATING PHYSICIAN: physician chosen by the member for his/her treatment and in possession of a specialist qualification duly recognised in Italy by the competent authorities.

MEDICAL SPECIALIST IN PUBLIC HEALTHCARE FACILITY: physician qualified in a speciality who performs his/her professional work as an employee of the Italian National Health Service/Regional Health Service at a public healthcare facility (university polyclinic, hospital, hospitalisation and treatment institute, local health authority, family consultant or other authorised public healthcare facility).

NOMENCLATURE: list of services included in the areas of activity of the Fund. The FasiOpen Nomenclature is arranged case by case. Services not included in the FasiOpen Nomenclature are not refundable by the Fund. Services included in the FasiOpen Nomenclature, on the other hand, are services for which the Fund provides for cost-sharing only if they are included in the Covers of a member's individual Health Plan to the extent and in the manner provided for by the individual Cover.

HOSPITAL: Healthcare facility with beds for the medical care of acute and/or chronic illnesses, duly authorised by the competent authorities. Hospitals can be either public or private.

SURGICAL PACKAGE: set of services concurrent to the performance of surgery for which a flat-rate refund is envisaged.

PREVENTION PACKAGES: set of non-divisible services and/or tests intended to prevent the appearance, spread and progression of illnesses and therefore the occurrence of damage, possibly irreversible, when the pathology is in progress, and for which a flat-rate refund is envisaged.

DIAGNOSTIC OUTPATIENT POLYCLINIC: Healthcare facility duly authorised by the competent authorities to perform outpatient diagnostic tests and/or specialist consultations and/or surgical operations and/or medical therapies.

UNIVERSITY POLYCLINIC: Authorised healthcare facility with beds for the medical care of acute and/or chronic illnesses, duly authorised by the competent authorities, at which teaching is also carried out. University Polyclinics can be either public or private.

SERVICES SUBJECT TO LIMITS: services included in the Fund's Nomenclature and Health Plans, for which FasiOpen has set administrative limits to their eligibility for refund. These limits may be time-based (e.g.: refundable once a year), quantitative (e.g.: a maximum of 10 services can be refunded), or related to age (e.g.: refundable from 0 to 3 years of age), gender (male or female), or part of the body (e.g. right eye, left leg).

HOSPITAL FEE FOR REHABILITATION: hospital fee recognised as refundable only for overnight hospitalizations.

REHABILITATION: therapies to re-educate body systems harmed by injuries and/or illness to restore their functionality for normal activities; can be provided as an outpatient service at healthcare facilities authorised for physiokinesis therapy and rehabilitation, or in particular cases at the patient's home (see also “Physiokinesis therapy”).

NEUROMOTORAL REHABILITATION FOR ACUTE AND CHRONIC NEURODEGENERATIVE PATHOLOGIES: therapies for the purpose, in the event of invalidating neurological damage, of recovering functional motor or neuromotor capacities recently reduced and/or lost due to illness or trauma and/or chronic degenerative pathologies (cerebral stroke, Parkinson's disease, multiple sclerosis, etc.).

HOSPITALISATION: a stay in a place giving healthcare with overnight stay or daytime stay in a day hospital or day surgery, made necessary by injury or illness.

SAME SESSION/DURING THE SAME SESSION: period of time required to perform one or more medical procedures carried out during the same occasion of access to the Healthcare Facility/Outpatient Clinic.

TABLE OF FEES: presentation of the maximum amounts refundable by FasiOpen and of any limits to the recognition of services, by both direct and indirect provision, for each service provided for in the Health Plan with refund case by case (recognisable under the conditions set out in the Health Plan itself), in which each fee displayed signifies “up to €.....”.

OCCUPATIONAL THERAPY: therapies for the purposes of recuperating or maintaining the skills needed to carry out daily life among people affected by pre-existing cognitive, physical and psychic disabilities.

PUBLIC HEALTHCARE CHARGES: contribution paid by citizens to the cost of specialist consultations and diagnostic tests, therapies etc. performed at public healthcare facilities, or at private healthcare facilities accredited by the Italian National Health Service/Regional Health Service. Please note that Public Healthcare Charges are a different item of expenditure to the Fixed Fee introduced in the 2011 Budget and the Additional Fixed Prescription Fee Contribution. Citizens are exempt from paying these charges if they are within certain age or income groups or if they are suffering from certain illnesses.

GENETIC MEDICAL CONSULTATION (CLINICAL GENETICS): specialist consultation carried out by a physician specialised in medical genetics.

SPECIALIST OUTPATIENT CONSULTATION: consultation carried out by a physician in possession of a specialist qualification duly recognised in Italy by the competent authorities and registered with the Italian Board of Physicians, Surgeons and Orthodontists, to diagnose and/or prescribe therapies within the context of his/her specialisation.

SPECIALIST CONSULTATION DURING HOSPITALISATION: consultation carried out by the treating physician and/or his or her team in the course of medical or surgical therapy on behalf of a hospitalised client.

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