FasiOpen

Fondo Aperto di Assistenza Sanitaria Integrativa

Piano Sanitario ORANGE

Guida per gli assistiti

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Guide for clients

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

A network of **affiliated partners** to **assist** you

This Guide sets out the Covers offered by the FasiOpen "ORANGE" 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.

We encourage you to also carefully read the information in the FasiOpen Basic Nomenclature.

Without prejudice to a citizen's right to "freely choose" his/her healthcare facility and/or qualified professional in Medicine and Surgery and/or Dentistry and Dental Prosthetics (duly qualified and recognised by the competent Authorities) we remind you that FasiOpen has an extensive network of direct affiliations with nursing homes, dental surgeries, hospitals/universities, diagnostic clinics, physiotherapy centres, day hospitals and day surgeries.

NETWORK OF AFFILIATIONS for "Direct Provision" healthcare

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.

"Direct Provision" care 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.

FasiOpen

FasiOpen Healthcare

FasiOpen has its own Basic Nomenclature, which is a list of services recognised as falling within its area of activity.

A Health Plan is subdivided into Covers which, in turn, cover the services actually refunded within the financial limits specified in them.

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).

The individual Covers list the services, methods and the amount of contribution towards the cost by the Fund, as well as the procedures that must be followed to request a refund. Useful information is thus provided on the correct way to follow the procedures, as well as a glossary of the terminology used which can be viewed on page 162 of the Basic Nomenclature).

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

"INDIRECT PROVISION" services

How to request a refund

Refund claim documentation, both for clients and Healthcare Facilities, should be sent using an online procedure which enables the digital transmission of healthcare and expenditure to your personal Private Area. The digital transmission of all documentation enables clients and the Healthcare Facilities to reduce the time needed for payment by FasiOpen and to view all expenditure documentation at any time (in the respective sections and limited to the information allowed by the privacy notice). For those without access to digital channels FasiOpen continues, in limited cases, to accept refund requests for services sent by registered mail to the Operational Headquarters of FasiOpen, Europa 175 – 00144 Roma.

Refund requests for indirect provision services must be accompanied by a "Healthcare Expense Refund Request" form or, in the case of dental services, a "Dental Services Request/Unified Form", the expenditure documentation (or a copy of this if submitting a printed document), and the medical documentation stipulated for the services.

Please note that, regardless of the submission method used, 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).

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

Terms of presentation

Refund requests must be fully completed and sent to FasiOpen online via the client's Private Area - 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, 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 specified - subject to the client sending two copies of a form downloadable from within his/her private area entitled "Declaration of Third Party Liability".

Medical records and medical certifications

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.

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

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

Services/treatments received in foreign countries

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

Procedures for submitting refund requests, all time and/or quantity and/or age and/or gender limits, deadlines for the submission of requests, and all medical documentation therefore also remain applicable for treatments received abroad.

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

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

Dentistry

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

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

Further information will be provided in the relevant Cover.

Please refer to page 18 of the Basic Nomenclature for further details and to Cover 10 of this Guide.

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 certain or presumed type of pathology (obligatory) that made the tests themselves essential (further specifying pre-surgery and/or post-surgery tests where applicable)**.

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.

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).

Please refer to page 13 of the Basic Nomenclature for further details and to the various Covers of this Guide.

Nursing Care

FasiOpen recognises refunds for Nursing Care during overnight hospitalisation if this is explicitly provided for in your Health Plan.

Please refer to page 18 of the Basic Nomenclature for further details and to Cover 1.

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).

Please refer to page 20 of the Basic Nomenclature for further details and to Cover 7 of this Guide.

Surgical Packages

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

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

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

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

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

Please refer to page 21 of the Basic Nomenclature for further details and to Cover 1 of this Guide.

Prevention

For Health Plans that have them, the Fund offers a range of Prevention Packages.

The member/client can freely choose 1 Prevention Package per year (if included in his/her Health Plan), bearing in mind that 1 prevention package is refundable per year but that the same package is not refundable before another 2 years have elapsed, with the exception of “Oncology Prevention Packages for Men/Women” which can be repeated once a year until the age of 65, after which they revert to the standard frequency of once every 2 years.

Please refer to page 23 and page 158 of the Basic Nomenclature and to Cover 9 of this Guide.

Hospitalisation Allowance

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

- ✓ Childbirth Hospitalisation Allowance, sub-cover 8.2
- ✓ Allowance in lieu of overnight hospitalisation following Surgery (set out in Cover 1), cover 11

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

To clarify further, please remember that a refund for an allowance (whatever type) is recognised only for the client receiving treatment, i.e. only and exclusively for the person directly receiving the treatment/therapy, if he/she belongs to the family unit registered with the Fund when hospitalisation

began, regardless of the "patient's" age, i.e., no additional allowance is recognised for any family member staying in hospital to assist the patient.

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

Transport by Ambulance

FasiOpen recognises a contribution towards the cost of "Transport by Ambulance", limited to indirect provision services and exclusively within Italy. Please refer to page 23 of the Basic Nomenclature and to Cover 13 of this Guide.

Non-refundable services

We request that you do not send receipts for expenditure relating to services not provided for by FasiOpen, as set out in the example list of "services not covered by FasiOpen".

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). Please refer to page 25 of the Basic Nomenclature for further details.

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 – Private Area

You can access your own personal Private Area 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 and change your personal details;
- ✓ print the necessary forms (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 healthcare facilities to prepare claims for refunds for 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.

INFORMATION CENTRE

The FasiOpen Information Centre 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.

Validity of "Direct Provision" refund authorisations for hospitalisation

IMPORTANT

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

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

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

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

Use of affiliated healthcare facilities

The list of affiliated facilities can be viewed at www.fasiopen.it, accessing the dedicated section "healthcare network".

To make use of direct affiliations, clients must communicate their:

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

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.

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

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

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

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

- ✓ confirms, by signing, that he/she has used the services indicated in the request in terms of both its type and quantity (since an advance request for services yet to be received is not eligible for refund);
- ✓ authorises the healthcare facility to recover the sum that it had paid in advance on his/her behalf, if due because they have been recognised as refundable by FasiOpen. Otherwise, he/she undertakes to pay for them personally;
- ✓ releases the physicians who have treated him/her from the obligation of professional secrecy (*vis a vis* FasiOpen and its collaborators);
- ✓ declares that he/she has paid any surplus amount for which, according to the terms of the chosen Health Plan, he/she is not entitled further refund by FasiOpen;
- ✓ undertakes, in compliance with article 13 of the Regulations, to refund FasiOpen, up to the amount paid by the Fund on his/her behalf, any sums received by third parties as compensation should the expenditure be for events connected with third party liability;
- ✓ undertakes to pay any amounts which, while assessing the refund request, FasiOpen detects as non-refundable and/or as not falling within the Cover of his/her Health Plan and/or as exceeding the limits;
- ✓ totally commits to paying for all services that, after they have been provided - regardless of whether relating to outpatient services and/or hospitalisation of any kind (daytime or night-time) - turn out to be not payable by the Fund due to loss of the right to assistance by FasiOpen;

- ✓ authorises the healthcare facility to forward to FasiOpen, Poste Welfare e Servizi S.r.l. and Pro.ge.sa S.r.l. a copy of the expenditure documentation and whatever else is needed to receive refunds from FasiOpen;
- ✓ grants his/her "consent" to the processing of personal, common and sensitive data, as required by Law 196/03 on Privacy and subsequent additions and/or modifications.

How to use the Servizio Sanitario Nazionale or Servizio Sanitario Regionale

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

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

IMPORTANT
Refund ceilings

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

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

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

Stamp Duty on Medical Receipts

Given that:

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

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

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

Stamp duty is not refundable by FasiOpen.

"Orange" Health Plan
Detailed description of covers

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

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

To obtain an "Indirect Provision" refund you must send FasiOpen the expenditure documentation (online procedure) unequivocally confirming payment in full of the medical services received. A complete and legible copy of the medical record relating to the subject of the refund must be attached. Otherwise, in the case of "direct provision" services,, it will be the responsibility of the healthcare facility to transmit the necessary refund documentation to the Fund[1].

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

Description	Refund ceilings
MAXIMUM REFUND PER YEAR AND PER CLIENT	€ 100,000
MAXIMUM REFUND PER EVENT	€ 90,000
REFUND QUOTA (inclusive of all competencies including the medical team)	100%
MINIMUM NON REFUNDABLE	None
Details	**Refund sub-ceilings**
HOSPITALISATION CHARGES	Up to €300 per night for "indirect provision"
ACCOMPANIMENT CHARGES	Up to €50 per day – maximum 30 days for "indirect provision" hospitalisation
NURSING CARE	Up to €60 per day – maximum 30 days for "direct" or "indirect provision" hospitalisation

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

OPERATING THEATRE	Refundable up to a maximum ceiling
MEDICINES, MATERIALS AND PROSTHESES	
SPECIALIST INPATIENT CONSULTATIONS	
INPATIENT DIAGNOSTICS	

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

56101- 222 Axillary lymphadenectomy (as a single operation)
43042 – 224 Radical mastectomy, any technique, with associated lymphadenectomies
43034 – 225 Simple total mastectomy with any lymphadenectomies
43109 – 226 Subcutaneous mastectomy (complete treatment)
41053– 229 Quadrantectomy with search for and removal of the sentinel lymph node and associated lymphadenectomies, any technique (including nuclear medicine/radiology)
59065 – 230 Quadrantectomy with search for and removal of the sentinel lymph node, any technique (including nuclear medicine/radiology), without other associated lymphadenectomies
43026 – 231 Quadrantectomy, including "NIPPLE-SPARING" technique, without associated lymphadenectomies
56119 - 232 Breast reconstruction after radical mastectomy with introduction of implants, including muscle flap if needed
56127– 233 Breast reconstruction after simple total mastectomy with introduction of prosthesis, including muscle flap if needed
56135 – 234 Breast reconstruction after subcutaneous mastectomy or quadrantectomy with introduction of implants, including muscle flap if needed
56143 – 235 Removal and possible replacement of breast prosthesis implanted in previous mastectomy or quadrantectomy surgery (as a single operation)
59073 – 236 Tumourectomy with sentinel node resection (including nuclear medicine/radiology)
59081 – 237 Tumourectomy with sentinel node resection and associated lymphadenectomies (including nuclear medicine/radiology)
56226 – 271 Tumours of any type, exeresis or excision en bloc
40923 – 360 Unilateral cervical lymphadenectomy (as a single operation)
41038 – 361 Bilateral cervical lymphadenectomy (as a single operation)
40931 - 362 Supraclavicular lymphadenectomy (as a single operation)
40949 – 361 Parathyroids - complete treatment, intervention on the
43000 – 365 Parathyroids, reinterventions
43463 – 367 Thyroid, lobectomies
40956 – 368 Subtotal thyroidectomy
56234 – 369 Total thyroidectomy, or total thyroidectomy, any route of access, without laterocervical emptying
43497 – 371 Total thyroidectomy for malignant neoplasms with unilateral laterocervical emptying
40980 – 372 Total thyroidectomy for malignant neoplasms with bilateral laterocervical emptying
40899 – 377 Malignant tumour of the neck, removal of (excluding described cases)
41210 – 380 Total oesophagectomy with oesophagoplasty, in one session, including lymphadenectomy
41202 – 382 Cervical oesophagus, resection of, with oesophagostomy
41186 – 383 Oesophagus, partial resection of, with oesophagostomy
41509 – 384 Total oesophagus-gastrectomy, by thoracic-laparotomy and possible lymphadenectomy
41269 – 390 Endo-oesophageal prostheses, placement of
56259 – 400 Partial or subtotal gastrectomy (including possible lymphadenectomy)
41491 – 401 Total gastrectomy with lymphadenectomy, including extended
47414 – 402 Total gastrectomy with extended lymphadenectomy with associated left splenopancreasectomy
43703 – 406 Gastro duodenal resection
41988 – 412 Miles abdominoperineal amputation, complete treatment
44024 – 419 Gastrointestinal or intestinal bypasses for malignant diseases
41632 – 422 Segmental colectomy (including possible ostomy)
41640 – 423 Segmental colectomy with lymphadenectomy and possible colostomy
41657 – 424 Total colectomy (including possible ostomy)
41665 – 425 Total colectomy with lymphadenectomy (including possible ostomy)
41731 – 436 Right hemicolectomy with lymphadenectomies
41749 – 437 Left hemicolectomy with lymphadenectomies and possible colostomy (Hartmann and others)
59181 – 457 Colon prosthesis placement
59198 – 458 Rectal prosthesis placement
44743 – 459 Total procto-colectomy with ileal pouch
59214– 466 Resection of the sigma-rectum for malignant pathology with possible associated lymphadenectomies
59222 – 467 Anterior recto-colic resection (also ultra-low) including lymphadenectomy and possible colostomy
59230 – 468 Rectum, amputation of, for neoplasm of the anus, including possible bilateral inguinal lymphadenectomy
56309 – 470 Malignant tumour of the rectum, by transanal or transanal endoscopic microsurgery (TEM), removal of
42143 – 488 Unilateral inguinal or crural lymphadenectomy (as a single operation)
42184 – 489 Bilateral inguinal or crural lymphadenectomy (as a single operation)
56317 – 490 Laparotomic lymphadenectomy (as a single operation)

44974 – 499 Exploratory laparotomy as main intervention for unresectable neoplasms or for staging of lymphadenopathies
42523 – 511 Retroperitoneal tumour or fibrosis (including ureterolysis and extensive viscerolysis), surgery for (complete treatment)
42705 – 522 Cholecystostomy for unresectable neoplasms
42747 – 530 Hepatic artery cannulation for antiblastic perfusion
57473 – 532 Papilla of Vater, ampullectomy for cancer with re-implantation of Wirsung duct and common bile duct
42630 – 535 Major hepatic resections
45203 – 536 Minor hepatic resections
59257 – 538 Radiofrequency thermoablation of primary hepatic tumours, any access route
45708 – 540 Biliary tract, palliative interventions
45740 – 545 Cephaloduodenum pancreasectomy including possible lymphadenectomy
45757 – 551 Endocrine pancreatic neoplasms, intervention for
45765 – 552 Left pancreatectomy including splenectomy and possible lymphadenectomy
42861 – 553 Total pancreatectomy (including possible lymphadenectomy)
42929 – 557 Splenectomy
57549 – 575 Exenteratio orbitae
57565 – 585 Submaxillary gland, removal for malignant neoplasms, including possible lymphadenectomy
46854 – 591 Tongue and oral floor, surgery for malignant tumours with functional or radical latero-cervical emptying
46797 – 592 Tongue and oral floor, surgery for malignant tumours without emptying the submaxillary lodge
40691 – 597 Mandible, partial resection for neoplasia of, including possible radical or functional unilateral latero-cervical emptying
56390 – 598 Mandible, partial resection for neoplasia of, including any bilateral radical or functional latero-cervical emptying
40667 – 599 Upper maxillary for neoplasms, including possible radical or functional unilateral latero-cervical emptying, resection of the
56408 – 600 Upper maxillary for neoplasms, including possible bilateral radical or functional latero-cervical emptying, resection of the
40709 – 601 Facial skeleton, tumour demolition surgery with orbital emptying
46888 – 602 Large endosseous neoplasms, exeresis of
40600 – 604 Malignant neoplasms of the lip/cheek with emptying of the submaxillary loggia, removal of
46904 – 605 Malignant neoplasms of the lip/cheek without emptying of the submaxillary loggia, removal of
40741 – 614 Total or subtotal parotidectomy
46714 – 682 Areola and nipple malformation, surgery for or reconstruction of the nipple after cancer surgery
47696– 692 Breast reconstruction after simple total mastectomy with introduction of prosthesis, including muscle flap if needed
46730 – 693 Breast reconstruction after subcutaneous mastectomy or quadrantectomy with introduction of implants, including muscle flap if needed
56465 – 695 Removal and possible replacement of breast prosthesis implanted in previous mastectomy or quadrantectomy surgery (as a single operation)
48678 – 714 Bilobectomy surgery (including possible lymphadenectomy and/or biopsy)
43224 - 740 Mediastinal lymphadenectomy (as a single operation)
48942 – 746 Malignant neoplasms ribs and/or sternum (including possible lymphadenectomy and/or biopsy)
59314 – 747 Malignant neoplasms of the diaphragm (as main stage of intervention)
48959 – 748 Malignant neoplasms of the trachea (including plastic surgery and possible lymphadenectomy and/or biopsy)
43216 – 749 Malignant neoplasms and/or cysts of the mediastinum (including possible lymphadenectomy and/or biopsy)
43174 – 750 Pleurectomies (including possible lymphadenectomy and/or biopsy)
43331 – 751 Pleuropneumectomy (including possible lymphadenectomy and/or biopsy)
43315 – 753 Pneumectomy surgery (including lymphadenectomy and/or biopsy)
57657 – 754 Pneumectomy with resection of trachea and tracheo-bronchial anastomosis
43364 – 758 Bronchial resection with reimplantation
43307 – 760 Segmental resection or lobectomy (including possible lymphadenectomies)
48975 – 761 Single or multiple atypical segmental lung resections (including possible lymphadenectomies)
48983 – 762 Typical segmental resections (including possible lymphadenectomies)
43455 – 766 Thymectomy
50815 – 879 Pelvic evisceration
50807 – 885 Radical laparotomic or vaginal hysterectomy with pelvic and/or lumbar/aortic lymphadenectomy, including anterior and/or posterior vaginal plastic surgery
50708 – 886 Radical hysterectomy by laparotomic or vaginal route without lymphadenectomy, including anterior and/or posterior vaginal plastic surgery
50724 – 887 Simple total hysterectomy with or without mono/bilateral adnexiectomy by laparotomic or vaginal route, including anterior and/or posterior vaginal plastic surgery
50690 – 927 Malignant vaginal tumours with lymphadenectomy, radical surgery for
52654 – 928 Malignant vaginal tumours without lymphadenectomy, radical surgery for
50856 – 930 Partial vulvectomy
52720 – 931 Partial vulvectomy with bilateral diagnostic lymphadenectomy of superficial inguinal lymph nodes, surgery for
50872 – 932 Wider radical vulvectomy with inguinal and pelvic lymphadenectomy, surgery for
52738 – 933 Simple vulvectomy (local or cutaneous), surgery for
50864 – 934 Total vulvectomy
52746 – 951 Craniotomy for cerebellar tumours, including basal tumours
44354 – 971 Laminectomy for extramedullary intra-dural tumours
44362 – 972 Laminectomy for intramedullary tumours
44115 – 976 Endocranial neoplasms, removal of
44370 – 977 Neoplasms, chordotomies, radicotomies and meningomideal affections, endorachid surgery
44123 – 1016 Orbital tumour, endocranial excision
45146 – 1017 Peripheral nerve tumours, removal of (excluding traumatic and non-traumatic nerve lesions of the hand and foot)
44214 – 1018 Cranial base tumours, trans-oral surgery
44222 – 1019 Orbital tumours, surgery for
52027 – 1022 Deep cysts or neoplasms around the orbit, removal of
52035 – 1024 Exenteratio orbitae

48231 – 1263 Hemipelvectomy
54692 – 1264 “Internal" hemipelvectomies with salvage of the limb
54858 – 1298 Resection of the sacrum (as a single operation)
54940 – 1316 Emptying of metastatic foci and reinforcement with synthesis plus cement
48066 – 1321 Bone tumours and pseudo-tumours, large segments or joints, removal of
54973 – 1322 Bone tumours and pseudo-tumours, medium-sized segments or joints, removal of
54981 – 1323 Bone tumours and pseudo-tumours, small segments or joints, removal of
47852 – 1324 Bone tumours and pseudo-tumours, vertebral tumours, removal of
55277 – 1355 Exploratory laparotomy with demolition surgery
55343 – 1380 Duct neoplasms, exeresis
53306 – 1396 Tumours of the middle ear, removal of
53678 – 1434 Malignant tumours of the nose or sinuses, removal of
59657 – 1442 Partial pharyngectomy
55483 – 1445 Parapharyngeal neoplasms
53876 – 1448 Malignant pharyngotonsillar tumour, removal of
54106 – 1457 Cordectomy
55491 – 1458 Laser cordectomy
59665 – 1462 Epiglottisectomy
55509 – 1464 Partial laryngectomy with unilateral laterocervical emptying
55525 – 1465 Total laryngectomy without laterocervical emptying
54122 – 1466 Total laryngectomy with unilateral laterocervical emptying
55517– 1467 Total laryngectomy with bilateral laterocervical emptying
54130 – 1469 Total laryngopharyngectomy
80820 – 1480 Abdominal aorta arteriography plus simple embolization of tumours
80887 – 1499 Embolization of malformations and/or aneurysms and/or cerebral vascular fistulas or endocranial tumours
58117 – 1511 Thermoablation or Cryoablation of primary or metastatic neoplasms
49304 – 1550 Bladder neoplasm, endoscopic resection of
49296 – 1553 Prostate, endoscopic resection or vaporisation of (any technique and equipment, excluding cases described)
55723 – 1568 Heminephrectomy
49379 – 1570 Wider nephrectomy for cancer with possible treatment of caval thrombus (including adrenectomy)
55764 – 1571 Polar nephrectomy
49361 – 1572 Simple nephrectomy
55772 – 1578 Radical nephroureterectomy with lymphadenectomy plus possible adrenectomy, surgery for
49411 – 1579 Radical nephroureterectomy (including possible adrenectomy)
49452 – 1584 Adrenectomy (complete treatment)
55822 – 1607 Partial cystectomy with ureterocystoneostomy
49692 – 1608 Simple partial cystectomy
49718 – 1609 Total cystectomy including lymphadenectomy and prostatovesiculectomy or uteroannessiectomy with ileum or colobladder
55848 – 1610 Total cystectomy including lymphadenectomy and prostatovesiculectomy or uteroannexectomy with rectal neobladder included
55830 – 1611 Total cystectomy including lymphadenectomy and prostatovesiculectomy or uteroannessiectomy with bilateral ureterosigmoidostomy or ureterocutaneostomy
56804 – 1630 Laparotomic lymphadenectomy (as a single operation)
49924 – 1631 1659 Radical prostatectomy for carcinoma with lymphadenectomies, including possible ligation of the vas deferens (any access and technique)
50245 - Total haemasculatio and possible lymphadenectomy
50328 – 1669 Wider orchidectomy with unilateral abdominal or retroperitoneal lymphadenectomy
58182 – 1670 Wider orchidectomy with bilateral abdominal or retroperitoneal lymphadenectomy
50302 – 1671 Bilateral subcapsular orchidectomy
50237 – 1676 Penis, total amputation with lymphadenectomy
56010 – 1677 Penis, total amputation of

Other major surgery for other pathologies

43802 – 177 Multiple coronary artery bypass (CEC)
43786 – 178 Single coronary artery bypass (CEC)
43836 – 179 Adult or neonatal open-heart cardiac surgery, including aneurysms or multiple valve replacements or aortic replacement or aortic plastic replacement (CEC), except for the interventions described
43851 – 182 Commissurotomy for mitral stenosis
43729 – 186 Wounds or foreign bodies or tumours of the heart or tamponade, surgery for
40147 – 187 Arteriovenous fistulas of the lung, surgery for
40154 – 188 Internal heart massage
43760 – 189 Partial pericardiectomy
43778 – 190 Total pericardiectomy
40162 – 192 Reintervention with restoration of CEC
43737 – 193 Section or ligation of the ductus arteriosus of Botallo
59860 – 194 Valve replacement with minimally invasive surgery (heart port)
43810 – 195 Single valve replacement (CEC)
40170 – 196 Valve replacements with coronary artery bypass (CEC)
43968 – 197 Cardiac transplantation (inclusive of all services and medical explantation and implantation operations)
43844 – 198 Cardiac valvuloplasty

59130 – 370 Total thyroidectomy for mediastinal goiter, surgery for
41137 – 378 Cervical oesophageal diverticula (including myotomy), surgery for
41145 – 379 Diverticula of the thoracic oesophagus, surgery for
41244 – 388 Megaoesophagus, surgery for
41251 – 389 Megaesophagus, reintervention for
41160 – 395 Oesophageal varices: transthoracic or abdominal surgery
41533 – 399 Gastro-digiunal-colic fistula, surgery for
41483 – 403 Total gastrectomy for benign pathology
41525 – 407 Gastro-digiunal resection for anastomotic peptic ulcer
56267 – 411 Gastric varices (surgical haemostasis)
41715 – 413 Preternatural anus, closure, continuity reconstruction
56283 – 414 Anoplasty and perineoplasty (as a single operation)
41624 – 415 Appendectomy with diffuse peritonitis
44057 – 428 Construction of artificial anus (as a single operation)
41772 – 452 Megacolon, surgery for
46219 – 453 Megacolon: colostomy
41756 – 471 Extended viscerolysis (enteroplication), surgery for (as a single operation)
57449 – 472 Extended viscerolysis (enteroplication), surgery for (as the main operation stage)
42549 – 507 Intestinal obstruction with resection
42895 – 513 Portocaval or splenic-renal or mesenteric-cava anastomosis
42648 – 517 Simple laparoscopic cholecystectomy (including lysis of adhesions)
57457 – 518 Laparoscopic cholecystectomy with intraoperative cholangiography and exploration of the biliary tract and possible stone extraction (including radiologist assistance) (including lysis of adhesions)
57465 – 519 Laparoscopic cholecystectomy with choledocholithotomy and stone extraction (including cholangiography and radiologist assistance) (including lysis of adhesions)
56333 – 520 Simple laparoscopic cholecystectomy (including lysis of adhesions)
42663 – 521 Cholecystogastrostomy or cholecystenterostomy
42697 – 523 Choledocal/hepatic/digiunal/duodenostomy with or without cholecystectomy
42689 – 524 Choledocal-hepatic jejunostomy with or without cholecystectomy
42671 – 525 Choledocal-hepatic duodenostomy with or without cholecystectomy
42655 – 526 Choledochotomy and choledocholithotomy (as a single operation)
45179 – 527 Hepatic dearterialisation, with or without chemotherapy
42911 – 528 Azygos-portal deconnection by abdominal route
45187 – 529 Intra-hepatic digestive bile drainage
45195 – 531 Papilla of Vater, exeresis
42713 – 533 Papillostomy, via transduodenal route and possible removal of stones (as a single operation)
45260 – 539 Liver transplant (all-inclusive of services and medical explantation and implantation operations)
42739 – 541 Biliary tract, reinterventions
42812 – 547 Pancreatic-Wirsung Digestive Derivatives
42945 – 550 Spleen, conservative surgery (splenorrhaphy, splenic resections)
45799– 558 Pancreas transplantation (inclusive of all services and medical explantation and implantation operations)
56382 – 578 Zygomatic fracture, orbit, surgical therapy for
40543 – 579 Maxillary fractures, surgical therapy for
57557 – 580 Frontal sinus fractures, surgical therapy for
46672 – 581 Fractures of the mandible and condyle, surgical therapy for (including possible fixation with ferrules)
40519 – 582 Mandibular fractures, reduction with ferrules
40576 – 593 Tongue, partial amputation for benign tumours, angiomas, macroglossia
46862 – 596 Dento-maxillofacial malformations of the mandible and maxilla (progenism, microgenia, prognathism, micrognathia, mandibular lateral deviation, etc.), including mentoplasty on the upper maxillary or mandible (full treatment)
46896 – 603 Small endosseous neoplasms (osteomas, cementomas, odontomas, palatine and mandibular torus), excisions of
46912 – 606 Limited malignant neoplasms of the lip or soft tissues of the oral cavity, removal of
46938 – 612 Dynamic or static facial nerve palsy, plastic surgery for
40733 – 613 Partial parotidectomy with possible sparing of the facial nerve
46755 – 664 Vaginal aplasia, reconstruction for
47647 – 680 Push-back surgery and pharyngoplasty
47654 – 684 Complex deformities of the hands or feet (complete treatment)
46748 – 694 Breast reconstruction after radical mastectomy with introduction of implants, including muscle flap if needed
46763 – 701 Intersexual states, surgery for
48595 – 704 Microvascular free flap transfer
43323 – 720 Pulmonary pleural decortication, surgery for
43448 – 728 Thoraco-abdominal wound with visceral damage
43265 – 730 Wounds with visceral damage to the chest
43356 – 731 Bronchial stump fistulas after exeresis or similar surgery, surgery for
48850 – 732 Bronchoesophageal and/or tracheoesophageal fistulas, operations for
43596 – 769 Thoracoplasty, first stage
43604 – 770 Thoracoplasty, second stage
49007 – 776 Lung transplantation (inclusive of all services and medical explantation and implantation operations)
45385 – 777 Abdominal or thoracic aorta aneurysms plus dissection: resection and prosthetic graft (open)
45229 – 778 Distal limb artery aneurysms, resection and/or prosthetic graft (open)
45278 – 780 Aneurysms, resection and prosthetic grafting: iliac, femoral, popliteal, humeral, axillary, gluteal arteries, visceral arteries and supra-aortic trunks (open)
49098 – 785 Aorto-anonimous bypass, aorto-carotid, carotid-subclavian
45351 – 786 Aorto-iliac or aorto-femoral bypass

45369 – 787 Aorto-renal or aorto-mesenteric or celiac bypass and possible TEA and vascular plastic surgery
59381 – 805 Endovascular treatment of aneurysms or dissecting aneurysms of the thoracic aorta
45328 – 810 Thromboendarterectomy and bypass and/or embolectomy of supra-aortic trunks
49882 – 811 Thromboendarterectomy and patching and/or embolectomy of supra-aortic trunks
49908 – 813 Thromboendarterectomy and prosthetic grafting and/or embolectomy of supra-aortic trunks (any technique)
44479 – 936 Intra-extra cranial vessel anastomosis
59465 – 937 Anterior vertebral arthrodesis also for spondylolisthesis, including possible lumbar stenosis, uncoforaminotomy, vertebrotomy and removal of osteophytes (as a single operation)
59473 – 938 Posterior vertebral arthrodesis also for spondylolisthesis, including possible lumbar stenosis, uncoforaminotomy, vertebrotomy and removal of osteophytes (as a single operation)
59481 – 939 Anterior and posterior vertebral arthrodesis also for spondylolisthesis, including possible lumbar stenosis, uncoforaminotomy, vertebrotomy and removal of osteophytes (as a single operation)
44206 – 944 Atlanto-occipital joint, surgery for anterior or posterior malformations
44636 – 945 Chordotomy, rhizotomy and various myeloradicular affections, surgery on
44180 – 947 Cranioplasty - including possible removal of synthetic material
44156 – 949 Craniotomy for extradural haematoma
44164 – 950 Craniotomy for traumatic intracerebral lesions
44305 – 956 Encephalomeningocele, surgery for
44230 – 957 Focal epilepsy, surgery for
52753 – 961 Cervical intervertebral disc herniation, myelopathies, radiculopathies including uncoforaminotomy, vertebrotomy and removal of osteophytes
44412 – 969 Pituitary gland, transsphenoidal adenoma surgery
44438 – 973 Intracranial aneurysmal malformation (saccular aneurysms, carotid aneurysms, other aneurysms)
56515 – 974 Aneurysmal or angiomatous malformation with root and/or spinal cord compression
45096 – 983 Brachial plexus, surgery on
45039 – 1012 Transplants, grafts and other plastic surgery operations (as a single operation)
44495 – 1014 Anterior vertebro-medullary trauma, surgery for
51979 – 1084 Full thickness corneal transplant
51961 – 1085 Lamellar corneal transplant
57881 – 1086 Limbal stem cell transplant
57898 – 1087 Limbal stem cell transplant combined with amniotic membrane apposition
54551 – 1218 Upper and/or lower limb stretching (per segment, complete treatment)
47944 – 1219 Large segment amputation (full treatment)
54569 – 1223 Anterior vertebral arthrodesis also for spondylolisthesis including possible lumbar stenosis (as a single operation)
54577 – 1224 Posterior vertebral arthrodesis also for spondylolisthesis including possible lumbar stenosis (as a single operation)
48645 – 1225 Anterior and posterior vertebral arthrodesis also for spondylolisthesis including possible lumbar stenosis (as a single operation)
48348 – 1226 Arthrodesis: large joints
48330 – 1227 Arthrodesis: medium joints
48363 – 1228 Arthrolysis: large
48355 – 1229 Arthrolysis: medium
48256 – 1231 Arthroplasty: large (any material)
48264 – 1232 Arthroplasty: medium (any material)
48272 – 1233 Arthroplasty: small (any material)
48462 – 1234 Arthroplasty: shoulder, partial
54585 – 1235 Arthroplasty; shoulder, total
48421 – 1236 Arthroplasty: partial hip (complete treatment)
48447 – 1240 Arthroplasty: knee
48454 – 1241 Arthroplasty: elbow
56580– 1242 Arthroplasty: removal and replacement of septic arthroplasty subsequently to the first operation (partial or total) as a single operation, except in the cases described
03249– 3249 Total hip arthroplasty (total hip arthroplasty - any technique - concurrent operation) refundable in the same operating session or hospitalisation not connected with the total hip prosthesis package)
03250 – 3250 Arthroplasty: total hip revision carried out in the same hospital in which the first operation was carried out (total hip revision arthroplasty - any technique - concurrent operation, refundable in the same operating session or hospitalisation not connected with the total hip revision package)
53301 – 6599 Total hip arthroplasty (complete treatment - concurrent with another main operation): for removal and repositioning carried out subsequently to the first hospitalisation
10094 – 10094 Surgical package (Traditional Technique) total hip prosthesis (arthroplasty: total hip - complete treatment). refund includes: medical team, operating theatre, hospital stay, materials, medicines, joint prosthesis, in-patient diagnostic tests
10095 – 10095 Surgical package (Traditional Technique) total hip revision prosthesis (arthroplasty: total hip revision - complete treatment) surgery for removal and replacement or repositioning carried out in the same hospital in which the first surgery was carried out. refund includes: medical team, operating theatre, hospital stay, materials, medicines, joint prosthesis, in-patient diagnostic tests
10099 – 10099 Surgical package (Traditional Technique) removal and repositioning of hip prosthesis carried out after the first hospitalisation (complete treatment). Refund includes: medical team, operating theatre, hospital stay, materials, medicines, joint prosthesis, in-patient diagnostic tests
10109 – 10109 Surgical package (Robotic Surgery - RAS) total hip prosthesis (arthroplasty: total hip - complete treatment). Refund includes: medical team, operating theatre, use of computer-assisted surgery equipment (any), hospital stay, materials, medicines, joint prosthesis, in-patient diagnostic tests
10110 – 10110 Surgical package (Robotic Surgery - RAS) total hip revision prosthesis (arthroplasty: total hip revision - complete treatment) surgery for removal and replacement or repositioning carried out in the same hospital in which the first surgery was carried out. Refund includes: medical team, operating theatre, use of computer-assisted surgery equipment (any), hospital stay, materials, medicines, joint prosthesis, in-patient diagnostic tests

10111 – 10111 Surgical package (Robotic Surgery - RAS) removal and repositioning of hip prosthesis performed after the first hospitalisation (complete treatment). Refund includes: medical team, operating theatre, use of computer-assisted surgery equipment (any), hospital stay, materials, medicines, joint prosthesis, in-patient diagnostic tests
48041 – 1257 Cervical rib and "outlet syndrome", surgery for
48223 – 1258 Thoracic interscapular disarticulation
54668 – 1259 Disarticulations, large
47910 – 1280 Osteomyelitis (complete treatment), intervention on the
48629 – 1281 Vertebral osteosynthesis
47894 – 1285 Complex osteotomy (pelvis, vertebral) including ablation of spinal osteophytes (by section)
54841 – 1296 Re-implantation of a limb or its segment
54874 – 1300 Surgical reduction and constriction of traumatic spinal dislocation
54924 – 1313 Shoulder, complete resections according to Tickhor-Limberg
57038 – 1319 Bone marrow transplant (all-inclusive of services and medical explantation and implantation operations)
54999 – 1325 Uncoforaminotomy or vertebrotomy (complete treatment)
48751 – 1339 Tendon and muscle or nerve transplants (complete treatment)
53231 – 1363 Brain abscess, opening via transmastoid
53280 – 1381 Vestibular nerve, section of
53298 – 1382 Eighth nerve neuroma
53157 – 1392 Tympanoplasty with mastoidectomy
53249 – 1393 Tympanoplasty without mastoidectomy
55376 – 1394 Tympanoplasty, second stage
53959 – 1450 Velopharyngoplasty or hyoid bone advancement
54155 – 1460 Laryngeal diaphragm, excision with plastic surgery reconstruction
54114 – 1463 Partial laryngectomy
58082 – 1507 Carotid stent placement with cerebral protection system for carotid stenosis treatment
58158 – 1515 TIPS (port-superhepatic shunt)
49460 – 1585 Kidney transplantation (inclusive of all services and medical explantation and implantation operations)
58174 – 1589 Megaureter, reshaping surgery
49817 – 1625 Bladder, plastic surgery for enlargement (colon/ileum)
49841 – 1626 Bilateral antireflux vesicoplasty
49833 – 1627 Unilateral antireflux vesicoplasty
55921 – 1650 Total urethrectomy

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

This cover only applies in the context of diagnostic tests and specialist consultations, carried out on an out-patient basis, **preliminary to subsequent overnight hospitalisation/s for major surgery** and limited to malignant oncological pathologies (see list under Cover 1) and only if carried out within 140 days prior to overnight hospitalisation for the above-mentioned operations. The above-mentioned services, which are included in this Cover, can only be recognised as refundable for "indirect provision" services.

The Cover does not include:

- ✓ diagnostic tests and/or specialist consultations received in the 140 days prior to daytime or outpatient hospitalisation, even if the operation is included in the list under Cover 1;
- ✓ tests and/or specialist consultations received in the 140 days prior to daytime or outpatient hospitalisation but not related to it (e.g.: hospitalisation for hip replacement - ophthalmology consultation carried out in the 140 days prior to hospitalisation. In this case, the ophthalmology consultation is not referable to the hospitalisation and, although carried out within the indicated time period, will not be recognised as refundable by the Fund);
- ✓ diagnostic tests and/or specialist consultations received in the 140 days prior to hospitalisation for major surgery which, in the final analysis, are not for malignant oncological pathologies, even if the operation is included in the list under Cover 1.
- ✓ diagnostic tests and/or specialist consultations that, while meeting the above requirements, are not among the areas of activity of the Fund (FasiOpen Basic Nomenclature).

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

To request refund for specialist tests you must attach an invoice from the specialist physician which must unequivocally show his/her specialist title (duly registered with and traceable at the Italian Board of Physicians, Surgeons and Orthodontists) and a description of the operation to be carried out (the tests must, therefore, be relevant to the operation).

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

Description	Refund ceilings
MAXIMUM REFUND PER YEAR AND PER CLIENT	€ 1,100
Details	**Sub-ceilings/CONDITIONS of refund**
Diagnostic tests and specialist consultations relevant to the operation (major surgery for malignant oncological pathologies)	Services must be received in the 140 days prior to the beginning of hospitalisation for major surgery made necessary by malignant oncological pathologies (see list).

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

"Orange" Health Plan
Detailed description of covers

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

This Cover only applies in the context of diagnostic tests, specialist consultations and post-hospitalisation therapies, carried out on an out-patient basis, **following overnight hospitalisation for major surgery** limited to malignant oncological pathologies (see list under Cover 1) and only if carried out within 140 days following overnight hospitalisation for the above-mentioned operation. The above-mentioned services, which are included in this Cover, can only be recognised as refundable for "indirect provision" services.

The Cover does not include:

- ✓ diagnostic tests and/or specialist consultations received in the 140 days following daytime or outpatient hospitalisation, even if the operation is included in the list under Cover 1;
- ✓ tests and/or specialist consultations received in the 140 days following the hospitalisation but not related to it (e.g.: hospitalisation for hip replacement - ophthalmology consultation carried out in the 140 days following hospitalisation. In this case, the ophthalmology consultation is not referable to the hospitalisation and, although carried out within the indicated time period, will not be recognised as refundable by the Fund);
- ✓ diagnostic tests and/or specialist consultations received in the 140 days following hospitalisation for major surgery which, in the final analysis, is not for malignant oncological pathologies, even if included in the list under Cover 1.
- ✓ diagnostic tests and/or specialist consultations that, while meeting the above requirements, are not among the areas of activity of the Fund (FasiOpen Basic Nomenclature).

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

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

Description	Refund ceilings
MAXIMUM REFUND PER YEAR AND PER CLIENT	€ 1,300
Details	**Sub-ceilings/conditions of refund**
Diagnostic tests and specialist consultations relevant to the operation carried out (major surgery for malignant oncological pathologies), therapies and physiotherapy or rehabilitation treatments on an outpatient basis	Services must be received in the 140 days following the beginning of hospitalisation for major surgery made necessary by malignant oncological pathologies (see list) and always relevant to the operation carried out.

"Orange" Health Plan
Detailed description of covers

COVER 4 - Ultrasound Diagnostics

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

The Cover does not include:

- ✓ ultrasound tests in pregnancy and/or related to this as provided for in Cover 8, sub-cover 8.1;
- ✓ ultrasound tests carried out as a preliminary examination relating to overnight hospitalisation for major surgery for malignant oncological pathologies, even if carried out in the 140 days prior to hospitalisation as provided for in Cover 2;
- ✓ ultrasound tests carried out as a post-overnight hospitalisation check-up examination following major surgery for malignant oncological pathologies, even if carried out in the 140 days after hospitalisation as provided for in Cover 3;
- ✓ ultrasound tests, even if deemed necessary, that do not fall within the Fund's area of activities (FasiOpen Basic Nomenclature) and that are not specifically included in the list below.
- ✓ any contrast medium used in addition to the basic test since, under this Cover, it is included in the examination itself.

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

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

Description	Refund ceilings
MAXIMUM REFUND PER YEAR AND PER CLIENT	€ 180
Details	**Sub-ceilings/conditions of refund**
ULTRASOUND DIAGNOSTICS (See list)	DIRECT PROVISION: Refund Amount 40% INDIRECT PROVISION: Refund Amount 40%

Please note that:

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

List of ultrasound tests

78246 – 2437 Upper abdominal (complete examination)
78238 – 2436 Lower abdominal-pelvis (complete examination)
78253 – 2438 Lower abdomen-pelvis and upper abdomen with bowel evaluation (complete examination)
78519 – 2440 Doppler echocardiogram or transesophageal Colour Doppler
73742 – 2441 M Mode 2D Echocardiogram
76859 – 2443 M MODE 2D Doppler and Colour Doppler echocardiogram, with possible pharmacological or stress tests (echocardiostress)
78501 – 2444 M MODE 2D and Doppler echocardiogram, with possible pharmacological or stress tests (echocardiostress)
65470 – 2445 Endobronchial ultrasound
73551 – 2448 Liver and biliary tract - Bilateral salivary glands - Large vessels - Intestinal - Mono/bilateral lymph nodes - Unilateral or bilateral breast - Mediastinal or hemithoracic - Spleen - Muscular, tendinous or articular - Ocular and Orbital - Pancreatic - Soft tissue - Pelvic (uterus, adnexa and bladder) - Penis - Prostate and bladder, suprapubic - Renal and adrenal bilateral - Testicular (bilateral) - Thyroid and parathyroid - Bladder (including possible use of contrast medium)
73809 – 2449 Prostatic and bladder or anal and rectal, transrectal
78428 – 2450 Renal, bilateral adrenal and bladder
78436 – 2451 Scrotal and inguinal for detecting undescended testicle
78469 – 2452 Transesophageal for gastroenterology
78477 – 2454 Transvaginal with possible Colour Doppler
78485 – 2455 Perminational bladder or transurethral intracavitary
73593 – 2737 Upper or lower limbs (bilateral): Doppler
73874 – 2738 Upper or lower limbs (bilateral): Echo Doppler
79574 – 2739 Upper or lower limbs (bilateral): Echo Colour Doppler
79582– 2740 Upper and lower limbs (four limbs): Doppler
79590– 2741 Upper and lower limbs (four limbs): Echo Doppler
79608– 2742 Upper and lower limbs (four limbs): Echo Colour Doppler
76665 – 2743 Echo Colour Doppler of any other non-described arterial-venous district or vascular segment
79616 – 2744 Penile or testicular: Doppler
79624 – 2745 Penile or testicular: Echo Doppler
79632 – 2746 Penile or testicular: Echo Colour Doppler
79640 – 2747 Complete Transcranial: Echo Doppler
79657 – 2748 Complete Transcranial: Echo Colour Doppler
79665 – 2749 Complete transcranial with spectral analysis
79673 – 2750 Supra-aortic trunks: Doppler
79681 – 2751 Supra-aortic trunks: Echo Doppler
79699 – 2752 Supra-aortic trunks: Echo Colour Doppler
79707 – 2753 Visceral: Doppler
79715 – 2754 Visceral: Echo Doppler
79723 – 2755 Visceral: Echo Colour Doppler

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COVER 5 - Highly specialist Diagnostics and Therapies

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

The Cover does not include:

- ✓ high-specialisation diagnostic tests carried out as a preliminary examination relating to overnight hospitalisation for major surgery for malignant oncological pathologies, even if carried out in the 140 days prior to hospitalisation as provided for in Cover 2;
- ✓ high-specialisation diagnostic tests carried out as a post-overnight hospitalisation check-up examinations following major surgery for malignant oncological pathologies, even if carried out in the 140 days following hospitalisation as provided for in Cover 3;
- ✓ high-specialisation diagnostic tests, even if deemed necessary, that do not fall within the Fund's area of activities (FasiOpen Basic Nomenclature) and/or are not included this Cover.

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

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

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

Description	Refund ceilings
MAXIMUM REFUND PER YEAR AND PER CLIENT	€ 10,000
MINIMUM NON-REFUNDABLE FOR EACH ITEM/SERVICE	€ 60
Details	**Sub-ceilings/conditions of refund**
NUCLEAR MAGNETIC RESONANCE	DIRECT PROVISION: Refund Amount 70% INDIRECT PROVISION: Refund percentage 70%
COMPUTERISED AXIAL TOMOGRAPHY	
NUCLEAR MEDICINE (SCINTIGRAPHY)	
ANGIOGRAPHY (ALSO WITH CONTRAST)	
TOMOGRAPHY (STRATIGRAPHY) OF ORGANS OR SYSTEMS	
TRADITIONAL RADIOLOGY (ONLY WITH CONTRAST)	
OUTPATIENT CHEMOTHERAPY	
OUTPATIENT RADIOTHERAPY	
NEUROLOGICAL DIAGNOSTICS (EEG AND/OR EMG)	
ANY TEST USING CONTRAST IN INTERVENTIONAL RADIOLOGY	

For “Traditional Radiology” tests, only those carried out using contrast medium are recognised as refundable under this Cover. Please note that, in this case, the contrast medium is an integral part of the examination itself, without which it is not possible to carry out the test. Only and exclusively in the case of the tests listed below, the contrast medium is quantified within the cost of the test.

List of Traditional Radiology services with contrast

75341 – 2468 Arthrography
78576 – 2469 Unilateral temporomandibular joint arthrography
78584 – 2470 Bilateral temporomandibular joint arthrography (comparative)
75390 – 2472 Bronchography, unilateral or bilateral
78592 – 2473 Cavernosography
78600 – 2474 Cavernosography with manometry
74567 – 2475 Cystography
78618 – 2476 Double contrast cystography
74559 – 2477 Micturating cystourethrography
74294– 2479 Opaque cyst with double contrast
78642 – 2480 Cholangiography through Kehr's tube or post-operatively
74401 – 2481 Intravenous cholangiography (with possible pharmacological tests)
74435 – 2482 Intra-operative cholangiography
74419 – 2483 Percutaneous cholangiography
78634 – 2484 Retrograde cholangiography
74443– 2485 Diagnostic cholangiopancreatography (ERCP Endoscopic Retrograde Cholangiopancreatography)
74385 – 2486 Cholecystography per OS with or without Bronner's test
74898 – 2487 Cervical, dorsal, lumbosacral, sacrococcygeal spinal column (by section)
74914 – 2488 Complete spinal column
78659 – 2489 Complete spinal column plus pelvis under load
78667 – 2490 Spinal column, morphometric examination (by section)
78691 – 2494 Dacryocystography
78709 – 2495 Defecography
74237 – 2502 Oesophagus with opaque contrast
78725 – 2503 Double contrast oesophagus
74302 – 2506 Opaque pharyngography
75325 – 2507 Fistulography

78758 – 2509 Galactography
74625 – 2512 Hysterosalpingography (including direct examination) - including services of radiologist/gynaecologist
74104 – 2514 Opaque laryngography
75234 – 2518 Cervical or dorsal myelography
78816 – 2523 Unilateral retrograde pyelography
78824 – 2524 Bilateral retrograde pyelography
78832 – 2525 Percutaneous pyelography
78865 – 2528 Radicolography
74328 – 2536 Sialography
78923 – 2541 Stomach with double contrast
74245 – 2542 Stomach, duodenum
78931 – 2543 Open and closed mouth stratigraphy of the TMJ, unilateral
78949 – 2544 Open and closed mouth stratigraphy of the TMJ, bilateral
78956 – 2545 Resting larynx and phonation stratigraphy
78964 – 2546 Mediastinal stratigraphy
78972 – 2547 Chest stratigraphy, unilateral
78980 – 2548 Chest stratigraphy, unilateral
74153 – 2549 Stratigraphy of any anatomical district or segment, except in the described cases
65023 – 2550 Study of intestinal transit times
78998 – 2551 Selective study of last loop
79004 – 2552 Heart tele-radiography with barium oesophagus
79012 – 2554 Small intestine, double-contrast with selective study
74260 – 2555 Small intestine, serial test
74336 – 2561 Digestive tract: upper (oesophagus, stomach, duodenum)
74252 – 2562 Digestive tract: lower (small intestine, colon)
74278 – 2563 Digestive tract: complete (stomach, duodenum, colon, oesophagus)
74542 – 2564 Ascending and micturating urethrocystography
74534 – 2565 Urography (complete examination)
79087 – 2567 Vesico-deferentography

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COVER 6 - Specialist outpatient consultations

Only specialist consultations for diagnostic purposes are eligible for refund, excluding those that are necessary to resolve the pathological event (check-up consultations and/or follow-ups).

The Cover does not include:

- ✓ specialist consultations carried out in the 140 days prior to/following overnight hospitalisation for major surgery for malignant oncological pathologies and related to the hospitalisation/surgery itself as provided for in Covers 2 and 3;
- ✓ medical consultations not carried out by a professional with specialisation registered and traceable at the Italian Board of Physicians;
- ✓ specialist consultations listed in "Exclusions" of the Basic Nomenclature or everything related to these and/or related to services not included in the Fund's area of activities.

Please note that the specialist qualification of the physician must be clearly stated in the expenditure documentation. Please also note that the service carried out must not relate to another Cover within this Health Plan.

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

Description	Refund ceilings
MAXIMUM REFUND PER YEAR AND PER CLIENT	€ 650
MAXIMUM REFUND PER EVENT (SINGLE SPECIALIST CONSULTATION)	DIRECT PROVISION: € 100 INDIRECT PROVISION: € 80
MINIMUM NON REFUNDABLE	€ 60 indirect provision
Details	**Sub-ceilings/conditions of refund**
Specialist outpatient consultations (received outside 140 days pre or post hospitalisation for major surgery for malignant oncological pathologies)	DIRECT PROVISION: Refund Amount 100% INDIRECT PROVISION: Refund percentage 70%

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

This Cover operates within the context of public healthcare charges for diagnostic tests, specialist consultations and therapies. Please note that, within the limits specified in the conditions, refunds are available for all public healthcare charges relating exclusively to services included in the Health Plan; this therefore excludes those relating to services not included therein, even if connected with diagnostic tests, specialist consultations, therapies and/or other services included in the Fund’s area of activities. Please also remember that public healthcare charges must always show details of the services received and that, in view of the different Regional laws, in the event of the simultaneous payment of public healthcare charges and private services not recognised by the S.S.R., with both appearing on the same healthcare receipt, you must ask the healthcare facility to indicate which amount refers only to the public healthcare charges and/or which amount refers to privately received services. With regard to this please note that, in the case of laboratory tests, there is no additional refund for samples since these are included in the services themselves (samples cannot, therefore, be regarded as a private service and/or payable over and above the prescription ceiling). In the case of samples taken at home that constitute an additional fee to the service itself, these are only included within the ceiling set by the Cover if specifically indicated in the medical prescription (the request must always be in-line with the pathology indicated in the prescription and with the critical clinical profile that necessitated the sample being taken at home). To request a refund you must attach expenditure documentation clearly showing the application of the public healthcare charges (and any private healthcare fees), the details of the services, and the medical prescription with certain or presumed diagnosis. This Cover applies to both “indirect provision” and “direct provision” services. Excluded from this Cover are all private services, all services mentioned in the “Exclusions” (in the Basic Nomenclature) and/or anything related to these, as well as spa treatments, medicines, dental services and anything else listed in the Basic Nomenclature as not falling within the Fund's area of activities. We underline once again that FasiOpen does not refund additional fees (introduced by the law of 15/07/2011 n.11 and/or Financial Fixed Fee 2011 and/or by the “Fixed Fee Budget 2011” and/or any other additional fees, in addition to public healthcare charges).

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

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COVER 8 - Maternity Package

This Cover is subdivided into 2 Sub-Covers.

Sub-Cover 8.1 - Maternity Package TESTS

This Sub-Cover applies to both "indirect" and "direct-provision" services at affiliated healthcare facilities belonging to the network recognised by the Fund.

This sub-cover consists of three different types of tests, clinical laboratory analyses, non-invasive prenatal diagnostics, ultrasound scans during pregnancy - with the provision of one excluding refunds for the other two.

In the event of a positive Bi-Test or Tri-Test result (if chosen as an alternative to analysis or ultrasound scans) a refund may also be claimed for amniocentesis or chorionic villus sampling. Please note that:

Any clinical laboratory tests recognised as refundable by this Sub-Cover:

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

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

Any pregnancy ultrasounds recognised as refundable by this Sub-Cover:

- ✓ are exclusively those referable/related to pregnancy;
- ✓ are exclusively those falling within the Fund's area of activities (again referable/relevant to pregnancy);
- ✓ are not covered under Cover 4 "Ultrasound Diagnostics" (and vice versa);

- ✓ are recognised as refundable, within the limits of this Sub-Cover, only and exclusively if "clinical laboratory analyses" are not refunded, whether the latter are received privately and/or through payment of public healthcare charges;
- ✓ rule out recognition of the allowance/daily allowance for Hospitalisation for Childbirth (whether received via public healthcare charges or privately).

To receive Refunds you must always attach, in addition to the expenditure documentation, a medical prescription for tests showing the "up-to-date" state of pregnancy in the diagnosis (i.e. it is not possible, in the case of services carried out privately, to submit for refund medical prescriptions that have already been forwarded to the Fund even though there are no variations in the tests themselves). Should a non-invasive prenatal diagnostic test be carried out as an alternative to clinical laboratory analyses, the medical prescription and the test report must be submitted in addition to the expenditure documentation. Only if the test reveals well-founded reasons for further investigation, refunds for Amniocentesis or Chorionic villus sampling may be recognised upon submission of the expenditure documentation, the Bi-Test/Tri-Test report and the medical prescription for the Amniocentesis or Chorionic villus sampling. Please note that Amniocentesis or Chorionic villus sampling can be recognised as refundable only and exclusively if a refund for a Bi-Test or Tri-Test (no Public Healthcare Charges) with a positive report has been previously requested from (and therefore paid by) FasiOpen.

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

Check-up	Description	Refund ceilings
CLINICAL LABORATORY ANALYSES	**MAXIMUM REFUND PER PREGNANCY**	€ 100
	MAXIMUM REFUND PER EVENT	€ 100
	Sub-ceilings/Conditions of refund	
	DIRECT PROVISION: Refund Amount 100% INDIRECT PROVISION: Refund percentage 80%	
Alternatively to clinical analyses		
NON-INVASIVE PRENATAL DIAGNOSTICS (BI-TEST OR TRI-TEST)	**MAXIMUM REFUND PER PREGNANCY**	€ 120
	MAXIMUM REFUND PER EVENT	€ 120
In the event of positive Bi-Test or Tri-Test		
AMNIOCENTESIS OR CHORIONIC VILLUS SAMPLING	**MAXIMUM REFUND PER PREGNANCY**	€ 120
	MAXIMUM REFUND PER EVENT	€ 120
As an alternative to clinical analyses **(i.e. as an alternative to non-invasive prenatal diagnostics)**		
ULTRASOUNDS IN PREGNANCY	**MAXIMUM REFUND PER PREGNANCY**	Maximum 4 Ultrasounds in Pregnancy
	Sub-ceilings/Conditions of refund	
	DIRECT PROVISION: Refund Amount 100% INDIRECT PROVISION: Refund Amount € 65 per single Ultrasound in Pregnancy	

Sub-Cover 8.2 - Maternity Package - HOSPITALISATION FOR CHILDBIRTH

This Sub-Cover provides for the recognition - only for indirect provision, in the case of hospitalisation for childbirth carried out through the S.S.N. - of an allowance/daily allowance per night.

Please note that this allowance/daily allowance is recognised solely for the person receiving care, i.e. only and exclusively for the woman giving birth, provided that her administrative status is in order at the time of hospitalisation for childbirth. No allowance is therefore recognised for any accompanying family members and/or children (even if registered with the Fund).

The allowance/daily allowance for hospitalisation for childbirth is recognised, within the limits set out in this Sub-Cover, upon explicit request of the client/woman giving birth, only and exclusively if no refund request has been submitted to FasiOpen for “Pregnancy Check-Ups” whether received via public healthcare charges or privately (and regardless of whether indirect or direct provision).

To request recognition of this allowance/daily allowance you must attach to your request a complete, legible copy of the medical record relating to the hospitalisation for childbirth within and not later than 3 months from the date of discharge from this hospitalisation.

The Sub-Cover recognises as refundable - for both indirect and direct-provision services - psychological support in the immediate post-natal period if carried out and invoiced (within 150 days following the birth) by a physician specialising in psychiatry or clinical psychology or if carried out by psychologists or psychotherapists duly registered with the board. These therapies must be given in a specialist clinical facility.

To request a refund, within the maximum limits set by the Cover itself, you must send - in addition to the expenditure documentation clearly showing the academic qualification of the professional and his/her registration number - a copy of the clinical file relating to the hospitalisation for childbirth and the specific dates of the individual sessions. Here too, please remember that the time limit for the above-mentioned consultations/sessions (150 days after childbirth) starts from the date of discharge from hospital.

Description	Refund ceilings
MAXIMUM REFUND PER PREGNANCY PER CLIENT	€ 1,040
MAXIMUM REFUND ALLOWANCE PER NIGHT (indirect provision only)	€ 80
MAXIMUM REFUND FOR POSTNATAL PSYCHOLOGICAL SUPPORT FOR PREGNANCY	€ 240
Details	**Sub-ceilings/conditions of refund**
CHILDBIRTH HOSPITALISATION ALLOWANCE (only indirect provision)	INDIRECT PROVISION: Maximum 10 nights of hospitalisation for childbirth through the S.S.N
POSTNATAL PSYCHOLOGICAL SUPPORT	DIRECT PROVISION: € 60 per consultation/session for a maximum of 4 consultations/sessions within 150 days after - childbirth INDIRECT PROVISION: € 60 per consultation/session for a maximum of 4 consultations/sessions within 150 days after - childbirth

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COVER 9 - Prevention Packages

This Cover applies to both "indirect provision" "direct provision" services. One prevention package of your choice is available per year (time span 1 January - 31 December), and the same package cannot be repeated before 2 years have elapsed with the exception of "Oncology Prevention Packages for Men/Women", which can be repeated once a year until the age of 65, after which they revert to the standard frequency of once every 2 years.

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

To request a refund for an indirect-provision Prevention Package you must forward the expenditure documentation, clearly showing all the tests contained in the Package itself and received in one single solution. Otherwise, in the case of "direct provision" services,, it will be the responsibility of the healthcare facility to transmit the necessary refund documentation to the Fund.

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

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

Code	Description	Services Included	Refund ceilings	Sex	Age Band
06142 - 6142	**CARDIOVASCULAR WOMEN**	- Hemochromocytometric and Morphological - Erythrocyte sedimentation rate (ESR) - Glycaemia - Azotaemia - Creatininemia - HDL cholesterol - LDL cholesterol - Total cholesterol - Glutamic oxalacetic transaminase (GOT) and glutamate-pyruvate transaminase (GPT) - Urine, complete chemical and microscopic examination - ECG	DIRECT PROVISION: 100% INDIRECT PROVISION: € 90	WOMEN	Age 40 or over

06140 - 6140	**ONCOLOGICAL WOMEN**	- Hemochromocytometric and Morphological - Erythrocyte sedimentation rate (ESR) - Glycaemia - Azotaemia - Creatininemia - HDL cholesterol - LDL cholesterol - Total cholesterol - Glutamic oxalacetic transaminase (GOT) and glutamate-pyruvate transaminase (GPT) - Urine, complete chemical and microscopic examination - Cytological for cancer diagnostics (pap test) or endocervical cytological - plus vaginal bacteriological smear - Bilateral mammography	DIRECT PROVISION: 100% INDIRECT PROVISION: € 200	WOMEN	Age 40 or over (repeatable once a year until the age of 65, after which repeatable once every 2 years).
06141 - 6141	**CARDIOVASCULAR MEN**	- Hemochromocytometric and Morphological - Erythrocyte sedimentation rate (ESR) - Glycaemia - Azotaemia - Creatininemia - HDL cholesterol - LDL cholesterol - Total cholesterol - Glutamic oxalacetic transaminase (GOT) and glutamate-pyruvate transaminase (GPT) - Urine, complete chemical and microscopic examination - ECG	DIRECT PROVISION: 100% INDIRECT PROVISION: € 90	MEN	Age 40 or over
06139 - 6139	**ONCOLOGICAL MEN**	- Hemochromocytometric and Morphological - Erythrocyte sedimentation rate (ESR) - Glycaemia - Azotaemia - Creatininemia - HDL cholesterol - LDL cholesterol - Total cholesterol - Glutamic oxalacetic transaminase (GOT) and glutamate-pyruvate transaminase (GPT) - Urine, complete chemical and microscopic examination - Prostate-specific antigen (PSA) - Suprapubic prostate and bladder ultrasound	DIRECT PROVISION: 100% INDIRECT PROVISION: € 150	MEN	Age 40 or over (repeatable once a year until the age of 65, after which repeatable once every 2 years).

67033 - 6253	**OPHTHALMOLOGY**	- O.C.T. – Optical coherence tomography - Corneal Pachymetry - Computerised Campimetry (VCP) - Delivery of the Report by the Ophthalmologist	DIRECT PROVISION: 100% INDIRECT PROVISION: € 120	MEN/ WOMEN	Age 40 or over
67047 - 6273	**THYROID CANCER**	TSH (Thyrotropic Hormone) Thyroid Ultrasound	DIRECT PROVISION: 100% INDIRECT PROVISION: € 50	MEN/ WOMEN	Age 40 or over
08009 - 8009	**MELANOMA**	- Dermatological examination - Nerve Mapping - Epiluminescence - Delivery of test images/photos	DIRECT PROVISION: 100% INDIRECT PROVISION: € 70	MEN/ WOMEN	Age 40 or over
30209 - 6291	**DYSMETABOLIC SYNDROME**	- Glycaemia - HDL cholesterol - LDL cholesterol - Total cholesterol - Triglycerides - Microalbuminuria - Uricemia	DIRECT PROVISION: 100% INDIRECT PROVISION: € 30	MEN/ WOMEN	Age 40 or over

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COVER 10 - Dentistry

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

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

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

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

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

To clarify further, please note that dental services are attributed to the individual teeth/sites/arches/hemiarches (where applicable) based on the invoice date for the balance of the services themselves. For example, if a filling is refundable once every 3 years on a certain tooth and is refunded with an invoice dated 03/03/2025, this will not be recognised again for the same tooth/site before 04/03/2028.

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

To submit a refund claim for indirect-provision services you may download the Unified Form from your private area. This must be completed in full and submitted as a refund claim for services that do not require a Treatment Plan. Otherwise, you may use the same form to request a preventive Care Plan. Having assessed this, the Fund will return the outcome telematically, together with the relevant form to be filled in for submitting the refund request.

The refund request for dental services must be submitted (correctly completed) to FasiOpen together with the balance invoice no later than 3 months from the date of the balance invoice itself.

We therefore urge clients to pay attention to the timetable for submitting the treatment plan (where necessary), since its submission does not constitute an exception to the maximum time limits for submitting a refund request. While reminding you that expenditure documentation must always be in the name of the client for whom the treatment has been carried out (in the case of minors, even if the invoice is in the name of the FasiOpen membership holder, the name of the minor receiving treatment must be clearly indicated on the invoice since the main person must always be identifiable as required by the tax regulations), and that it is not possible to submit an expenditure receipt for expenses relating to services received by more than one family member/client, we underline that invoices for payments on account are not refundable. In particular, we urge you to read the contents of the Basic Nomenclature, above all regarding the distinction between invoices on account, partial balance invoices and balance invoices.

For “direct-provision” dental services, FasiOpen (where the conditions are met) pays the relevant ceiling amount for cost-sharing directly to the affiliated healthcare facility. For direct-provision dental services, all administrative procedures for submitting refund request/s are the responsibility of the facility itself.

Implants and associated crowns

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

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

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

Dental Treatments

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

Please note that it is not possible to submit a refund claim for dental treatments with expenditure documentation that refers to multiple years of treatment. The sub-ceiling for dental treatments, within the annual ceiling specified by the Cover, applies regardless of the number of arches per year. Any

unused annual sub-ceilings and/or residual unused annual sub-ceilings cannot be added to those of subsequent years (if remaining).

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

Obligatory documentation to be submitted in order to obtain a refund

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

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

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

- ✓ intrabuccal x-ray and/or bite wings showing the positioning of the fixture, and intraoral photograph, showing the permanent prosthetic crown cemented onto the relevant implant;
- ✓ intraoral photograph clearly showing the "healing screw" before fitting of the prosthesis, and intraoral photograph showing the successful cementing of the permanent prosthetic crown.
- ✓ Post-treatment photographic documentation for orthodontic treatment that shows the appliance positioned in the individual arches.

Description		Refund ceilings	
MAXIMUM REFUND PER YEAR AND PER CLIENT		€ 2,000	
Service code	**Details**	**Sub-ceilings/Conditions of refund**	
07006 - 6130	**SPECIALIST DENTAL EXAMINATION WITH ANY TREATMENT PLAN**	Refundable maximum once a year	DIRECT PROVISION CARE ONLY

07007 - 6137	**ORAL HYGIENE: DEBRIDEMENT**	Refundable maximum twice a year	DIRECT PROVISION: Maximum excess charged to the client € 10 for Debridement INDIRECT PROVISION: Maximum Refund amount € 35
24014 - 6261	**PREVENTION OF ORAL CAVITY CANCER**	Refundable maximum once a year	DIRECT PROVISION CARE ONLY
20439 - 2650	**FILLING OF CAVITIES, CLASS 1 - 3 - 5 - ANY MATERIAL - PER PERMANENT TOOTH FROM 17 YEARS OF AGE**	Refundable once every 3 years, on the same tooth, whether deciduous or permanent, and regardless of age	DIRECT PROVISION: Maximum excess charged to the client € 40 per single filling INDIRECT PROVISION: Maximum Refund amount € 20 per single filling
23151 - 2667	**FILLING OF CAVITIES, CLASS 2 - 4 - ANY MATERIAL - PER PERMANENT TOOTH FROM 17 YEARS OF AGE**		
30324 - 30324	**FILLING OF ANY CAVITIES, CLASS 1 - 2 - 3 - 4 - 5 - ANY MATERIAL - PER PERMANENT TOOTH UP TO 16 YEARS OF AGE**		
30325 - 30325	**FILLING OF DECIDUOUS TOOTH (ANY CLASS - ANY MATERIAL - REFUNDABLE ONCE EVERY 3 YEARS IN THE SAME TOOTH REGARDLESS OF WHETHER IT IS DECIDUOUS OR PERMANENT)**		
20115 - 2594	**EXTRACTION OF TOOTH OR ROOT (SIMPLE OR COMPLEX) OF PERMANENT TOOTH INCLUDING ANY SUTURES - PER NATURAL TOOTH**	Refundable only once for the same tooth. Not equatable with the extraction of implants and/or fragments.	DIRECT PROVISION: Maximum excess charged to the client € 20 per single extraction INDIRECT PROVISION: Maximum Refund amount € 20 per single filling
30318 - 30318	**EXTRACTION OF A TOOTH OR A SIMPLE OR COMPLEX ROOT OF A DECIDUOUS TOOTH (INCLUDING ANY SUTURES AND SEDATION)**		
20156 - 2595	**EXTRACTION OF TOTALLY BONE-IMPACTED TOOTH, INCLUDING 3RD MOLAR - ONLY FOR TEETH THAT HAVE NEVER ERUPTED IN THE DENTAL ARCH (EXCLUDING GERMECTOMY) - INCLUDING ANY SUTURES PER NATURAL TOOTH**	Refundable only once for the same tooth. Not equatable with the extraction of implants and/or fragments. OBLIGATORY: preventive care plan to be sent with PRE-EXTRACTION (pre-treatment) radiography	DIRECT PROVISION: Maximum excess charged to the client € 40 per single extraction INDIRECT PROVISION: Maximum Refund amount € 75 per single filling
20149 - 2596	**EXTRACTION OF PARTIALLY BONE-IMPACTED 3RD MOLAR - ONLY FOR TEETH THAT HAVE NEVER ERUPTED IN THE DENTAL ARCH - INCLUDING ANY SUTURES PER NATURAL TOOTH**		DIRECT PROVISION: Maximum excess charged to the client € 40 per single extraction INDIRECT PROVISION: Maximum Refund amount € 70 per single extraction

30319 - 30319	**GERMECTOMY (INCLUDING ALL SURGICAL STAGES AND ACTIVITIES INCLUDING MUCOGINGIVAL FLAP AND/OR OSTEOTOMY AND/OR ODONTOTOMY - SUTURES AND SEDATION - EXCLUDING SEDATION WITH NITROUS OXIDE) UP TO 16 YEARS OF AGE**	Refundable only once for the same tooth. Not equatable with the extraction of implants and/or fragments. OBLIGATORY: preventive care plan to be sent with PRE-EXTRACTION (pre-treatment) radiography	DIRECT PROVISION: Maximum excess charged to the client € 40 per single extraction INDIRECT PROVISION: Maximum Refund amount € 75 per single extraction
21089 - 2615	**OSSEOINTEGRATED IMPLANTS (ANY TYPE INCLUDING ZYGOMATIC OR PTERYGOID IMPLANTS EXCLUDING MINI-ORTHODONTIC IMPLANTS OR IMPLANTS OTHER THAN OSSEOINTEGRATED) PER DENTAL LOCATION**	Refundable only once per same tooth regardless of the number of roots and/or the space to be rehabilitated. OBLIGATORY: preventive care plan to be sent with PRE-REHABILITATION (pre-treatment) radiography Post-treatment radiography to be sent with the refund request (i.e. permanent crown on implant)	DIRECT PROVISION: Maximum refund per implant with crown € 550, of which: € 400 per osseointegrated implant € 150 per permanent prosthetic crown INDIRECT PROVISION: Maximum refund per implant with crown € 550, of which: € 400 per osseointegrated implant € 150 per permanent prosthetic crown
23155 - 2671	**POLYMER-COATED, METAL-FREE, CERAMIC-FREE PERMANENT CROWN, CERTIFIABLE AS PERMANENT MATERIAL - PER TOOTH/IMPLANT FROM 17 YEARS OF AGE**	Refundable once every 5 years on the same implant. Not refundable on natural teeth and/or intermediate bridge locations and/or pre-existing implants or not paid by FasiOpen. OBLIGATORY: preventive care plan to be sent with PRE-REHABILITATION (pre-treatment) radiography Post-treatment radiography to be sent with the refund request (i.e. permanent crown on implant)	
21022 - 2618	**PERMANENT CROWN IN BIOMEDICAL ALLOY/RESIN/COMPOSITE CERTIFIABLE AS PERMANENT MATERIAL (ANY TYPE) - PER TOOTH/IMPLANT FROM AGE 17 UPWARDS**		
21055 - 2619	**PRECIOUS ALLOY AND CERAMIC CROWN - METAL-FREE CROWN (CERAMIC OR INTEGRAL/MONOLITHIC CERAMIC MATERIALS - CAD CAM SYSTEMS) PER TOOTH/IMPLANT FROM 17 YEARS OF AGE**		

20412 - 2649	**ENDORAL X-RAYS/BITE WINGS**	A maximum of 1 pre-treatment endoral and 1 post-treatment endoral according to the codes relevant to them (implants and permanent crowns) up to a maximum of 6 endorals/bite wings per year (1 January - 31 December) OBLIGATORY: submission of the preventive treatment plan (since the request must be made at the same time as implants/definitive crowns), with the mandatory submission of intraoral X-rays/bitewings requested before rehabilitation (pre-treatment). When submitting the reimbursement request, it is mandatory to provide the intraoral X-rays/bitewings taken after treatment (post-treatment).	DIRECT PROVISION: Maximum excess charged to the client € 10 per single endoral x-ray/bite wings INDIRECT PROVISION: Maximum Refund amount € 10 single per single endoral x-ray/bite wings
30307 - 30307	**DENTAL THERAPY WITH FIXED APPLIANCES PER ARCH PER YEAR, INCLUDING CEPHALOMETRIC ANALYSIS**	Refundable once a year (1 January - 31 December), for a maximum of 3 years, also not consecutive, up to 18 years of age. Cannot overlap with other dental treatment items during the year. OBLIGATORY: TREATMENT PLAN PER YEAR OF TREATMENT with telecranium or photo of pre-treatment “bite/reverse bite” - Refund Phase per year of treatment - telecranium o photo of models in occlusion	DIRECT PROVISION: Maximum Refund amount € 140 per year regardless of number of arches treated INDIRECT PROVISION: Maximum Refund amount € 140 per year regardless of number of arches treated
30308 - 30308	**DENTAL THERAPY WITH MOBILE/FUNCTIONAL APPLIANCES PER ARCH PER YEAR, INCLUDING CEPHALOMETRIC ANALYSIS**		
30309 - 30309	**DENTAL THERAPY WITH INVISIBLE APPLIANCES (ANY TYPE/MATERIAL) PER ARCH - PER YEAR - INCLUDING CEPHALOMETRIC ANALYSIS**		
30310 - 30310	**DENTAL MAINTENANCE THERAPY WITH FIXED OR MOBILE RETAINER REGARDLESS OF THE NUMBER OF ARCHES**	Refundable for maximum 1 year (1 January - 31 December) within a maximum of 3 years of treatment recognised for refund. Cannot overlap with other dental treatment items during the year. OBLIGATORY: TREATMENT PLAN FOR YEAR OF TREATMENT with intraoral photo of retainer in position - Refund Phase for 1 year of treatment - telecranium or intraoral photo of completed treatment (if completed) or intraoral photo of retainer in position (different from pre-treatment)	DIRECT PROVISION: Maximum Refund amount € 140 per year regardless of number of arches treated INDIRECT PROVISION: Maximum Refund amount € 140 per year regardless of number of arches treated

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

This Cover applies exclusively to "indirect provision" services. Please note that recognition of the allowance/daily allowance can be issued only if explicitly requested by the member/client, and only when:

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

The Cover does not apply in the case of daytime and/or overnight hospitalisation provided privately and/or for a difference in class. Likewise, no refund of allowance/daily allowance is available in the event of overnight hospitalisation for major surgery other than as specified in Cover 1 and/or for rehabilitation hospitalisation even if provided as a consequence of major surgery.. Please remember that any refund for an allowance/daily allowance is recognised for the client receiving treatment, i.e. only and exclusively for the person directly receiving the treatment/therapy (if he/she belongs to the family unit registered with the Fund when hospitalisation began), regardless of the "patient's" age, i.e., no additional allowance is recognised for any family member staying in hospital to assist the patient.

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

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

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COVER 12 - Newborn Protection

This Cover applies to both "indirect" and "direct-provision" services and is reserved for children up to 2 years (24 months) of age maximum provided that they are members of the family unit assisted by FasiOpen at the time of hospitalisation.

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

Description	Refund ceilings
MAXIMUM REFUND PER YEAR PER CLIENT	€ 30,000
MAXIMUM AGE	2 years (24 months)
Details	**Sub-ceilings/conditions of refund**
LARGE SURGICAL OPERATIONS TO CORRECT CONGENITAL MALFORMATIONS	DIRECT PROVISION: Refund Amount 100% INDIRECT PROVISION: Refund percentage 100%

List of major surgical operations to correct congenital malformations

43836 – 179 Adult or neonatal open-heart cardiac surgery, including aneurysms or multiple valve replacements or aortic replacement or aortic plastic replacement (CEC), except for the interventions described
40162 – 192 Reintervention with restoration of CEC
43737 – 193 Section or ligation of the ductus arteriosus of Botallo
43968 – 197 Cardiac transplantation (inclusive of all services and medical explantation and implantation operations)
56150 – 249 Boutonniere deformity of the hand
48512– 287 Correction of congenital clubfoot, soft and/or bone parts
55228 – 288 Boutonniere deformity of the toes
40873 – 358 Congenital cyst or fistula, removal of
42994 – 359 Oesophago-tracheal fistula, surgery for
41244 – 388 Megaoesophagus, surgery for
41251 – 389 Megaesophagus, reintervention for
46367 – 573 Labial outcomes of cleft lip and palate
46375 – 574 Nasal outcomes of cleft lip and palate
46680 – 588 Unilateral labioalveoloschisis
46698 – 589 Bilateral labioalveoloschisis
46920– 610 Anterior, posterior cleft palate of the soft palate
46615 – 611 Total cleft palate
46185 – 624 Wilms tumour removal
46102 – 625 Atresia of the anus with recto-urethral, recto-vulvar fistula: abdominal perineal descent
46086 – 626 Simple atresia of the anus: abdomino-perineal descent
46094 – 627 Atresia of the anus: perineal operation
46995– 628 Biliary tract atresia, explorations
45815 – 629 Cephalohematoma, aspiration of
47001 – 630 Anterior bowel cysts (enterogenic and bronchogenic), surgery for
45823 – 631 Cranium bifidum with meningocele

45831 – 632 Cranium bifidum with meningoencephalocele
45849 – 633 Craniostenosis
46136 – 634 Dilatation due to congenital stenosis of the anus
45997 – 635 Bochdalek diaphragmatic hernia
46003 – 636 Morgagni diaphragmatic hernia
45955 – 637 Oesophagus (complete treatment), atresia or congenital fistulas of the
46243 – 638 Esonphalon or gastroschisis
46276 – 639 Umbilical fistula and cyst: from the omphalomesenteric canal with intestinal resection
46284 – 640 Umbilical granuloma, cauterisation
47126 – 641 Abdominal neuroblastoma
47134 – 642 Endothoracic neuroblastoma
47142 – 643 Pelvic neuroblastoma
47159 – 644 Newborn intestinal obstruction, atresia (need for anastomosis)
47167 – 645 Newborn intestinal obstruction with intestinal resection
47175 – 646 Newborn intestinal obstruction without intestinal resection
46045 – 647 Newborn intestinal obstruction-ileomeconeal: simple ileostomy
46060 – 648 Newborn intestinal obstruction-ileomeconial: resection with primitive anastomosis
46052 – 649 Newborn intestinal obstruction-ileomeconial: Mickulicz resection
45989 – 650 Pylorus, congenital stenosis of the
46144 – 651 Anal plastic surgery for congenital stenosis
45914 – 652 Brachial plexus, neurolysis for obstetrical paralysis of the
46318 – 653 Vein preparation for IV therapy and transfusion
46110 – 654 Rectum, prolapse with anal cerclage of the
46128 – 655 Rectum, prolapse with abdominal operation of the
46193 – 656 Spina bifida: meningocele
46201 – 657 Spina bifida: myelomeningocele
46151 – 658 Sacrococcygeal teratoma
47555 – 1214 Obstetric lower limb trauma, treatment of
47548 – 1215 Obstetric upper limb trauma, treatment of

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COVER 13 - Transportation by ambulance

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

Transportation by ambulance is recognised as refundable only for serious pathologies, when clients cannot be transported with their own means, from their home to the chosen care facility for hospitalisation and vice versa.

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

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

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

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

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

Description	Refund ceilings
MAXIMUM REFUND PER YEAR AND PER CLIENT	€ 1,700
MINIMUM NON REFUNDABLE	Not provided for
Details	**Sub-ceilings/conditions of refund**
TRANSPORTATION BY AMBULANCE FOR SERIOUS PATHOLOGIES	INDIRECT PROVISION: Refund percentage 100%

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COVER 14 - Lenses

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

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

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

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

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

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

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

Description	Refund ceilings
MAXIMUM REFUND PER YEAR AND PER CLIENT	€ 120
MINIMUM NON REFUNDABLE	€ 55 for corrective lenses/pack of non-disposable contact lenses
Details	**Sub-ceilings/conditions of refund**
LENSES (FOLLOWING CHANGE IN EYESIGHT)	INDIRECT PROVISION: Maximum refund percentage 100% net of minimum non-refundable amount

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COVER 15 - Physiokinesis Therapy following injury

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

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

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

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

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

Description		Refund ceilings
MAXIMUM REFUND PER YEAR AND PER CLIENT (only following an accident, for services treated and invoiced within 120 days after the day of the documented accident)		€ 750
Code	**Details**	**Sub-ceilings/conditions of refund**
80036 - 2922	**RADIAL SHOCK WAVES - DIATHERMY: SHORTWAVE/MICROWAVE/MARCONI/RADARTHERAPY**	DIRECT PROVISION: 100% INDIRECT PROVISION: € 6 per service
80093 - 2923	**ANTALGIC ELECTROTHERAPY (DIADYNAMIC OR TENS)**	DIRECT PROVISION: 100% INDIRECT PROVISION: € 5 per service
80119 - 2924	**ELECTROTHERAPY OF NORMAL OR DENERVATED MUSCLES (ELECTROSTIMULATION, FARADIC, GALVANIC, HYDROGALVANIC, INTERFERENTIAL)**	DIRECT PROVISION: 100% INDIRECT PROVISION: € 5 per service
80069 - 2925	**INFRARED IRRADIATION**	DIRECT PROVISION: 100% INDIRECT PROVISION: € 5 per service
80101 - 2926	**IONTOPHORESIS**	DIRECT PROVISION: 100% INDIRECT PROVISION: € 5 per service
81422 - 2927	**SEGMENTAL HYPERTHERMIA**	DIRECT PROVISION: 100% INDIRECT PROVISION: € 7 per service
80259 - 2928	**ANTALGIC LASER THERAPY**	DIRECT PROVISION: 100% INDIRECT PROVISION: € 9 per service
80127 - 2929	**MAGNETOTHERAPY**	DIRECT PROVISION: 100% INDIRECT PROVISION: € 8 per service
80242 - 2930	**PRESSOTHERAPY OR INTERMITTENT DEPRESSOTHERAPY OR MANUAL LYMPHODRAGE** (limited to cases of lymphoedema, axillary/inguinal lymphadenectomy or in cases of hip prosthesis surgery in the context of post-hospitalisation therapy).	DIRECT PROVISION: 100% INDIRECT PROVISION: € 7 per service
85522 - 2931	**TECAR THERAPY**	DIRECT PROVISION: 100% INDIRECT PROVISION: € 8 per service
80051 - 2932	**ULTRAVIOLET LIGHT OR PUVA THERAPY (PER SESSION)**	DIRECT PROVISION: 100% INDIRECT PROVISION: € 5 per service
80226 - 2933	**ULTRASOUND THERAPY**	DIRECT PROVISION: 100% INDIRECT PROVISION: € 5 per service
80218 - 2934	**ACUPUNCTURE (MANU MEDICA)**	DIRECT PROVISION: 100% INDIRECT PROVISION: € 14 per service maximum 10 services per year
81364 - 2935	**ASSISTED EXERCISES IN WATER (PER SESSION)**	DIRECT PROVISION: 100% INDIRECT PROVISION: € 9 per service
81555 - 2936	**EXERCISES WITH ISOKINETIC EQUIPMENT (PER SESSION)**	DIRECT PROVISION: 100% INDIRECT PROVISION: € 10 per service
80135 - 2937	**POSTURAL EXERCISES**	DIRECT PROVISION: 100% INDIRECT PROVISION: € 5 per service
80192 - 2938	**MOTOR AND PROPRIOCEPTIVE REHABILITATION**	DIRECT PROVISION: 100% INDIRECT PROVISION: € 6 per service
80184 - 2939	**SPINAL MANIPULATIONS OR CHIROTHERAPY (MANU MEDICA)**	DIRECT PROVISION: 100% INDIRECT PROVISION: € 13 per service maximum 10 services per year
80143 - 2940	**MASSAGE THERAPY**	DIRECT PROVISION: 100% INDIRECT PROVISION: € 5 per service
80325 - 2941	**LOCALISED MASSAGE THERAPY - REFLEXOLOGY (MANU MEDICA)**	DIRECT PROVISION: 100% INDIRECT PROVISION: € 7 per service
81563 - 2942	**JOINT MOBILISATIONS**	DIRECT PROVISION: 100% INDIRECT PROVISION: € 6 per service
81571 - 2943	**SPINAL MOBILISATIONS**	DIRECT PROVISION: 100% INDIRECT PROVISION: € 7 per service
81356 - 2944	**OCCUPATIONAL THERAPY (PER SESSION)**	DIRECT PROVISION: 100% INDIRECT PROVISION: € 9 per service
80200 - 2945	**MECHANICAL SPINAL TRACTIONS (PER SESSION)**	DIRECT PROVISION: 100% INDIRECT PROVISION: € 6 per service

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