LOT 4B

INSURANCE SPECIFICATIONS

"ASSISTANCE AND REIMBURSEMENT OF MEDICAL COSTS FOR PERSONNEL WORKING ABROAD"

POLICYHOLDER

POLITECNICO DI MILANO

TABLE OF CONTENTS

DEFINITIONS [DEF] 1

GENERAL TERMS OF INSURANCE [GTI] 3

EFFECTIVENESS OF INSURANCE AND CONTRACTUAL TERMS 3

Art. 1 Term of Insurance - Extension - Cancellation 3
Art. 2 Payment of premium and effectiveness of Insurance 3
Art. 3 Payments for changes with Premium collection 3
Art. 4 Form of communications and changes of Insurance 3
Art. 5 Payment Traceability 4
Art. 6 Variation of risk 4
Art. 7 Review of prices and other contractual clauses 4
Art. 8 Withdrawal clause 4
Art. 9 Inaccurate and reticent declarations without intent or gross negligence 5
Art. 10 Reduction of Risk 5
Art. 11 Policy Interpretation 5
Art. 12 Previous damages 5
Art. 13 Exoneration of reporting of infirmities, physical defects and mutilations 5
Art. 14 Exoneration of reporting other Insurance 5
Art. 15 Tax costs 5
Art. 16 Court with jurisdiction 6
Art. 17 Reference to rules of law 6
Art. 18 Data processing 6
Art. 19 Co-insurance and Delegation 6
Art. 20 Premium Adjustment 6
Art. 21 Legitimacy 7
Art. 22 Payment of Compensation 7
Art. 23 Disputes 7
Art. 24 Waiver of right of recourse 7
Art. 25 Withdrawal in the event of a Claim 8
Art. 26 Production of information on claims 8

RISK CHARACTERISTICS 10

PREMIUM CALCULATION [PREM] 10

ASSISTANCE SECTION [ASS SEC] 12

SUBJECT OF THE INSURANCE 12

Art. 1 Medical consultations by telephone 12
Art. 2 Travel of a relative 12
Art. 3 Extension of stay abroad 12
Art. 4 Transportation to a hospital centre 12
Art. 5 Medical return 12
Art. 6 Transportation of the body 13
Art. 7 Early return 13
Art. 8 Advance of urgent costs 13

TERMS RELATING TO THE ASSISTANCE SECTION 14

Art. 9 Effectiveness and duration of guarantee 14
Art. 10 Exclusions 14

Art. 11 Notice of Claim - Methods for requesting Assistance *14*
Art. 12 Exposure limits *15*
Art. 13 Lack of use of performances *15*

MEDICAL COSTS REIMBURSEMENT SECTION [MCR SEC] **16**

SUBJECT OF THE INSURANCE **16**
Art. 1 Hospital Costs Reimbursement *16*
Art. 2 Non-Hospital Costs Reimbursement *16*

TERMS RELATING TO THE MEDICAL COSTS REIMBURSEMENT SECTION **17**
Art. 3 Exclusions *17*
Art. 4 Age limits *17*
Art. 5 Territorial validity *17*
Art. 6 Obligations in the event of a Claim *17*
Art. 7 Maximum limit of compensation *18*
Art. 8 Liquidation criteria *18*

DEFINITIONS [DEF]

Insurance	The insurance contract
Policy	The document that proves and regulates the insurance
Policyholder	The entity that enters into the insurance contract in its own name and in the interest of those entitled
Insured	The Entity whose interest is protected by the insurance
Company	The insurance Company, or group of Companies, that has underwritten this insurance
Premium	The sum due from the Policyholder to the Company in view of the guarantees provided by it under the terms of this insurance
Risk	The probability of the claim occurring and the amount of damages that may derive from it
Claim	The occurrence of the injurious event for which the insurance is provided
Accident	The event due to a fortuitous, violent and external cause that produces objectively ascertainable bodily injuries
Permanent Invalidity	The definitive loss, following an accident, totally or partially, of the capacity of the Insured to carry out any work, irrespective of his/her profession
Temporary Invalidity	The temporary loss, following an accident, totally or partially, of the capacity of the Insured to fulfil his/her professional activities
Compensation - Indemnity	The sum due from the Company to the Insured or to those entitled in the event of a claim indemnifiable under the policy terms
Health Institution	Any Health Institution duly authorised to provide hospital assistance
Admission	Admission to a Health Institution that involves at least an overnight stay
Assistance	Temporary assistance, in cash or in kind, provided to the Insured who finds himself/herself in difficulty as a result of the occurrence of a claim
Emergency	Alteration of the state of health characterised by acute situations of such severity as to constitute a danger to the life of the Insured, requiring the intervention of the public facilities responsible based upon the rules of law in force

Illness	Any alteration of the state of health not resulting from an accident
Sudden Illness	Acute onset illness of which the Insured was not aware and that, in any case, is not a manifestation, albeit sudden, of a previous disease known to the Insured
Pathological State	Any alteration of the state of health consequent to an accident or illness
Operations Centre	The Structure of the Company, or connected with the Company, constituted by: doctors, experts, operators, open every day of the year, 24 hours a day, which, in the name and on behalf of the Company itself, makes telephone contact with the Insured and organises and provides the services envisaged by the policy
Foreign Work	Activity carried out away from the ordinary place of service in a foreign territory
Study leave and exchange	as defined by Article 10 of Law 18 March 1958, no. 311 and subsequent amendments and additions, by Article 8 of Law 18 March 1958, no. 349 and subsequent amendments and additions, by Article 17 of Presidential Decree 11 July 1980, no. 382 and subsequent amendments and additions.
Abroad	The entire world excluding the territory of the Italian Republic, the Vatican City and the Republic of San Marino
Deductible	The amount established contractually that, in the event of a claim, is borne exclusively by the Insured, or by those entitled
Compensation Limit	Maximum sum due from the Company
Insurance period	The period, equal to or less than 12 months, between the effective date and the annual expiry date

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GENERAL TERMS OF INSURANCE [GTI]

EFFECTIVENESS OF INSURANCE AND CONTRACTUAL TERMS

Art. 1 TERM OF INSURANCE - EXTENSION - CANCELLATION

This policy has a term from midnight on 31.12.2020 and expires at midnight on 31.12.2023; at that date, the policy expires with no obligation of prior cancellation, subject to the possibility for the Policyholder to manifest, with prior notice of 30 (thirty) days from the expiry, the intention to renew for a further three years.

The Policyholder may also, by the natural expiry, ask the Company to extend this Insurance, until the complete performance of the award procedures of the new insurance and in any case for a maximum period of 180 (one hundred and eighty) days.

The Company undertakes to extend the insurance, for the aforementioned maximum period, under the same contractual and economic terms in force and the respective premium instalment will be paid within 30 (thirty) days from the start of the extension.

Art. 2 PAYMENT OF PREMIUM AND EFFECTIVENESS OF INSURANCE

The insurance takes effect, with immediate cover, from midnight on the day indicated in the policy even though the Policyholder may pay the first premium by midnight on 31.03.2021.

The subsequent premium instalments must be paid by 31.03 of each year.

If the Policyholder fails to pay by those deadlines, the insurance is suspended and comes back into force from midnight on the day of payment, without prejudice to the subsequent deadlines.

If, however, the Policyholder fails to make the payment by the aforementioned deadlines due to a breach by the Company which, in conformity with the provisions of Art. 48(2) of Presidential Decree 602/73 and subsequent amendments and additions, has prevented the due payment of the premium, the insurance guarantee will remain fully effective provided that the Policyholder, by the deadlines set for paying the premium, has formally notified that circumstance. In that case, the Company will subsequently be obliged to send clearance to the payment issued by the collection agent and the Policyholder must pay the premium instalment within fifteen days of receiving that documentation.

Art. 3 PAYMENTS FOR CHANGES WITH PREMIUM COLLECTION

Any changes involving a premium collection must also be paid within 90 (ninety) days from the date of receipt, by the Policyholder, of the respective document correctly issued by the Company.

However, the insurance will take immediate effect from midnight on the day indicated in the change document.

Art. 4 FORM OF COMMUNICATIONS AND CHANGES OF INSURANCE

All communications between the Parties must be made in writing; any changes to the insurance must be proven in writing.

Art. 5 PAYMENT TRACEABILITY

The Company must comply fully with the provisions of Art. 3 of Law 136/2010 and subsequent amendments and additions.

Art. 6 VARIATION OF RISK

Variation of risk means any change that determines a different probability of a claim occurring or an alteration of its consequences, unexpected or unforeseeable, at the time of entering into the contract.

Any element that occurs after the award of the contract, which involves a variation of risk, must be communicated immediately, namely within fifteen days from becoming aware of the same, in writing to the Insurer.

It is also agreed that, in the event of variations of the risk consequent to legislative changes, new rules and/or regulations by virtue of which the obligation of the Policyholder to obtain the guarantees regulated by this policies is no longer in place, for one or more categories, this will not involve any revision of the terms awarded in the tender which will therefore remain in force for the remaining insured categories.

The policyholder Administration is not required to communicate in writing variations of risk resulting from regulatory changes or from modifications of case law guidance.

Art. 7 REVIEW OF PRICES AND OTHER CONTRACTUAL CLAUSES

For multiyear contracts, if, following significant, motivated and specific circumstances of variations of risk that alter the economic balance of the contract, the Insurer considers it essential to request a price review, six months before the expiry of the annual contractual term, based upon available data to be communicated to the Administration, the Insurer may inform the policyholder Administration of the occurrence of the circumstances of variation of risk envisaged by Art. 6 and request, with motivation, in accordance with Art. 106 of Legislative Decree 50/2016 , a review of the premiums or contractual terms relating to deductibles, percentage excesses or insured maximum limits.

The policyholder Administration, within 15 days, after the respective investigation and taking account of the requests made, will decide on the same, making its own review counter-proposal.

If the Parties reach an agreement, the contract is amended commencing from the new annual contractual term.

Art. 8 WITHDRAWAL CLAUSE

If there is no agreement between the Parties in accordance with Art. 7, the Insurer may withdraw from the insurance contract. The withdrawal commences from the expiry of the annual contractual term.

The right of withdrawal is exercised within 30 (thirty) days from the proposal indicated in the first paragraph of Art. 7, presented by the Insurer, or, in the circumstances indicated in the second paragraph of that article, within thirty days from receipt of the counter-proposal of the Administration.

If, at the effective date of the withdrawal, the contracting Administration has not managed to assign the new insurance contract, at the simple request of the latter, the Insurer undertakes to extend the insurance under the

same regulatory and economic terms in force for a maximum period of 30 (thirty) days. The policyholder Administration pays the premium supplement at the same time.

The withdrawal does not produce any effect if the details of all claims reported by the Policyholder, indicated in Art. 26 "Production of information on claims", reported up to the month prior to that of exercising the withdrawal are not produced.

Art. 9 INACCURATE AND RETICENT DECLARATIONS WITHOUT INTENT OR GROSS NEGLIGENCE

In the circumstance indicated in Art. 1893, paragraph 1 of the Civil Code and in partial derogation of the same, in the absence of intent or gross negligence, the Insurer's right of withdrawal is excluded.

Inaccurate or reticent declarations of the Policyholder and/or the Insured when entering into the policy and relating to circumstances that affect the assessment of risk, along with the failure to communicate subsequent circumstances or changes that aggravate the risk, will not involve the forfeiture of the right to compensation or the reduction of the same or the termination of the insurance as referred to in Articles 1892, 1893, 1894 and 1898 of the Civil Code, provided that the Policyholder or the Insured has not acted with intent.

Art. 10 REDUCTION OF RISK

In partial derogation of Article 1897 of the Civil Code, if the risk reduces, along with the insured values, the premium will be immediately reduced.

The Company will refund the corresponding portion of the premium paid and not enjoyed (excluding government taxes if already paid to the Treasury) within 60 (sixty) days from the communication and will waive the right to terminate the contract and the right of withdrawal due to it under the terms of Article 1897 referred to above.

Art. 11 POLICY INTERPRETATION

If there is any doubt with regard to the interpretation of the policy clauses, the same should be interpreted in the sense more favourable to the Insured and/or the Policyholder.

Art. 12 PREVIOUS DAMAGES

The Insured and the Policyholder are exonerated from the obligation of declaring any damages that have affected the insured parties.

Art. 13 EXONERATION OF REPORTING OF INFIRMITIES, PHYSICAL DEFECTS AND MUTILATIONS

The Policyholder is exonerated from the obligation of reporting infirmities from which the individual Insured parties are suffering at the time of entering into this Convention or that may occur thereafter, without prejudice to the contents of the Article "Indemnification Criteria and Liquidation of Damage".

Art. 14 EXONERATION OF REPORTING OTHER INSURANCE

The Policyholder is exonerated from the obligation to report any other insurance that the individual Insured parties have in progress or enter into personally for the same events.

Art. 15 TAX COSTS

The tax costs relating to the insurance are borne by the Policyholder.

Art. 16 COURT WITH JURISDICTION

For disputes concerning the application and execution of this policy, at the discretion of the Policyholder, the Court in the district of which the same or the Insured is based will have jurisdiction.

Art. 17 REFERENCE TO RULES OF LAW

For anything not regulated here, the rules of law apply.

Art. 18 DATA PROCESSING

In accordance with regulation (EU) 2016/679 the Parties consent to the processing of personal data contained in this policy or deriving from it, for purposes strictly connected to the fulfilment of the contractual obligations.

Art. 19 CO-INSURANCE AND DELEGATION

If the insurance contract is awarded to a temporary group of companies, established within legal terms, the provisions of Art. 1911 of the Civil Code will be derogated, as all underwriting companies are jointly liable towards the policyholder.

If the insurance is divided by shares between the different Companies indicated in the Offer Sheet relating to this insurance, the total amount of the premiums - within the terms regulated by Art. 2 - will be paid in full to the Lead Company which will give an overall receipt for the sum collected.

In the event of a claim, the Lead Company (hereafter Company) will manage and settle directly with the Policyholder/Insured the settlement and the Co-Insurer Companies, which undertake to accept the settlement made by the Company, will contribute to the payment in proportion to the share insured by them, without prejudice to the joint liability; the Company also undertakes, in any case, to issue a deed of settlement for the entire amount of the claims and to issue to the Insured a receipt for the total amount of the compensation.

Again in the circumstance where the insurance is split by shares between different Companies, by signing this policy, the Co-Insurer Companies give a mandate to the Company to sign the subsequent modification documents even in their name and on their behalf; therefore, the signature affixed by the Company renders the subsequent documents valid for all effects, even for the Co-Insurer Companies

Art. 20 PREMIUM ADJUSTMENT

As the premium is agreed on the basis of elements of variable risk, within 120 (one hundred and twenty) days from the end of each insurance period, the Policyholder must communicate in writing to the Company the respective final figures so that the Company may proceed to adjust the premium, which will be determined based upon the increases or decreases of the variable elements used as parameters for the guaranteed insurance performance.

The Company must issue, within 60 (sixty) days from receiving the communication, the respective premium adjustment appendix.

The positive and negative differences resulting from the adjustment must be paid respectively by the Policyholder within 90 (ninety) days from the date of receipt, by the Policyholder itself, of the adjustment document, correctly issued, or by the Company, within 30 (thirty) days from the date of issuance of the adjustment document.

If the Policyholder does not communicate the aforementioned data within the set terms or does not pay the positive difference due, the Company may fix a further deadline, after which the premium paid in advance provisionally for the future instalment is considered to be paid on account or in guarantee of that relating to the insurance period for which the adjustment or the payment of the positive difference has not taken place and the insurance remains suspended until midnight on the day on which the Policyholder has fulfilled its obligations, subject to the right of the Company to take judicial action or to declare, by recorded delivery letter, the contract terminated.

If, however, the Policyholder fails to make the payment by the aforementioned deadlines due to a breach by the Company which, in conformity with the provisions of Art. 48(2) of Presidential Decree 602/73 and subsequent amendments and additions, has prevented the due payment of the premium, the insurance guarantee will remain fully effective provided that the Policyholder, by the deadlines set for paying the premium, has formally notified that circumstance. In that case, the Company will subsequently be obliged to send clearance to the payment issued by the collection agent and the Policyholder must pay the premium instalment within fifteen days of receiving that documentation.

In the event of a contract that has definitively expired, if the Policyholder fails to fulfil the obligations relating to the premium adjustment, the Company, subject to its right to take legal action, will prioritise the payment of the premium adjustment in arrears over the settlement of any claims.

Art. 21 LEGITIMACY

The Company acknowledges that, in compliance with the National Collective Labour Agreements in force and/or the other obligations existing in that regard, this policy is entered into, in favour of the Insured parties, by the Policyholder which fulfils the obligations envisaged by the insurance itself. By virtue of the foregoing, the Company recognises the consent of the Insured parties themselves from the signature of the contract even if not formally documented. The Company will agree directly with the Insured parties the amount of compensation due.

Art. 22 PAYMENT OF COMPENSATION

Having completed the necessary documentation and carried out the appropriate assessments, the Company calculates the compensation due, communicates this to those entitled and, having received their acceptance, makes the payment within 30 (thirty) days.

Art. 23 DISPUTES

In the event of a disagreement on the nature or consequences of an illness, accident, surgery or in any case one of the performances envisaged by this contract or the amount of the reimbursements, the Insured may make recourse to an Arbitration Board consisting of three doctors, one of whom is appointed by the Insured, another by the Company and the third by the first two appointees or, failing that, by the Chairman of the Board of Physicians having jurisdiction in the location in which the Medical Board is to meet. The Medical Board resides in the Municipality, home to the Forensic Medicine Institution, closest to the place of residence of the Insured.

Each of the Parties remunerates, at its own expense, the Doctor designated by it, contributing for half to the costs and dues of the third Doctor. If the opinion of the Board is even only partially favourable to the Insured, the Company will also bear the costs for which the latter is responsible.

The decisions of the Medical Board are made by majority of votes, dispensing any legal formality, and they are binding for the Parties even if one of the doctors refuses to sign the respective report.

Art. 24 WAIVER OF RIGHT OF RECOURSE

The Company waives the right of subrogation envisaged by Article 1916 of the Civil Code.

Art. 25 WITHDRAWAL IN THE EVENT OF A CLAIM

This does not apply to this policy.

Art. 26 PRODUCTION OF INFORMATION ON CLAIMS

Within three months from the expiry of each half-year and in any case six months prior to the contractual expiry, within 30 subsequent calendar days, under penalty of application of the penalties indicated in the next paragraph, the Insurer, in respect of the provisions in force on personal data confidentiality, undertakes to provide to the policyholder Administration evidence of claims reported commencing from the effective date of the contract. That list will be provided in open digital standard format (e.g. CSV) by way of modifiable (not in read-only version) and non-modifiable files, and it must report for each claim:

- the claim number attributed by the Insurer; - the date of occurrence of the event; - the date of the report; - the type of event;
- the type of insured risk (for example, insurance branch); - the type of indemnity (if direct or indirect);
- the indication of the status of the claim according to the following classification and with the details indicated below:

  a) claim archived, without follow-up, specifying the reasons in writing;

  b) claim settled, on _____ with settlement of € _____;

  c) claim open, being assessed, with respective amount estimated at €_____.]:

All claims must be accompanied by the opening date of the case at the Company, the date of occurrence of the reported claim, an indication of the damaged Property and respective location, the type of event and the date of any closure of the case due to settlement or for another reason.

The obligations described above may not prevent the Policyholder from requesting and obtaining an update, by the methods indicated above, on dates other than those indicated.

If the provisions of the first paragraph of this article are not respected, in the absence of adequate motivations linked to causes of force majeure, the Insurer must pay to the Administration a sum equal to 0.05% of the total annual premium for each calendar day of delay, up to the maximum amount of 10% of the contractual net amount.

The Insurer undertakes to provide any other available information relating to the insurance contract in place which the Administration, in agreement with the Insurer, sees fit to obtain during the validity of the contract. In that regard, the Administration must provide adequate motivation.

For fulfilments relating to information to be provided after the contract expiry date, the application of any penalties is guaranteed by the security deposit, which may not be released until all the information indicated in the first paragraph has been sent.

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RISK CHARACTERISTICS

The guarantees indicated in this contract are effective for the Persons indicated in the Foreign Work Regulation of Politecnico di Milano (issued with Rector's Decree no. 5612 of 26 July 2019) who travel abroad for work, within the terms identified by the specific authorisation of Politecnico.

The guarantees indicated in this contract are also effective for Personnel of the various structures of Politecnico who travel abroad for study leave or exchanges (as defined by Article 10 of Law 18 March 1958, no. 311 and subsequent amendments and additions, by Article 8 of Law 18 March 1958, no. 349 and subsequent amendments and additions, by Article 17 of Presidential Decree 11 July 1980, no. 382 and subsequent amendments and additions) within the terms recorded by the specific authorisation of Politecnico.

The guarantees will be effective from the time the Insured leaves his/her residence or place of work, for the whole duration of the foreign work, until his/her return to the residence or place of work.

For the identification of the insured persons and the travel specifications, the documentation stored by the Policyholder will be used.

PREMIUM CALCULATION [PREM]

The premium is determined in relation to the number of Persons authorised for the foreign work and/or study leave, as well as the time spent abroad in conformity with the following schedule. Therefore, the Policyholder will pay an advance premium calculated as an estimate on a number of 2,300 people working abroad as follows:

- no. 2,290 people working/travelling abroad for a period of up to 10 (ten) days, at the per capita premium of € …… (as per the **assistance guarantee Offer Sheet**)

- no. 2,290 people working/travelling abroad for a period of up to 10 (ten) days, at the per capita premium of € …… (as per the **medical costs reimbursement guarantee Offer Sheet**)

- no. 10 people working/on study leave abroad for a period of over 6 (six) months and up to 1 year, at the per capita premium of €……. (as per the **assistance guarantee Offer Sheet**)

- no. 10 people working/on study leave abroad for a period of over 6 (six) months and up to 1 year, at the per capita premium of €……. (as per the **medical costs reimbursement guarantee Offer Sheet**)

At the end of each insurance period, the Policyholder will communicate the actual number of people authorised for foreign work and, for each person, the respective period of stay. The Company will issue a specific summary appendix of the insured trips and will calculate the respective premium according to the following schedule:

- **For trips of up to 10 (ten) days**
    - Assistance Section: no. of Insured parties multiplied by the per capita taxable premium indicated in the **Offer Sheet**;

- Medical Costs Reimbursement Section: no. of Insured parties multiplied by the per capita taxable premium indicated in the **Offer Sheet**;

- **For trips of up to 15 (fifteen) days**
  - Assistance Section: No. of Insured parties multiplied by the per capita taxable premium indicated in the **Offer Sheet**;
  - Medical Costs Reimbursement Section: No. of Insured parties multiplied by the per capita taxable premium indicated in the **Offer Sheet**;
- **For trips of over 15 (fifteen) days and up to 30 (thirty) days**
  - Assistance Section: no. of Insured parties multiplied by the per capita taxable premium indicated in the **Offer Sheet**;
  - Medical Costs Reimbursement Section: no. of Insured parties multiplied by the per capita taxable premium indicated in the **Offer Sheet**;
- **For trips of over 30 (thirty) days and up to 6 (six) months**
  - Assistance Section: no. of Insured parties multiplied by the per capita taxable premium indicated in the **Offer Sheet**;
  - Medical Costs Reimbursement Section: no. of Insured parties multiplied by the per capita taxable premium indicated in the **Offer Sheet**;
- **For trips of over 6 (six) months and up to 1 year**
  - Assistance Section: no. of Insured parties multiplied by the per capita taxable premium indicated in the **Offer Sheet**;
  - Medical Costs Reimbursement Section: no. of Insured parties multiplied by the per capita taxable premium indicated in the **Offer Sheet**;

It is agreed that for trips of annual duration, the adjustment premium will be calculated in the following terms:

- full annual premium if the departure for the authorised foreign work/travel occurred in the 1st half of the insurance period
- 60% (sixty per cent) of the annual premium if the departure for the authorised foreign work/travel occurred in the 2nd half of the insurance period

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ASSISTANCE SECTION [ASS SEC]

SUBJECT OF THE INSURANCE

The Company undertakes to provide the following performances:

Art. 1 MEDICAL CONSULTATIONS BY TELEPHONE

If, in the event of accident or illness, the Insured is unable to contact his/her usual doctor, he/she may, by making communication with the medical service of the Operations Centre, receive advice and instructions on the initial therapies to be followed.

Art. 2 TRAVEL OF A RELATIVE

If the Insured is admitted to hospital following an accident or sudden illness and, subject to assessment between the on-call doctor of the Operations Centre and the treating doctors in situ, he/she cannot be discharged within 7 (seven) days from the date of admission and asks to be visited by a relative, the Company, by way of the Operations Centre, will organise the trip, providing a return ticket, by train (first class) or aircraft (economy class), bearing the respective costs; all other expenses are excluded.

The guarantee is provided up to the limit of €1,500.00 (one thousand five hundred) per claim.

Art. 3 EXTENSION OF STAY ABROAD

If the Insured, as a result of an accident or sudden illness is unable, in view of a due medical certificate, to return on the date initially planned, the Company, by way of the Operations Centre, will organise the overnight accommodation originated by the extension of the stay.

The Company will bear the respective costs for up to a maximum of 10 (ten) days within the limit of €3,000.00 (three thousand).

Art. 4 TRANSPORTATION TO A HOSPITAL CENTRE

If, as a result of accident or illness, the Insured needs to be transferred to a hospital centre, the Company will organise the transportation of the Insured, to the nearest equipped medical facility for the necessary treatments. During the transportation, if necessary, the Insured will be assisted by medical staff and/or paramedics. The guarantee is provided within the limit of **€5,000.00 (five thousand)** per claim.

Art. 5 MEDICAL RETURN

If the conditions of the Insured, as a result of an accident or sudden illness, required a hospital admission and upon discharge it is necessary to return to Italy by medical transport, the Company, via the Operations Centre, organises the repatriation of the patient by the most suitable means.

During the transportation, if necessary, the Insured will be assisted by medical staff and/or paramedics.

All costs of organisation and transportation of the patient, including the fees of medical staff and/or paramedics sent to the location and who accompany the patient, are borne by the Company.

The guarantee is provided with no limit on expenditure per claim.

Art. 6 TRANSPORTATION OF THE BODY

In the event of death of the Insured, the Company, via the Operations Centre, organises the transportation of the remains to the burial location in Italy, after fulfilling all formalities of the death in situ. The transportation is carried out in accordance with international rules in that regard, with the relatives being responsible for paying the funeral and burial costs, as well as any recovery of the body.

It the legal rules of the location prevent the transportation of the body to Italy or the Insured has expressed the desire to be buried in situ, the Company, via the Operations Centre, provides to a relative a return ticket by aircraft (economy class) or train (first class) to attend the funeral.

If it is necessary to identify the body, the Company will provide to a relative a return ticket by aircraft (economy class) or by train (first class).

The guarantee is provided with no limit on expenditure per claim.

Art. 7 EARLY RETURN

If the Insured, as a result of a death or hospital admission with imminent danger of life of a relative (spouse, cohabiting partner, child, sibling, parent, father-in-law, mother-in-law, son-in-law, daughter-in-law), must return early to the residence, the Company, via the Operations Centre, will organise the return journey of the Insured by aircraft (economy class), bearing the respective costs.

The guarantee is provided within the limit of € 1,500.00 (one thousand five hundred).

Art. 8 ADVANCE OF URGENT COSTS

If the Insured, as a result of an accident of illness occurring while travelling, needs to be hospitalised and finds himself/herself incurring costs which he/she cannot immediately pay directly and immediately, the Company, via the Operations Centre, pays the invoices relating to the costs for the admission, on behalf of the Insured, by way of an interest-free loan, up to a maximum of €2,600.00 (two thousand six hundred).

The performance is effective provided that the Insured is able to provide, at the time of the intervention request, adequate bank sureties or those of another nature for the return of the advanced sum.

The Insured must repay what is received as soon as possible and in any case within 30 (thirty) days from the date of the advance being paid; once that period has elapsed, he/she must repay the advanced sum plus interest at the legal rate in force.

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TERMS RELATING TO THE ASSISTANCE SECTION

Art. 9 EFFECTIVENESS AND DURATION OF GUARANTEE

The guarantee is effective and valid from the time the Insured leaves his/her residence or place of work; it continues for the whole duration of the foreign work, until his/her return to the residence or place of work.

Art. 10 EXCLUSIONS

The guarantee does not include claims caused by:

a. acts of war, insurrections, riots, strikes, uprisings, acts of terrorism, sabotage, military occupations, invasions;

b. volcanic eruptions, earthquakes, hurricanes, floods, downpours;

c. development, however it arose - controlled or otherwise - of nuclear energy or radioactivity;

d. abuse of alcohol, psychotropic drugs and non-therapeutic use of narcotic drugs and hallucinogens;

e. intent of the Policyholder and/or Insured, therein including suicide or attempted suicide;

f. car, motorbike or motorboat races and respective heats and trials, mountaineering with rock climbing or access to glaciers, trampolining with skis or hydro-skis, use of bobsleighs or practice of aerial sports in general;

g. preexisting illnesses at the time of entering into the contract;

h. travel not linked to professional reasons.

In addition, the specific exclusions envisaged by the special terms that regulate the individual performances also apply.

Art. 11 NOTICE OF CLAIM - METHODS FOR REQUESTING ASSISTANCE

In order to be entitled to the guaranteed performances, the Insured, before undertaking any personal initiative, must contact the Operations Centre.

Requests for assistance, which must specify the personal identification details, policy number, home address and address of the location in which the Insured is found and the type of assistance requested, may be made by telephone or telegram, at any time 24 hours a day, to the telephone number of the Operations Centre.

The Insured is responsible for sending promptly to the Operations Centre a copy of the consent.

The Operations Centre may intervene directly or explicitly authorise the interventions to receive the necessary assistance.

In the event of an indirect performance:

- the Insured and/or the persons on his/her behalf, as soon as reasonably possible, must inform the Company of the circumstances and developments of the case, providing at the same time the medical documentation,

including any copy of the complete medical records, **originals** of the supporting documents of expenditure: invoices, receipts;

- the Insured and/or the persons on his/her behalf must consent to the examination of the doctors sent by the Company and to any investigation deemed necessary, releasing the treating doctors from professional secrecy.

Any breach of those obligations may involve the total or partial loss of the right to compensation (Art. 1915 of the Italian Civil Code)

Art. 12 EXPOSURE LIMITS

The maximum limits indicated for each individual performance are understood to include taxes and other legal costs.

Art. 13 LACK OF USE OF PERFORMANCES

In the event of performances that are not used or are used only partially at the discretion of the insured, or due to his/her negligence, the Company is not required to provide any other alternative assistance or compensation with respect to what was offered.

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MEDICAL COSTS REIMBURSEMENT SECTION [MCR SEC]

SUBJECT OF THE INSURANCE

The Company undertakes to provide the following performances:

ART. 1 HOSPITAL COSTS REIMBURSEMENT

The insurance cover concerns, up to the amount of the maximum limit of **€350,000.00 (three hundred and fifty thousand)** per Insured, the reimbursement of hospital costs as a result of admission due to acute onset accident and illness with the exclusion of previous pathologies and acute manifestations of previous pathologies for:

1. medical-surgical performances, as well as therapeutic treatments, undergone during admission to a medical institution, excluding discretionary expenses such as bar, television, telephone, etc.;
2. hospitalisation fee;
3. medical costs relating to outpatient surgery.

The Insured is entitled, in the event of hospital admission, to request from the Company the direct payment to the medical facilities of the costs incurred and indemnifiable under the policy terms, in accordance with what is established in the contractual terms.

ART. 2 NON-HOSPITAL COSTS REIMBURSEMENT

Within the limits of **20% (twenty per cent)** of the maximum limit relating to the Hospital Costs Reimbursement, irrespective of the admission and provided that they were rendered necessary due to acute onset accident or illness, excluding any previous pathologies and acute manifestations of previous pathologies, costs for the following are guaranteed:

1. medical performances;
2. diagnostic, laboratory and imaging examinations;
3. medicines.

The reimbursement of costs will be made with the application of a fixed deductible of €100.00 (one hundred) per claim.

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TERMS RELATING TO THE MEDICAL COSTS REIMBURSEMENT SECTION

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ART. 3 EXCLUSIONS

The guarantee does not include claims caused by:

a. the direct consequences of pathological conditions prior to the date of entering into the policy;

b. the elimination or correction of physical defects and malformations preexisting the date of signature of the policy;

c. mental illnesses and mental disorders in general, therein including neurotic behaviours;

d. accidents deriving from intentional crimes of the insured (including, on the other hand, accidents caused by gross negligence);

e. accidents and intoxications consequent to abuse of alcohol or non-therapeutic use of psychotropic or narcotic drugs;

f. pregnancy, except for pregnancy complications within the first 6 (six) months of pregnancy;

g. tissue cell, physiotherapy, hydrotherapy and spa treatments in general as well as performances for aesthetic purposes;

h. dental and periodontal treatments;

i. purchase, maintenance and repair of prosthetic and therapeutic devices, with the exception of costs relating to the purchase of those applied as a result of surgery;

j. direct or indirect consequences of natural or provoked energy transformations or settlements of the atom and accelerations of atomic particles (nuclear fission, radioactive isotopes, accelerating machines, x-rays, etc.);

k. consequences of wars, insurrections, earthquakes or volcanic eruptions.

ART. 4 AGE LIMITS

The Insurance is valid for persons aged not above 75 (seventy-five) years old.

ART. 5 TERRITORIAL VALIDITY

The insurance is valid for the whole World with the exclusion of Italy.

ART. 6 OBLIGATIONS IN THE EVENT OF A CLAIM

In the event of a claim

1) the Insured, the persons on his/her behalf or the Policyholder must notify the Company thereof within thirty days from awareness of the same, in partial derogation of Article 1913 of the Civil Code.

The report must be accompanied by medical certification, including any copy of the full medical records.

2) the Insured and/or the Policyholder must consent to the examination of doctors sent by the Company and to any investigation that the latter deems necessary, releasing the treating doctors from professional secrecy.

Any breach of those obligations may lead to the total or partial loss of the right to compensation (Art. 1915 of the Italian Civil Code).

ART. 7 MAXIMUM LIMIT OF COMPENSATION

During each insurance period, the total amount of compensation, for the set of guaranteed performances, may not exceed the sum of €350,000.00 (three hundred and fifty thousand) for each Insured.

ART. 8 LIQUIDATION CRITERIA

The payment of compensation is made upon completion of the treatment and submission of the medical records, examination reports and medical certificates certifying the illness suffered or the accident that has occurred, together with the originals of the fee notes, invoices and receipts, duly receipted.

Once the claim has been settled, the Company returns the aforementioned originals, subject to affixing the liquidation date and the amount paid.

If the Insured has submitted to third parties the originals of the fee notes, payment lists and receipts to obtain their reimbursement, the Company makes the payment of what is due under the terms of this contract subject to submission of a copy of the certification of any costs incurred, net of what is borne by the aforementioned third parties.

For costs incurred abroad, the reimbursements are made in Italy, in Euros, at the average exchange rate of the week in which the cost was incurred by the Insured, obtained from the quotations of the Italian Exchange Office.

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