Mosaic 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*

V1.26

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

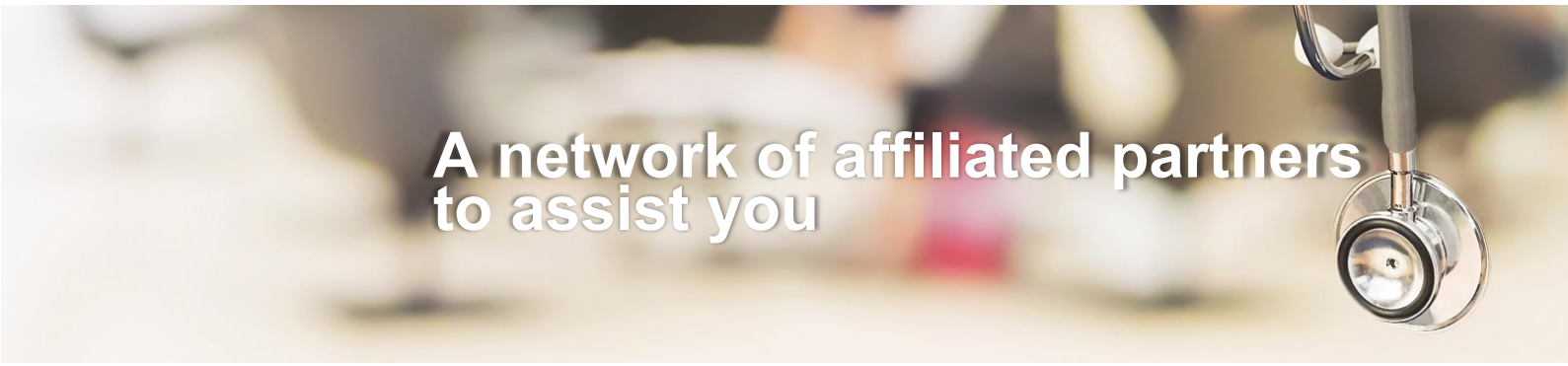
GUIDE FOR CLIENTS

This Guide sets out the Covers offered by the FasiOpen “MOSAIC” 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;
- ✓ possible payments that do not meet with expectations.



Without prejudice to a client'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 provides an extensive network of direct affiliations with nursing homes, dental surgeries, hospitals/universities, diagnostic clinics, 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 (the maximum financial amount) towards the cost by the Fund, as well as the procedures that must be followed to be able 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).

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 Beethoven, 11 – 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 (any type of request, for any type of service) 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) if included

in your Health Plan, 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 record should also show requests for consultations with specialisations other than that of the treating medical-surgical team, the diagnostic issue for which consultations are requested, the relevant medical reports/references of the specialists consulted, and also any physiotherapy diary if this treatment is carried out during hospitalisation.

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) and/or to request further documentation if it deems this to be necessary.

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

Only **"Direct Provision"** refunds are available. 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 there is a mandatory requirement to submit pre- and post-treatment documentation as well as a preventive treatment plan. 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, even for direct-provision services, refund requests must be received by FasiOpen within and no later than 3 months after the date of the balance invoice for the services that you wish to request from the Fund. Any refund requests for services, even if direct-provision, received after the deadline will be rejected and will have to be settled personally by the member client (who will no longer be able to forward

them to the Fund since they will be beyond the expiry date).

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, where contrast medium is referred to in the Cover, it is deemed to be a separate service and thus also subject to a ceiling of refundability by the Fund, limited to the branches/sub-branches that refer to it on a case-by-case basis.

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).

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.

As regards the refund calculation nothing changes with respect to the previous valuation, since the refund total for packages is equal to the sum of the individual case-by-case totals of the services they include, and always within the limits of the provisions set out for the individual items.

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%.

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 provided for 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, 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 (dental services excluded).

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

The FasiOpen **Information Centre** (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 a surgical operation (no hospitalisation/refunds for dental surgical operations are included, even if these are carried out as secondary services to other operations).

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 (separate invoicing must therefore be issued for the period recognised by the Fund and for the period fully payable by the member/client - for which FasiOpen does not offer any cost-sharing either for direct or indirect-provision services).

"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.

Excesses payable by the client for direct provision services

A financial excess is the difference between the amount agreed upon the act of affiliation (for each individual service offered via direct provision by the affiliated healthcare facility) and the maximum refund fee (for the same service) recognised by FasiOpen (if the prerequisites for refund apply).

We remind members that excesses may vary between direct provision facilities, although the refunds by FasiOpen specified in the applicable Guide at the time of invoicing the balance remain constant.

Further information is available by calling the FasiOpen Health Information Centre, open Monday to Friday, from 9 AM to 5 PM non-stop.

INFORMATION CENTRE

The FasiOpen **Information Centre** (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.

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.

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 Public Healthcare 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.

Stamp Duty on Medical Receipts

Please note that, to request FasiOpen to refund services, you must always forward, telematically, the expenditure documentation unequivocally stating that the original document, where applicable, is subject to stamp duty (Art. 13 of Presidential Decree no. 642/72; Law no. 71/2013).

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.

Stamp duty is not refundable by FasiOpen.

Value added tax (VAT)

Pursuant to Presidential Decree 26/10/1972 no. 633 and subsequent amendments and additions regarding the application of VAT, the services of physicians-surgeons-dentists are exempt from VAT.

Healthcare facilities charge VAT for:

- ✓ services (hospitalisation, operating theatres, materials, medicines). The VAT rate for hospitalisation is 22% in non-accredited private healthcare facilities; it is 10% in many accredited private healthcare facilities;
- ✓ diagnostic services, specialist consultations and physiokinesis therapy services, during hospitalisation, if provided and invoiced by the same healthcare facility authorised for hospitalisation.

The Fund, in the context of the MOSAIC Health Plan, does not refund this tax for either direct or indirect-provision services, it remaining fully payable by the client.

“MOSAIC” HEALTH PLAN
DETAILED DESCRIPTION OF COVERS INCLUDED

Introductions

The information above, together with that generically referred to in the FasiOpen Basic Nomenclature, is an integral part of the MOSAIC Health Plan. The MOSAIC Health Plan is subdivided into individual areas which can be combined in different ways and which, depending on the client's choices at the time of registration, constitute his/her Health Plan. Each individual area provides for healthcare services that are recognised by the Fund as refundable on a case-by-case basis (per individual item) within the maximum limits indicated for that item. The services/items are recognised only and exclusively within the operational context of the individual area (by way of example only: a Health Plan that includes the basic surgical area only - the client is given an X-ray of the ankle as an outpatient - this service would not be refundable because the basic surgical area only operates within the context of hospitalisation. If the same service were given in the context of hospitalisation for surgery, it would be duly paid by the Fund); therefore, services not explicitly referred to should be regarded as non-refundable by the Fund even if they are included in the FasiOpen Basic Nomenclature.

This analytical Fee Schedule should be exhaustive as regards the services available in Medicine and Surgery, clearly always within the limits imposed by the continual evolution of medicine-surgery-dentistry. FasiOpen will nonetheless make every effort to note any new “items” that may arise in its daily work, to assess them from the technical-medical viewpoint and, if appropriate, to publish them in a subsequent edition/version.

The areas provided for by the MOSAIC Health Plan are:

- ✓ basic surgical area (201);
- ✓ gastroenterological surgical area (202);
- ✓ obstetrics (surgical) area (203);
- ✓ hospitalisations medical area (204);
- ✓ medium-cost diagnostic area (205);
- ✓ analyses and clinical tests diagnostic area (206);
- ✓ high-cost diagnostic area (207);
- ✓ basic dental area (208);
- ✓ dental implantology and prostheses area (209);
- ✓ specialist consultations (210);
- ✓ physiokinesis therapy (211);
- ✓ public healthcare charges (212);
- ✓ spa treatments (213);
- ✓ surgery area - major surgery (214).

The individual areas of your Health Plan may be preceded by “Area Introductions” with useful information relating to refund requests. Likewise, the individual areas may be subdivided into branches, with relevant further introductions set out in the Basic Nomenclature (valid across all the areas involved), which will make it easier to identify the items included in your MOSAIC Health Plan.

Please note that services included in the individual Areas will be recognised as refundable by the Fund if they are correctly submitted within the term set by the regulations (3 months from the date of the balance invoice), if they are sent complete with any required documentation and if they effectively correspond to the services carried out (i.e. if they are recognised as refundable because they do not fall under Exclusions and comply with the information shown).

COVER 1 – Surgical Area (201, 202, 203, 214)

The Surgical Area is made up of three sections:

- ✓ the basic surgical area (201);
- ✓ the gastroenterological surgical area (202);
- ✓ obstetrics (203).

For the inclusion of areas 202 or 203 in the health plan, basic surgery (201) must also be chosen. There is also a Major Surgery area (214) providing refunds for approximately 260 surgical operations.

The fee specified for individual items within the Surgical Area (201-202-203-214), is all-inclusive of the services of all those taking part in the surgical/medical activity (operator/s, assistants, technicians, etc.), the anaesthetist and the support of the surgical team during hospitalisation and until discharge, as recorded in the operative report and medical records.

All operations/services are all-inclusive of all phases of the standard procedures involved in the surgical technique.

In any intraoperative switch from a “closed procedure” to an “open procedure”, being the technique with which the operation is completed, only the “open technique” (i.e. only one procedure) is recognised as refundable.

A biopsy is defined as being regardless of the number of samples/fragments taken in the same session, i.e. it is refundable only once per session of surgery if carried out on the same organ, internal tissue or portion of skin.

For diagnostic/exploratory procedures carried out simultaneously with operative procedures with the same access route, if included in an individual client's cover, only the operative procedure is deemed refundable, with the diagnostic procedure regarded as a preparatory act.

Please note that procedures involving the removal (using any instrument) of polyps up to 3 mm in size are also deemed to be diagnostic endoscopies.

For surgical operations carried out using special instruments/equipment, the same fees are applied as for traditionally performed operations (if not otherwise specified) but increased, if appropriate, by the fees specified for the use of high-cost instruments (if explicitly listed among the services contained in the Areas of your Modular Plan), and exclusively for those shown.

In the event of concurrent and simultaneous surgical operations, even with a different access route but performed in the same operating session, the maximum fee for the main or most financially costly operation is applied - obviously within the limits of the expenditure incurred - while for the other one or for the other operations the relevant maximum fee is reduced by 50%.

In all cases, the type of operation carried out must be unequivocally shown by the operating theatre record within the medical record (regardless of whether carried out through direct or indirect provision).

Please note that some procedures can be carried out on an outpatient basis (regardless of the type of anaesthesia/sedation), so that approval of these within the context of hospitalisation (any) will be subject to an assessment of the documented

systemic pictures of critical relevance to the patient's health.

As regards invasive operations and/or procedures carried out as an outpatient service, the doctor's appropriate and detailed certification must be provided, on headed paper, regarding the type of operation carried out by him/her.

Excluded from the operational context of the area are everything specified in the "Exclusions" paragraph (of the Basic Nomenclature), everything specified in the "services not covered by FasiOpen" paragraph and/or everything related to these.

Should the Fund perceive the need for further investigations in the context of the envisaged and normal checks, it reserves the right to request additional documentation even if this is not explicitly mentioned. We therefore urge you to arrange in advance for pre and post-operative photographs in the case of minor operations, with particular reference to general surgery, dermatology, reconstructive plastic surgery and ophthalmology.

Use of operating theatres

The use of the operating theatre is refundable based on the identification of the relevant code within the Fee Schedule. The operating theatre category is defined by the amount or sum of amounts indicated as the maximum refund for the operation carried out in the same operating session, without prejudice to the rules for surgical operations within the Areas of your Modular Plan. The refund will therefore be allocated as specified for the relevant category and in the context of the executional method for the procedures, always obviously within the limits of the expenditure incurred, and will be added to the amount recognised for the operation itself.

Refunds for the outpatient theatre (for minor surgical operations) are inclusive of medicines and healthcare materials.

Fees for theatres are inclusive of the use of any equipment unless otherwise specified.

Hospitalisations, day hospitals, day surgeries

The daily hospitalisation fee is refundable for a maximum of 90 days in the calendar year (regardless of the type of surgical or medical hospitalisation), the calendar year being the period of 365 days prior to each single day of hospitalisation. The hospitalisation fee (any) applies within the limits of the expenditure effectively incurred for stays in non-accredited public or private healthcare facilities or in accredited nursing homes.

The hospitalisation fee in reanimation/intensive care wards and coronary and sub-intensive care units (which count towards the total of 90 days of hospitalisation per year) is inclusive of the ordinary hospitalisation fee and continuous medical-nursing care (24 hours) as well as the use of special equipment. Expenditure on higher comfort of accommodation in the context of hospitalisation at the aforementioned facilities, i.e. solely on the difference in class, will be recognised at a specific maximum daily fee, again within the limits of the expenditure incurred. "Higher comfort of accommodation" also counts towards the total of 90 days per year.

The daily hospitalisation (Day Hospital) fee is limited to cancer treatments, pain therapy and chemotherapy, while the fee for Day Surgery (same service code) is limited to surgical operations (excluding procedures that can be carried out and/or

have been carried out on an outpatient basis). Day hospitalisation for diagnostic tests and/or other reasons is strictly excluded. Please note that refunds of daily Day Hospital/Day Surgery fees are therefore also excluded for package-based procedures (e.g. Cataract Package, gastroenterology packages, etc.) and for the delivery only of chemotherapy/medicines drugs. Any type of hospitalisation for prevention, check-ups and/or services not expressly specified above are strictly excluded.

Branch	Specific conditions per branch
CARDIAC SURGERY	All services/operations can be carried out with any technique, equipment/instrumentation, except in the cases explicitly described.
INTERVENTIONAL CARDIOLOGY	All services/operations can be carried out with any technique, equipment/instrumentation, except in the cases explicitly described.
BREAST SURGERY	All refunds for demolitive surgery are inclusive of plastic breast reconstruction (excluding prostheses). Refunds for surgery to position or replace breast implants is recognised only following demolitive surgical operations for neoplasia. All services for aesthetic purposes and/or ascribable to these and/or resulting from these are excluded. All services/operations can be carried out with any technique, equipment/instrumentation.
HAND SURGERY (COMPLETE TREATMENTS)	Complete treatment also includes any arthrolysis, neurolysis and/or synovectomy and/or tenolysis within the context of the main operation. Missing items in Hand Surgery: see also Orthopaedics and Traumatology, and Reconstructive Plastic Surgery. All services/operations can be carried out with any technique, equipment/instrumentation.
FOOT SURGERY (COMPLETE TREATMENTS)	Complete treatment also includes any arthrolysis, neurolysis and/or synovectomy and/or tenolysis within the context of the main operation. Missing items in Foot Surgery: see also Orthopaedics and Traumatology, and Reconstructive Plastic Surgery. All services/operations can be carried out with any technique, equipment/instrumentation.
DERMATOLOGICAL SURGERY - CRYOTHERAPY - LASER THERAPY (COMPLETE TREATMENTS)	Nerve mapping is included in specialist consultations and/or treatments. All aesthetic treatments (peelings, dermabrasion, fillers and others) and/or anything related to these and/or resulting from previous aesthetic treatments are excluded, even if the items are referred to in the section. Superficial tumours are defined as suprafascial neoplasms; deep tumours are defined as subfascial neoplasms. In the case of outpatient operations for the removal of malignant tumours, regardless of the technique used, submission of the histological examination report is also mandatory for the refund to be recognised. FasiOpen nonetheless reserves the right to request pre and post-surgery photographic documentation also for the removal of benign tumours; as set out under Warnings in the Basic Nomenclature, we therefore urge you to arrange in advance for these to be taken. Fees relate to surgical operations carried out using any technique, instrument and equipment except as described. Please note that the term “single session” is meant regardless of the location (body part) and number of removals. Please also note that dermabrasion is equatable solely with the code/service of diathermocoagulation and/or cryotherapy. Laser and/or surgical treatments for telangiectasia, cherry angiomas, spider angiomas and similar are not deemed to be refundable services (with no exceptions). For missing items in Dermatological Surgery see Reconstructive Plastic Surgery.
Branch	Specific conditions per branch

GENERAL SURGERY (COMPLETE TREATMENTS FOR MINOR SURGICAL OPERATIONS)	Superficial tumours are defined as suprafascial/extrafascial neoplasms; deep tumours are defined as subfascial neoplasms. Deep extracavitary tumours are defined as: tumours of the skeletal muscle, fibrous tumours or simil-tumoral lesions. Therapeutic injection treatments are defined as: treatment using botulinum toxin for anal fissures and treatment using sclerosing agents for haemorrhoids (no other types are included). In the case of outpatient operations for the removal of malignant tumours, regardless of the surgical technique used, submission of the histological examination report is also mandatory for the refund to be recognised. FasiOpen nonetheless reserves the right to request pre and post-surgery photographic documentation also for the removal of benign tumours; as set out under Warnings in the Basic Nomenclature, we therefore urge you to arrange in advance for these to be taken. Fees relate to surgical operations carried out using any technique (traditional, endoscopic or with other instruments/equipment etc.). Dressings (simple and/or advanced) for any type of wound or skin ulcer are not refundable if provided on an out-patient basis, while during hospitalisation (any) they are included within the procedures/the hospitalisation itself (i.e. they are not refundable as an additional fee).
ORAL, MAXILLOFACIAL SURGERY	All services/operations in this section are understood as being carried out by a specialist in maxillofacial surgery using any technique, equipment/instrumentation (inclusive), at an authorised healthcare facility for day surgery or overnight hospitalisation (services carried out on an outpatient basis and/or in dental surgeries are not recognised as refundable even if carried out by a specialist in oral-maxillofacial surgery). For certain surgical procedures carried out on an outpatient basis at a clinic/surgery/medical facility/authorised dental service for dentistry and dental prostheses in direct affiliation, even if carried out by a surgeon specialising in oral-maxillofacial surgery, reference should be made to the provisions of the Dentistry section if these are included in the services provided by the Fund and/or your Health Plan.
PAEDIATRIC SURGERY	For missing items in Paediatric Surgery: refer also to the other surgical branches. All services/operations in this section can be carried out with any technique, equipment/instrumentation, except in the cases described. Please remember once again, as for all the services listed in the Basic Nomenclature, that services are recognised as refundable by FasiOpen only and exclusively if they are included in your Health Plan under the financial conditions and limits specified within it. Please note that services can only be recognised for refund if the client is duly registered with the Fund at the start of hospitalisation.
PLASTIC RECONSTRUCTIVE SURGERY **(COMPLETE TREATMENTS)**	No treatments carried out for aesthetic purposes and/or anything related to these and/or resulting from previous aesthetic treatments can be refunded, even if the items are referred to in the section. Superficial tumours are defined as suprafascial/extrafascial neoplasms; deep tumours are defined as subfascial neoplasms. As regards to the surgical removal of keloids or scars you must, for the purposes of a refund, submit an Accident and Emergency (first aid) report if the service is a consequence of prior traumatic events, or an operative report if it is a consequence of surgical procedures causing a functional limitation. FasiOpen nonetheless reserves the right to request pre and post-surgery photographic documentation also for the removal of benign tumours; as set out under Warnings in the Basic Nomenclature, we therefore urge you to arrange in advance for these to be taken. Laser and/or surgical treatments for telangiectasia, cherry angiomas, spider angiomas and similar are not deemed to be refundable services (with no exceptions). The above applies to surgical operations carried out using any technique (any instrumentation/equipment). For missing items in Reconstructive Plastic Surgery see Dermatological Surgery.
Branch	**Specific conditions per branch**

THORACIC-PULMONARY SURGERY	All services/operations listed below can be carried out with any technique, equipment/instrumentation, except in the cases described.
VASCULAR SURGERY	All services/operations listed below can be carried out with any technique, equipment/instrumentation, except in the cases described.
GASTROENTEROLOGY (GASTROENTEROLOGICAL SURGERY - COMPLETE TREATMENTS)	All services/operations listed can be carried out with any technique, equipment/instrumentation, except in the cases described. Anoscopy and proctoscopy are included in the consultation. For diagnostic/exploratory procedures carried out together with operative procedures with the same access route, only the operative procedure is deemed refundable, with the diagnostic procedure regarded as a preparatory act. Please note that procedures involving the removal (using any instrument) of polyps up to 3 mm in size are also deemed to be diagnostic endoscopies. If provided for in the Cover of the individual Health Plan and within the limits and conditions specified, oesophagogastroduodenoscopy (diagnostic and operative) and pancolonoscopy (diagnostic and operative) procedures are only recognised as refundable within the "package" format, which fully replaces the items/codes listed in previous editions of the Nomenclature. For the above-mentioned procedures carried out at the same time as, and therefore concurrently with, other main operations/procedures, their respective "concurrent" items are available for which, in an exception to the regulations for operations, the valuation for refund purposes is 100%.
GYNAECOLOGY	All surgical operations in this section can be carried out with any route of access, any technique and equipment/instrumentation except in the cases described.
NEUROSURGERY **(COMPLETE TREATMENTS)**	All surgical operations in this section can be carried out with any route of access, any technique and equipment/instrumentation except in the cases described. Tract is defined as: cervical column or dorsal column or lumbo-sacral column. For refund purposes, therefore, the valuation of the operation/s will be equal to 1 if the procedure itself involves the same tract (example: in the case of an intervention on 2 vertebrae in the same tract, the refund value is 1 in relation to the corresponding operation code).
OPHTHALMOLOGY **(COMPLETE TREATMENTS)**	Fees relate to surgical operations carried out using any technique, instrumentation or equipment - excluding laser - except as described. Operations carried out using lasers that are recognised as refundable are only described in the "Laser Treatments" paragraph. Any type of treatment or surgical operation for treating myopia, astigmatism, hypermetropia, presbyopia and corneal correction, using any method and equipment, are not refundable except as described. Should the Fund perceive the need for further investigations in the context of the envisaged and normal checks, it reserves the right to request additional documentation even if this is not explicitly mentioned. We therefore urge you to arrange in advance for pre and post-operative photographs in the case of minor operations (pre and post-procedure photographs are obligatory for eyelid ptosis operations). Pre and post-operative photographs are obligatory, together with the medical/operative report, in the case of procedures on the eyelids and/or conjunctiva. These procedures are inclusive of the endothelial cell count (particularly for procedures on the cornea and lens). Cataract surgery is only provided for within the package format. In the case of a bilateral cataract operation, the (unilateral) Cataract Package and the service provided for in the concurrent cataract operation is recognised as refundable (only if carried out at the same time as the package itself). In this case, the valuation for refund purposes will be equal to the value of the package, to which only the concurrent cataract operation and the prosthetic lens relating to the concurrent cataract will be added (no other possibilities are available).
Branch	**Specific conditions per branch**

ORTHOPAEDICS **(COMPLETE TREATMENTS)**	Joints are defined as: large (hip, knee, shoulder); medium (elbow, wrist, tibial-peroneal-astragalic); small (the remainder). Bone segments are defined as: large (femur, humerus, tibia); medium (clavicle, sternum, patella, radius, ulna, fibula); small (the remainder). Section is defined as: cervical column or dorsal column or lumbo-sacral column. For refund purposes, therefore, the valuation of the operation/s will be equal to 1 if the procedure itself involves the same tract (example: in the case of an intervention on 2 vertebrae in the same tract, the refund value is 1 in relation to the corresponding operation code). Complete treatment also includes any arthrolysis, neurolysis and/or synovectomy and/or tenolysis within the context of the main operation, except as specifically described. "Neurolysis" and "tenolysis" procedures cannot be combined with all procedures defined as a "complete treatment", since they are already included in them. Fees relate to surgical operations carried out using any technique, instrument or equipment except as described. Total hip replacement/revision total hip replacement operations (any type shown in the Basic Nomenclature) are only refundable within the "package" format, which fully replaces the individual case-by-case items/codes listed in previous editions of the Nomenclature. For the above-mentioned procedures carried out at the same time as, and therefore concurrently with, other main operations/procedures, their respective "concurrent" items are available for which, in an exception to the regulations for operations, the valuation for refund purposes is 100%.
OBSTETRICS **(COMPLETE TREATMENTS)**	Fees include the cost of the obstetrician and neonatological care during the entire duration of the mother's hospitalisation. All services/operations listed can be carried out with any technique, equipment or instrumentation, except as described.
OTOLARYNGOLOGY (COMPLETE TREATMENTS)	Rhinoseptoplasty and septoplasty operations for aesthetic purposes, or consequent to surgical corrections of an aesthetic nature and/or operations ascribable to all of these, are never refundable even when concurrent with other refundable operations. Fees are for surgical operations carried out using any technique, method and equipment/instrumentation. Please note that some services included in this section (and its sub-branches) are refundable, subject to the specified conditions, only and exclusively during the specialist consultation, i.e. are not refundable if carried out in separate sessions and/or by different practitioners.
INTERVENTIONAL RADIOLOGY (COMPLETE TREATMENTS)	Fees include the entire medical-surgical-radiological-anaesthesiological team, the use of contrast and x-rays as required (all necessary projections) and the professional fee for any insertion of stents. Special high-cost materials and any medicines, except for anything set out case by case in the Basic Nomenclature or considered to be included, are refunded as described in "Medicines and Healthcare Materials". Tract is defined as: cervical column or dorsal column or lumbo-sacral column. For refund purposes, therefore, the valuation of the operation/s will be equal to 1 if the procedure itself involves the same tract. All services/operations listed are understood as being carried out with any technique, equipment or instrumentation, except as described.
UROLOGY (COMPLETE TREATMENTS) **UROLOGICAL DIAGNOSTICS - ENDOSCOPIC AND OPERATIVE UROLOGY**	Special high-cost materials and any medicines, except for anything set out case by case in the Basic Nomenclature or considered to be included, are refunded as described in "Medicines and Healthcare Materials". All the services and operations listed below can be carried out with any technique, equipment or instrumentation, except as described. Endoscopic procedures include instrumentation/equipment (disposable materials related to the instrumentation), any urethrotomy, lysis of transurethral adhesions, and incision of the bladder neck. Please note that the term "single session" is meant regardless of the number of services carried out.
UROLOGY - SURGICAL PROCEDURES	All services/operations in this section can be carried out with any technique, instrumentation and equipment except in the cases described. Please note that peniscopies are included in the specialist consultation.
Branch	**Specific conditions per branch**

MAJOR SURGERY	Fees include the entire medical-surgical-radiological-anaesthesiological team. This area also includes any diagnostic tests to be carried out during overnight hospitalisation. Operations can be carried out with any technique, equipment or instrumentation, except as expressly stated in the Fee Schedule. Operations for preventive purposes are not refundable. For the procedures and/or tests included in this Area, all the information in the respective branches of the services/items/procedures is valid, as well as that described in full in the FasiOpen Basic Nomenclature.

"Mosaic" Health Plan

Detailed description of covers included

COVER 2 – Hospitalisations Medical Area (204)

The Medical Hospitalisations Area refers exclusively to hospitalisations taking place **without surgical operations**. Refunds are available for hospitalisation fees for intensive care wards or coronary units and include, in addition to ordinary hospitalisation fees, continuous medical and nursing care (24 hours), care from technical/auxiliary staff and the use of special equipment. Refunds for any type of hospitalisation for preventive purposes and in the absence of an ongoing illness are excluded, i.e. hospitalisations for check-ups (and/or anything equatable with/related to these) are excluded.

The fees shown for care by a medical team during night-time hospitalisation in medical wards are inclusive of the professional services of the entire medical team during hospitalisation with night-time stay.

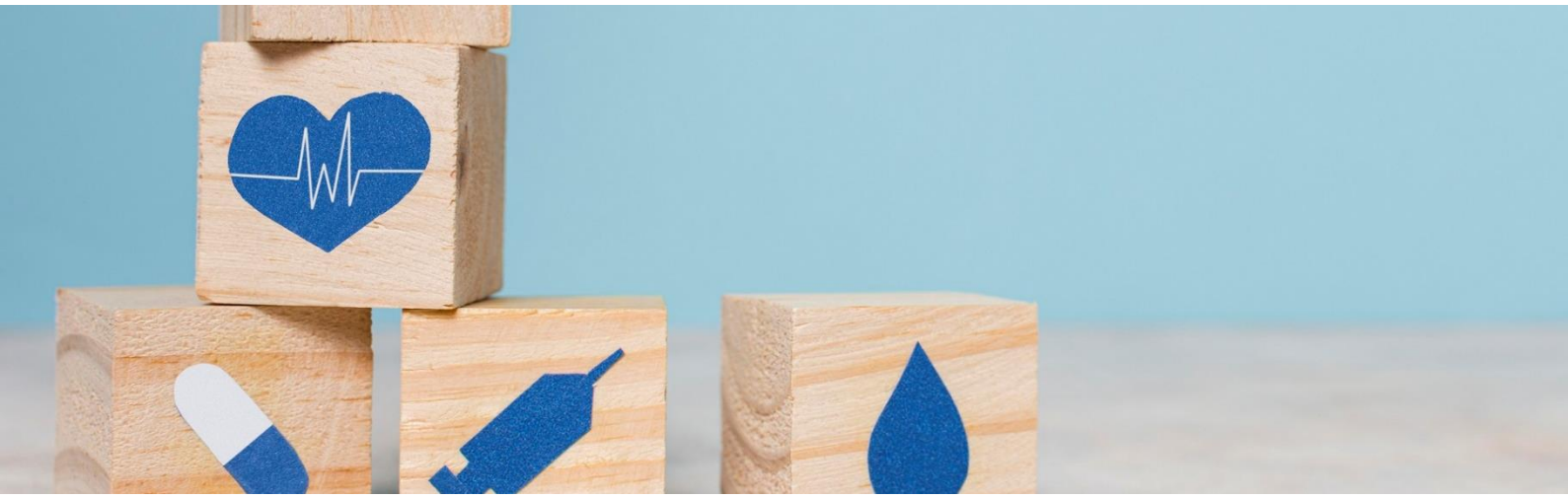
Refunds for medical care during a stay are excluded if provided in a day hospital for any type of pathology, with the exception of cancer chemotherapy and pain therapy services.

Fees for medical oncology and chemotherapy are inclusive of the services of the professional services of the entire medical-oncology team.

For radiotherapy (complete treatments except as expressly described) the fees shown are per session unless otherwise indicated, regardless of whether carried out on an outpatient basis or with hospitalisation (daytime or night-time). They include: use of equipment, preparation of the treatment plan, check-up consultations and assessment systems during treatment, dosimetry in vivo, contrast mediums and anaesthesiological care, commonly-used materials, where necessary, except as specifically described.

For analgesic therapy (complete treatments except as expressly described) fees are inclusive of care by the medical team during hospitalisation. Services are refundable when provided in daytime or night-time hospitalisation or on an outpatient basis.

The contents of the FasiOpen Basic Nomenclature (as applicable to your Health Plan) remain valid for this Area.



COVER 3 – Diagnostics Area (205, 206, 207)

Diagnostics are sub-divided into three areas:

- ✓ medium-cost diagnostics (205);
- ✓ diagnostics through analyses and clinical tests (206);
- ✓ high-cost diagnostics (207).

To obtain the specified refunds you must send, together with the relevant invoices (online procedure), details of the services provided as well as the prescription of the treating physician (qualified to make diagnoses) indicating the type of pathology and/or diagnostic outcome (different from symptomatology) that made the tests themselves essential. The Fund does not refund services relating to check-ups, preventive/experimental medicine and/or research and/or anything else mentioned in or related to the contents of the "Exclusions" (in the Basic Nomenclature) and the "Services not covered by FasiOpen" paragraph, regardless of their type or the reason for which they are carried out. The Fund therefore reserves the right to assess, case-by-case, the relevance of tests carried out to the stated pathology/diagnostic outcome and/or to the specialisation of the professional (also viewable on the website of the Italian Board of Physicians, Surgeons and Orthodontists) who prescribes them.

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

Please remember that diagnostic tests are refundable, even if received upon payment of public healthcare charges, if the latter explicitly refer to services covered by the Basic Nomenclature and included in the provisions of your Health Plan; i.e. if the service is covered by the FasiOpen Basic Nomenclature but is not listed among the outpatient diagnostic tests covered in your Health Plan, it cannot be refunded even if received upon payment of public healthcare charges. In the event of simultaneous payment of public healthcare charges for services in affiliation with the S.S.R. (Italian Regional Health Service) and private services, you must ask the healthcare facility to indicate not only the type of service but also the breakdown of the amounts between the those relating to public healthcare charges and those relating to private services. Please note that any quantitative and/or time limits for services will also apply to those subject to the payment public healthcare charges only.

All laboratory analyses contained in the Fee Schedule are refundable solely and exclusively if correctly invoiced by authorised analysis laboratories.

All tests shown in the detailed list of the individual area are refunded, including genetic analyses carried out solely for diagnostic-therapeutic purposes and according to the diagnostic protocols sanctioned by conventional medicine.

Laboratory analyses and medical-surgical procedures involved in the treatment of stem cells are refundable only if described in the current Nomenclature-Fee Schedule (in the Areas of the relevant Modular Plan) and within the limits (financial/time-based/quantitative) specified.

As regards clinical analyses, please note that the taking of samples is included in the services themselves. Any request for the taking of samples at home, as an additional item to the test itself and limited to those covered by the Basic Nomenclature and included in your Health Plan, must be clearly mentioned in the medical prescription

and must be in-line with the pathology, i.e. it must be compatible with the clinical picture that made taking samples at home necessary. For radiological tests and/or diagnostic tests using nuclear medicine, the relevant fees relate to complete examinations of projections and the number of x-rays needed for an exhaustive test to be provided. These also include radiologist fees and/or those of the nuclear medicine specialist and/or other specialists (e.g. anaesthetist/anaesthesiologist), of the technical staff and, where used and not otherwise expressly provided for in the specific introductions, also contrast media, materials, medicines and anything else necessary for the purposes of the test. It is therefore excluded that healthcare facilities will charge clients of the Fund for the above services in addition to for the tests themselves. For some diagnostic tests, a reduction of 50% is applicable on the second test (or, in any case, on the least costly one), as mentioned in the respective "Specific Branch Introductions". As regards the above, the term "during the same session" means during the same access to the healthcare facility (documented or detectable); thus, in the case of 2 tests carried out, the 50% reduction (where applicable) will be applied if a different access occasion is not unequivocally detectable.

Branch	Specific conditions per branch
CLINICAL ANALYSES	The taking of samples is included in the fee for the test concerned, except for in cases specifically described in the "samples" section. In the latter case, please note that any request for "sample taking at home" must be indicated in the medical prescription and must be supported by a clinical picture that is compatible with the request itself. Analyses can be carried out with any technique or method and the fee is for each analysis, except as specified in the individual items. Unless otherwise specified, tests relate to any type of liquid or biological tissue. The Fund reserves the right to assess, on a case-by-case basis, the relevance of the tests carried out to the stated pathology. Laboratory analyses and medical-surgical procedures involved in the treatment of stem cells are only refundable if included in the Basic Nomenclature and in the Area of the respective Health Plan. All laboratory analyses listed in the Basic Nomenclature are refundable solely and exclusively if invoiced by authorised analysis laboratories and accompanied by the relevant medical prescription with diagnosis. All tests, including genetic analyses, if provided for by your Health Plan and within the specified limits and conditions, are refunded solely if carried out for diagnostic-therapeutic purposes and according to the diagnostic protocols sanctioned by conventional medicine. Strictly excluded from refund are services relating to preventive medicine/check-ups, experimental and/or research medicine and/or anything mentioned in the "Exclusions" (in the Basic Nomenclature) and the "Services not covered by FasiOpen" paragraph. Please note that "Total Proteinemia" tests are included within "Serum Protein Electrophoresis" tests. "Cytogenetics (prenatal and postnatal)" tests, limited to those included in the Fund's area of activity (specified case by case - no other possibilities are available), are refunded within the specified limits and only with a prescription by a physician specialising in "Medical Genetics" (clinical genetics). "Tests included in the "Molecular Genetics" sub-section, limited to those included in the Fund's area of activity (specified case by case - no other possibilities are available), are refunded within the specified limits and only with a prescription by a physician specialising in "Medical Genetics" (clinical genetics) or Oncology. Please note that, since the results of many tests do not change over time, the safe-keeping of the results from these is the responsibility of the client (the Fund does not provide copies of any received).
Branch	**Specific conditions per branch**

CYTO/HISTOLOGICAL/IMMUNOHISTOCHEMICAL TESTS	Tests can be carried out using any technique or method. Please note that, within the context of the Basic Nomenclature, "Cytology tests for tumour diagnosis (Pap Tests)" are refundable, if provided for in the Cover for diagnostic tests in your Health Plan (and within the limits specified therein) in the case of both standard "Pap Tests" and "Thin Prep" tests.
HISTOLOGICAL/IMMUNOHISTOCHEMICAL TESTS	Tests can be carried out using any technique or method. "Histological (1 anatomical part or neoplasm)" means an examination carried out on a single anatomical part/neoplasm, while "Histological, each additional inclusion" relates to "Histological (1 anatomical part or neoplasm)" and therefore a further examination carried out on partial samples of the same, illustrated by the following example: assuming 1 neoplasm, a "histological (1 anatomical part or neoplasm)" is carried out and 2 further histological examinations of parts/fragments of this same neoplasm are carried out - i.e. 2 "histological, each additional inclusion" examinations are carried out; assuming 2 different neoplasms, the histological examination of both neoplasms is carried out, i.e. 2 "histological (1 anatomical part or neoplasm)" examinations are carried out.
TAKING OF SAMPLES	Please note that taking of samples is included in the services themselves and is therefore not refundable (or chargeable by affiliated healthcare centres) as a separate item, even if included within public healthcare charges (in the case of services provided in affiliation with the S.S.R. (Italian Regional Health Service). Any request for the taking of samples at home, as an additional item to the test itself and limited to those covered by the Basic Nomenclature, must be clearly mentioned in the medical prescription and must be in-line with the pathology, i.e. it must be compatible with the clinical picture that made taking samples at home necessary.
CARDIOLOGY	The items described again include the use of equipment and professional fees. Basic ECGs always require a doctor's prescription with a definite or presumed diagnosis, unless carried out during a cardiological consultation, in which case the professional's report is sufficient. Please note that "ergometric tests" include a basic ECG. No refund is available for tests carried out to issue certificates (driving licence, sports fitness, etc.), and/or for anything mentioned in the "Exclusions" (in the Basic Nomenclature) and in the "Services not covered by FasiOpen" paragraph and/or anything related to these.
ANGIOGRAPHY	Fees include the entire medical-radiological-anaesthesiological team, the technical/auxiliary staff, and the contrast and x-rays required (complete with the necessary projections and number of radiographs). Special materials and any medicines are refunded as described in the relevant "Medicines and Healthcare Materials" section. For any further service in addition to the first one during the same session, a rate reduced by 50% is applied. Vascular district is defined as the study of the cerebral, supraortic, thoracic, abdominal-splanchnic vessels or of a limb or spinal metamer.
ULTRASOUND SCAN	All services can be carried out using any technique, method or equipment and, where necessary, are inclusive of medicines/drugs. For tests carried out during the same session, or at the same time as tests included in the vascular diagnostics section (any test), fees for tests subsequent to the first one are reduced by 50% (applied to the least expensive test/s). Tests are inclusive of any anaesthetic treatment and, where specified in the service code, also include the contrast medium. 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 (example: an ultrasound of the axillary lymph nodes corresponds to 1 single service code).
Branch	**Specific conditions per branch**

MINERALOMETRY - **BONE DENSITOMETRY**	Bone segments are defined as: large (femur, humerus, tibia); medium (clavicle, sternum, patella, radius, ulna, fibula); small (the remainder). Section is defined as: cervical column or dorsal column or lumbo-sacral column.
TRADITIONAL RADIOLOGY	Tests are considered to be complete with all projections, all necessary x-rays, any contrast and/or gas insufflation used and any necessary professional services, including assistance with diagnostic equipment. Please note that contrast medium, for services that include this in the section, is included in the test itself, i.e. there is no additional refund amount. Section is defined as: cervical column or dorsal column or lumbo-sacral column. A “pelvis for hip” examination corresponds to a single pelvis X-ray code and is not summed with the hip X-ray code. A “hip” study or “comparative hip study” is not equatable with a “pelvis for hip” examination and corresponds to the summation of “right hip” and “left hip” radiographs. Radiological tests carried out by a dentist or dental facility can only be requested within the context of the specific dental procedure (see Dental Area) and are therefore not recognised as refundable within indirect-provision services.
NUCLEAR MAGNETIC RESONANCE	Tests are considered to be complete with all necessary acquisition sequences, any anaesthesiological services where necessary (regardless of the type of anaesthesia or sedation) and any other medical and/or technical professionals involved. For any further examination or tract examined in addition to the first one during the same session, a rate reduced by 50% is applied (to the least expensive examination/s). The fee for any examination carried out “with contrast” or “without and with contrast” will be increased by the relevant fee specified for the contrast (only one contrast medium code will be recognised regardless of the number of examinations carried out in the same session). Bone segments are defined as: large (femur, humerus, tibia); medium (clavicle, sternum, patella, radius, ulna, fibula); small (the remainder). Joints or joint areas are defined as: large (hip, knee, shoulder); medium (elbow, wrist, tibial-peroneal-astragalic); small (the remainder). Section is defined as: cervical column or dorsal column or lumbo-sacral column. Vascular district is defined as the study of the cerebral, supraortic, thoracic, abdominal-splanchnic vessels or of a limb or spinal metamer. Tests can be carried out with any equipment/instrumentation. Please also note that “Total Body” tests also include the “neck” section, so that no additional "MRI Neck" tests are recognised. Also in this edition of the Nomenclature, the “Cine MRI Heart” test is recognised as “MRI Heart” and therefore is not equatable with the “Cine MRI as a functional study of joints” test.
COMPUTERISED AXIAL TOMOGRAPHY	Tests are considered to be complete with scanogram and all necessary scans, any anaesthesiological services where necessary (regardless of the type of anaesthesia or sedation) and any other medical and/or technical professionals involved. For any further examination or tract examined in addition to the first one during the same session, a rate reduced by 50% is applied (to the least expensive examination/s). The fee for any examination carried out “with contrast” or “without and with contrast” will be increased by the relevant fee specified for the contrast (only one contrast medium code will be recognised regardless of the number of examinations carried out in the same session). Bone segments are defined as: large (femur, humerus, tibia); medium (clavicle, sternum, patella, radius, ulna, fibula); small (the remainder). Joints or joint areas are defined as: large (hip, knee, shoulder); medium (elbow, wrist, tibial-peroneal-astragalic); small (the remainder). Section is defined as: cervical column or dorsal column or lumbo-sacral column. Vascular district is defined as the study of the cerebral, supraortic, thoracic, abdominal-splanchnic vessels or of a limb or spinal metamer. Tests can be carried out with any equipment/instrumentation. Please also note that “Total Body” tests also include the “neck” section, so that no additional “CT spinal column” tests: 1 segment with a minimum of 3 intersomatic spaces”: are recognised as refundable. In “CT of the spinal column”, the segment refers to the tract/s specified in the codes themselves.
Branch	**Specific conditions per branch**

DOPPLER ULTRASOUND - ECHO DOPPLER - ECHO COLOUR DOPPLER	Tests relate to both sides, including examination of the arterial and venous circulation, and double charging/refunds are therefore not recognised. The items/fees shown are also valid for any Doppler examination combining other techniques and methods such as lasers, etc. For tests carried out during the same session, or at the same time as ultrasound investigations (any), fees for tests subsequent to the first one are reduced by 50% (applied to the least expensive test/s). Bilateral upper limb tests carried out in the same session as bilateral lower limb tests correspond to a four-limb test, for which reference should be made to the relevant code. Doppler echocardiograms and/or cardiac Echo Colour Dopplers are not equatable with the items in this section. For such services, please refer to the Ultrasound section.
NUCLEAR MEDICINE **(SCINTIGRAPHY)**	Fees are inclusive of medicines, indicators, consumables, cardiological and anaesthesiological services (where necessary) and technical staff. Fees are inclusive of any pharmacological and ergometric tests and any type of provocative diagnostic procedure.
NEUROLOGY	The need to receive the services in this section must be certified/prescribed by a physician specialising in neurology. For prescriptions issued by professionals with a different specialisation from that indicated, the Fund will accept these at its own discretion on the basis of its unchallengeable assessment of the relevance of the request according to the specialisation and the diagnostic query provided (obligatory). For tests carried out during the same session, fees for tests subsequent to the first one are reduced by 50% (applied to the least expensive test/s). Fees are all-inclusive of consumables and medicines.
OPHTHALMOLOGY	The need to receive the services in this section must be certified/prescribed by a physician specialising in ophthalmology. For prescriptions issued by professionals with a different specialisation from that indicated, the Fund will accept these at its own discretion on the basis of its unchallengeable assessment of the relevance of the request according to the specialisation and the diagnostic query provided (obligatory). For tests carried out during the same session, fees for tests subsequent to the first one are reduced by 50% (applied to the least expensive test/s). Materials and medicines are included in the fees shown. Transillumination tests, Shirmer's tests, Fundus Oculi tests, Shirmer's tests, BUT tests and Hess Screen tests are included in the consultation. Photographs of the ocular fundus are only refundable if taken by a physician specialising in ophthalmology and only in the context of specialist consultations. Tonometries are only refundable if carried out separately from the specialist consultation, otherwise they are deemed to be included in the consultation itself.
OTORHINOLARYNGOLOGY	The need to receive the services in this section must be certified/prescribed by a physician specialising in otorhinolaryngology. For prescriptions issued by professionals with a different specialisation from that indicated, the Fund will accept these at its own discretion on the basis of its unchallengeable assessment of the relevance of the request according to the specialisation and the diagnostic query provided (obligatory). For tests carried out during the same session, fees for tests subsequent to the first one are reduced by 50% (applied to the least expensive test/s). Materials and medicines are included in the fees shown.
PNEUMOLOGY	The need to receive the services in this section must be certified/prescribed by a physician specialising in pneumology. For prescriptions issued by professionals with a different specialisation from that indicated, the Fund will accept these at its own discretion on the basis of its unchallengeable assessment of the relevance of the request according to the specialisation and the diagnostic query provided (obligatory). For tests carried out during the same session, fees for tests subsequent to the first one are reduced by 50% (applied to the least expensive test/s). Fees are inclusive of consumables and any medicines.
Branch	**Specific conditions per branch**

ALLERGOMETRIC TESTS/ALLERGOLOGY	Fees represent professional fees and include consumables. Medicines and/or the substances used for tests (series of allergens) are excluded from refunds. Fees are per session, to which the fee for the consultation can be added once only per course of sessions/therapies. The expenditure documentation must always be accompanied by a medical certificate showing precisely: the diagnosis and the number of sessions/therapies considered necessary. The services in this section are not equatable with vaccines (of any type).

“Mosaic” Health Plan

Detailed description of covers included

COVER 4 – Dental Area (208, 209)

The Dental Area includes basic dentistry (208) and the dental implantology and prostheses area (209). For the inclusion of area 209 in the health plan, basic dentistry (208) must also be chosen. Please remember that dental services can only be received via “**direct provision**” on an outpatient basis.

Dental services received via indirect provision during hospitalisation (regardless of the reason for hospitalisation) are therefore non-refundable, as are public healthcare charges relating to dental services.

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The list of dental health facilities belonging to the network recognised by FasiOpen can be seen at www.fasiopen.it. All administrative procedures for managing the file with the Fund are free of charge and entirely chargeable to the affiliated healthcare facility.

Please remember that with “direct provision” affiliations the Fund pays the client's chosen dental facility the amount chargeable to FasiOpen based on the refund fee specified in the current Nomenclature-Fee Schedule. Consequently, the client must pay the dental facility only the previously agreed excess (calculated as the difference between the fee charged by the affiliated dental facility, agreed upon the act of affiliation, and the maximum refund fee payable by FasiOpen for the service/s received listed in the Areas of the individual Modular Plan).

We also specify that, for purely medical reasons, FasiOpen uses the services of the Pro.ge.sa. company (Progetti e Gestioni Sanitarie), which works with the Fund through its physicians, surgeons and dentists. This company is assisted by dental consultants with proven experience in purely scientific matters.

Procedures for accessing direct provision dental services (at affiliated healthcare facilities)

Given the above, the procedures to follow for access to direct provision dental services at affiliated facilities are set out below:

- ✓ Clients wishing to make use of direct affiliations must immediately, at the offices of affiliated healthcare facilities, communicate and prove their membership of the Fund by communicating their FasiOpen membership number and an ID document (for minors, that of a parent or guardian) and obtain or request confirmation (at the same offices) of all necessary information for the correct use of the affiliation in order to avoid any misunderstandings;
- ✓ Having established the treatments to be carried out in consultation with the client, the chosen dentist will draw up the "Treatment Plan" and communicate this to FasiOpen, together with any obligatory pre-treatment documentation (where required), telematically;
- ✓ Upon sending the treatment plan telematically, the healthcare facility may receive a generic communication regarding any barriers to refund via "direct provision" due to anomalies detected in the personal details/contributory status of the client. In this case the facility will receive immediate and summary notification that the case is "Ineligible" without specifying the reasons. Should this happen the client can contact the Central Information Service on dedicated number 800 085 502 - Option 1 - Dial 2 Administrative Information - Contributions, in order to investigate any issues.

For the services included in the telematic treatment plan and listed in the Areas of the client's Modular Plan, the Fund will carry out the specified checks for compatibility with the current Fee Schedule and will provide the dental facility, **within 7 working days** after its submission:

- ✓ the reasons for any of the services not being eligible for refund;
- ✓ suggestions on how to overcome any time-based/administrative limits to the provision of refunds for specific treatments;
- ✓ **the healthcare facility, upon receipt of approval to provide the services** as specified for "direct provision", **will inform the client which services are subject to pre- and post-treatment obligations**, the documentation for which will be sent directly to FasiOpen by the healthcare facility at the end of the treatment itself (which the client is aware of and authorises);
- ✓ upon completion of all or some services specified in the "Treatment Plan", **the healthcare facility will issue the relevant expenditure receipts (any invoices for down payment and balance, or partial balance), sending these telematically** together with the radiographic (or photographic) and/or dental laboratory documentation and the required administrative documentation, giving the originals of the aforementioned expenditure certificates to the client. The client, therefore, will pay the amount in excess of the FasiOpen refund fee and the amount that is not included within the Fund's area of activity and/or the client's Health Plan. **Please note that, in this case also, invoices must be correctly subjected to stamp duty;**

- ✓ FasiOpen, upon telematic receipt of the expenditure receipts and all specified medical documentation, will begin examining this documentation with the help of its dental consultants and **will arrange for payment of the sum due (if due) in the name of and on behalf of its clients**, within the limits of the maximum fees specified for direct provision services in the current Nomenclature-Fee Schedule. For their part, **clients will pay the sums** relating to any service specified therein that, upon examination of the request, is found to be not eligible for refund[1];
- ✓ **should any further checks on the client's personal details/contributory status** carried out by the Fund at the request of the Odontologist **highlight any irregularities** - during the performance of treatment or immediately prior to the payment of refund requests already sent by the facility and received by the Fund - **the client must pay the entire cost of the services received directly to the facility itself**.

Administrative/healthcare warnings for direct provision services

Please remember that:

- ✓ Clients receiving "direct provision" dental health services must under no circumstances send any medical invoices/receipts to FasiOpen for refund, since the Fund pays any sums within its competence, in the name of and on behalf of the client or right holder, directly to healthcare facilities based on the documentation sent telematically to FasiOpen by the healthcare facilities themselves;
- ✓ **it is prohibited under current legislation to issue two original medical invoices/receipts** for the same service; for this reason, if "direct provision" affiliated healthcare facilities make this error, which is moreover a **criminal offence**, clients are urged to return these immediately to the healthcare facility and to request the corresponding correction;
- ✓ FasiOpen will receive all expenditure documentation telematically, meaning that the healthcare facility is obliged to deliver the original documentation (which is also usable for tax purposes) at the moment of payment. The client must also ask for delivery of the original documentation in the case of expenditure entirely charged to the Fund (without the payment of any part of it by the client);
- ✓ For all services not recognised as refundable or not described, the affiliated healthcare facilities have undertaken to charge lower fees with respect to their private rates;
- ✓ Some services are not refundable by the Fund. To avoid possible misunderstandings, if in doubt clients can call the FasiOpen Health Information Centre, open Monday to Friday from 9 AM to 5 PM non-stop, for any clarifications needed;

[1](*) Direct provision refunds may not be paid to the facility concerned if the obligations specified in the current Nomenclature-Fee Schedule are not complied with, or if the client does not deliver the x-rays, photographs, etc. needed to complete the required paperwork and/or in the event that the authorised services are not carried out and/or are different to those actually carried out.

- ✓ At the end of the provision of services, also for dental treatments, clients must sign the appropriate form prepared by FasiOpen and in the possession of the **affiliated healthcare facilities (which will be kept on file by the healthcare facilities themselves)** in which the client, who requested and used 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 dental healthcare facility to recover the sum that it had paid in advance on his/her behalf, if due, because it has been recognised as refundable by FasiOpen. Otherwise, he/she undertakes to pay for them personally;
  - ✓ releases the physicians-surgeons-dentists 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 excess for which he/she is liable and for which he/she is not entitled to further refund by FasiOpen;
  - ✓ undertakes, in accordance with the provisions of art. 13 of the Regulations, to refund FasiOpen, up to the amount paid by the Fund in his/her name, any sums received from third parties in compensation - should the expenditure relate to events connected to third-party liability, within the limits of the amount paid by FasiOpen in the name and on behalf of the client;
  - ✓ 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;
  - ✓ give their “consent” to the processing of personal, common and sensitive data, pursuant to Legislative Decree 196/2003 on privacy and subsequent amendments.

COVER 5 - Specialist consultations (210)

Specialist consultations, in the sense of diagnostic services (excluding those necessary to resolve a pathological event, i.e. follow-up/successive consultations), are refundable if the documentation clearly shows the specialist academic qualification of the physician who performed the consultation.

No refunds are available for follow-up consultations; for general medicine services including, among others, consultations, injections, drips, vaccinations, etc. Also excluded from refunds are dental consultations, dietary consultations, psychologist consultations and psychotherapy sessions, even if carried out by specialist medical physicians in neurology or psychiatry, everything listed under “Exclusions” (in the Basic Nomenclature), everything in the “Services not covered by FasiOpen” paragraph and/or everything related to these.

Specialist consultations are not equatable with medical assistance during overnight hospitalisation and/or specialist oncological care. Specialist consultations during overnight hospitalisation will only be recognised as refundable if carried out by a professional with a different specialisation to that for which the hospitalisation was requested. In this case, the medical record must include the primary team's diagnostic query and the report of the consultant involved. In this case too, only the specialist consultation for diagnostic purposes is recognised as refundable.

Specialist oncological care is defined as that provided by specialists during infusional chemotherapy sessions on an outpatient basis, at home, in day hospitals or with night-time hospitalisation; or that provided by specialist oncologists only during night-time hospitalisation and without chemotherapy. The documentation must clearly show the type of therapy given.

Medical care during hospitalisation means care provided on a daily basis by the medical team during hospitalisations without surgical operations. **This item is not, however, recognised as refundable in the event of hospitalisation in day hospitals (daytime medical hospitalisation).**

Please note that for specialist consultations given by the entire medical-surgical-anaesthesiological team during hospitalisation with night-time or daytime stay (day hospitals-day surgeries) with or without surgery, the amounts due are included in the fees shown for each individual medical operation or care.

Consultations carried out by persons other than graduates in medicine and surgery duly registered with the Italian Board of Physicians (also indicating the professional's specialisation/s) are not refundable.

COVER 6 – Physiokinesis Therapy (211)

Refunds of expenditure relating to physiokinesis therapy are limited to a total of 80 services (not sessions) per year (1 January - 31 December) per client for neurological, neuromotor and osteo-articular pathologies regardless of type, technique, instrumentation, and the anatomical district treated.

Items relating to the "Rehabilitation" section, for which the term "per session" is explicitly shown, cannot be combined with other services/items in the Physiokinesis therapy section since they are already included in Rehabilitation.

Anatomical district means the entire spinal column, or the upper or lower limbs.

The limits specified above are not applicable in a quantitative sense for acupuncture, spinal manipulation and focal shock waves, which have their own annual limits but count towards calculation of the maximum of 80 services per year.

Please remember that physiokinesis therapy services provided through the S.S.N. (Italian National Health Service), and therefore upon payment of public healthcare charges, still count towards calculation of 80 services per year and the quantitative/time limits specified for the services themselves. In this case too, therefore, please note that even if the services are received upon payment of public healthcare charges, the type/s of service/s and the respective quantity must always be clearly shown.

Equipment hire, which is also subject to annual limits, does not count towards calculation of the maximum annual limits.

The items/fees are all-inclusive of consumables and medications.

Therapies for aesthetic purposes and/or ascribable to these are not refundable.

To access the specified refunds you must send, together with photocopies of the relevant invoices, details of the therapies carried out (type, number of sessions, number of services per session and their frequency) as well as the medical prescription with the corresponding definite diagnosis of the pathology (not to be confused with the symptomatology) that made them necessary and essential.

For physiokinesis therapy, moreover, the professional qualification of the person who performed and invoiced the services or, in the case of therapies carried out at centres authorised for rehabilitative services (with these authorisations issued by the competent authorities), the specialisation of the centre itself, must be clearly shown.

Please note that services with "manu medica" in their description will be recognised as refundable only and exclusively if carried out by a specialised physician, in other words they cannot be recognised if carried out by a professional figure other than a physician with the respective specialisation (relevant to the pathology and the therapy given).

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.

The same rules, relevant maximum rates and limitations apply to home treatments as those specified in the Nomenclature in force at the time of invoicing, i.e. no additional sharing of the cost is recognised for any fees charged for the provision of these services (any) at home. If shown in the expenditure/healthcare documentation, this additional charge will be separated out and will be non-refundable.

“Occupational therapy” is recognised as refundable by the Fund for clients/members suffering from pre-existing cognitive, physical or mental disabilities, while “Neuromotor rehabilitation for acute and chronic neurodegenerative pathologies” is recognised by the Fund in cases of disabling neurological damage and - therefore - therapy for the recovery of functional motor or neuromotor skills recently reduced and/or lost due to illness or trauma and/or chronic-degenerative pathologies (e.g. cerebral strokes, Parkinson's disease, multiple sclerosis, etc.). The above items are defined as being per session, regardless of the number of therapies/services carried out within the same session, i.e., the above items/services cannot be summed with other items/therapies/services in the same Physiokinesis therapy section. For refunds of “Occupational Therapy” to be recognised, the qualification of the practitioner who carried out the treatment/services must be clearly indicated.

Moreover, without affecting the above as regards the annual limits to refundability, in order to safeguard those suffering from serious symptomatological pictures, **limitations to the number of refundable services** (with the exception of limitations for acupuncture, focal shock waves, spinal manipulations and equipment hire, which remain confirmed) **will not apply if the relevant treatments are necessary and connected to the symptomatological pictures/pathologies described below**.

To this end all documentation for the expenditure incurred, dating from the first request of the year, must be accompanied by detailed certification issued by the treating physician highlighting at least one of the symptomatological pictures/pathologies described below:

- ✓ complete paralysis, partial paralysis, paralysis of single nerves, progressive paralysis of the muscle/s;
- ✓ spasticity;
- ✓ traumatic (tetra, paraplegia) and non-traumatic myelopathies (amyotrophic lateral sclerosis, plaques, etc.);
- ✓ infantile cerebropathies (spastic, etc.);
- ✓ intrinsic neurological pathologies (Huntington's chorea, Parkinson's disease, etc.);
- ✓ rehabilitation of amputees;
- ✓ intrinsic muscular pathologies (progressive muscular dystrophy, etc.).

To this end all documentation for the expenditure incurred, dating from the first request of the year and for each refund request for physiokinesis therapy services (regardless of how they are received) must be accompanied by an **up-to-date and detailed report from the specialist physician qualified to make the diagnosis highlighting the clinical picture and the therapeutic procedure, particularly in relation to the number and type of physiokinesis therapy services needed to maintain/stabilise the clinical picture itself**.

Moreover, without prejudice to the above, surgical paid as a result of operations (excluding non-invasive reductions) such as:

- ✓ hip, knee, ankle or humerus prostheses;
- ✓ capsular ligament injuries of the knee, ankle or shoulder;
- ✓ cervical, dorsal or lumbar hernias or vertebral stabilisations (spondylolisthesis).

Upon explicit request of the client (or the healthcare facility in agreement with the client), physiokinesis therapy treatments (limited to those that can be unequivocally linked to a surgical operation among those mentioned immediately above) received and invoiced in the 90 days following the day of surgery (the day of surgery itself, not the day of discharge from hospital) may be recognised as refundable regardless of the limit of 80 services per year (again with the exception of acupuncture, spinal manipulation, focal shock waves and equipment rental, for which the limits for services remain valid).

To temporarily waive the limit during the period mentioned above, and regardless of whether the services are received with direct or indirect provision, you must attach a copy of the medical record, even if previously sent with another refund request, supported by the hospital discharge letter and an up-to-date report from the physician-surgeon who carried out the operation confirming the actual number and type of physiokinesis therapy treatments needed to resolve the event.

A possible temporary waiver of the limit of 80 services per year may be granted by the Fund at its sole discretion, once only per pathology/operation/traumatic event.

FasiOpen, both before and after paying refunds for services, reserves the right to request a copy of the daily physiokinesis therapy diary signed by the client in the case of out-patient and in-home services (please note that, in the case of hospitalisation, the daily physiokinesis therapy diary is an integral part of the medical record) and/or reserves the right to perform administrative-health checks and/or checks on the academic qualification/specialisation of the professional providing the services also by reference to registrations listed at the Professional Boards and/or Registers.

COVER 7 – Public Healthcare Charges (212)

Public healthcare charges must always show details of the services carried out and are refundable, always within the maximum limits of the individual fees and of the expenditure incurred, **only if they relate to the specialist services expressly included in the** Basic Nomenclature and therefore your Health Plan. Services received solely though the payment of public healthcare charges are subject to the same quantitative and/or time limits specified for each service. Please note that public healthcare charges for dental services and/or check-ups and/or everything specified in the "Exclusions" paragraph (of the Basic Nomenclature) and the "Services not covered by FasiOpen" paragraph and/or everything related to these, are not refundable.

COVER 8 – Spa Treatments (213)

Refunds for spa treatments are recognised only if these have been carried out at authorised establishments equipped for this purpose located in spa resorts. For simultaneous treatments with mud therapy or balneotherapy treatments and hydropinic or inhalation therapies, the higher fee only is applied (i.e. the fees cannot be summed).

Mud therapy and balneotherapy treatments are refundable for a maximum of 12 days a year (1 January - 31 December). **Hydropinic and inhalation therapies** are refundable for a **maximum of 10 days a year** (1 January - 31 December) **and for no more than 3 years**.

To obtain a refund for spa treatments a specific medical prescription must be sent certifying the need for the treatment itself, specifying the pathology currently suffered and including expenditure documentation for entry to the spa facility.

Please note that the fees shown are inclusive of the fees of the persons providing the services and/or all equipment/instrumentation.

Refunds strictly exclude any accommodation costs and/or any costs ascribable to and/or accessory to these.

Materials and Medicines in the course of Hospitalisation

Refunds are not available for:

- ✓ the cost of storing medicines;
- ✓ secretarial fees;
- ✓ administrative fees;
- ✓ the issuing of copies of medical records;
- ✓ the issuing of copies of x-rays;
- ✓ VHS tapes, CDs, DVDs;
- ✓ and anything else shown in "exclusions".

Only eligible for refund, according to the maximum amounts shown, are those

medicines used during hospitalisation (night-time or daytime) and duly specified on the invoice issued by the healthcare facility, including blood and its derivatives (dedicated item) which must be debited according to the current regulations regarding this specific matter.

All healthcare materials used during hospitalisation (night-time or daytime) in the healthcare facility and duly specified on the invoice are refundable to the extent specified in the individual Health Plans.

For operations and/or procedures carried out on an outpatient basis (outpatient operating theatre), materials, medicines and instruments are included in the fees for the operating theatres themselves.

Please note that, in the case of “packages” received by direct provision, the amount accepted by the healthcare facility in the signed affiliation the maximum that can be invoiced for that specific procedure/surgical operation (including materials, medicines and prostheses where relevant).

No type of device and/or prosthesis can be equated with the materials code.

As regards materials and medicines used during dental surgery, the costs involved are included in the maximum refund fees for the services themselves and are not payable even if specified on the invoice, regardless of whether they are related to the operating theatre and/or to any stay in hospital.

FasiOpen reserves the right to request details of the materials and/or medicines for which a refund request has been submitted.

"Mosaic" Health Plan

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/Areas included in your Health Plan (which also indicates its limits and conditions), the following is a brief list of services not provided for 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 (where provided for);
- ✓ 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**;

"Mosaic" Health Plan

Services not covered

- ✓ **spa treatments** (if not explicitly provided for);
- ✓ 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 and/or if not explicitly provided for within the individual areas of the Mosaic Plan and in any case within the limits specified therein);
- ✓ **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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