AON

S&P GLOBAL

Executives

2025

INTRODUCTION

This document is written with the intention of providing users with a reference tool relating to the current Employee Benefits programme for the Executives category.

This document is a guide to the knowledge and use of the policies and the health plan website.

Please note that this document is for information purposes only and under no circumstancesreplaces the terms and conditions of the current insurance contract.

Life

Coverage scope

The insurance provides for the payment of a lump sum to claimants in the event of:

- Death due to sickness

As this is a company cover, the indemnity is only payable if the insured is still employed at the time of death.

Insured Sum

The insured capital is equal to 2 times the basic salary
Free cover limit €600,000

Beneficiaries

The benefit is attributed to the legitimate and/or testamentary heirs of the insured person.

Territorial limits

The insurance applies worldwide.

Main exclusions

Deaths resulting directly or indirectly from:

- Fraud on the part of the Policyholder or Beneficiary
- Active participation of the insured in malicious acts
- Active participation by the insured in acts of war, declared or undeclared, civil war, acts of terrorism. Revolution, popular uprising or any military operation; coverage is excluded if the insured did not actively participate in acts of war, declared or undeclared, and the death occurs after 14 days from the beginning of the hostilities if and insofar as the insured was already in the territory of the event; the existence of a war situation and similar in a country at the time of the insured's arrival implies the exclusion of insurance coverage.
- Flight accidents if the insured person is travelling in an aircraft that is not authorised to fly or with a pilot who does not hold a suitable licence, and in any case if he/she is travelling as a crew member;
- Suicide, if it occurs in the first year of the insurance taking effect;
- Non-therapeutic use of drugs or drug abuse or acute or chronic alcoholism.

All group members over 75 years of age cannot be included in the insurance

What to do in the event of a claim

Contact Aon at:
Aon Spa
Health & Benefits Division
V. Calindri, 6 - 20143 - Milan Ms
Gloria Lorenzi
Tel 02/45434.086
Gloria.lorenzi@aon.it

who will respond by asking for the documentation needed to liquidate the capital, which generically could be as follows:

- Death certificate issued by the municipality;
- Medical certificate on the cause of death;
- Original family status;
- Notarial deed showing the legal heirs. The full name, age, marital status and capacity to act of each of them must be indicated
- Possible separation judgment;
- If there are minors among the legitimate heirs, a decree of the Tutelary Judge ordering the use of the share allocated to them, with release from any liability of the
- Company on the manner of reuse;
- If applicable certificate of non-pregnancy of the widow.

The Claims Department will handle the file:

- requesting relevant information or documentation;
- informing the Beneficiary of developments;
- providing advice and suggesting the most appropriate interventions for a successful conclusion of the file.

Accident

Coverage scope

The plan provides 24 hours coverage for occupational and non occupational accident. The coverage pays a lump sum both in case of death and permanent disability.

Accident means an event due to accidental, violent and external cause, objectively ascertainable that produces bodily injuries which have to result in death or permanent disability (partial or total).

Insured sum

- Death Case: 5 times the gross annual salary with a maximum of € 3,500,000
- Permanent Disability: 6 times the gross annual salary with a maximum of € 4,000,000

The indemnity is calculated in proportion to the degree of permanent disability.

For the payment of benefits, the injured person's ' annual salary' is considered to be that received during the 12 months preceding the month in which the accident occurred.

Beneficiaries

In the event of disability the employee, in the event of death the legal and/or testamentary heirs.

Deductibles

No deductible.

Age limits

The Accidental Death and Permanent Invalidity Insurance is valid for all Insured Persons who have not yet reached 86 (eighty-six) years of age.

Main exclusions

They are excluded:

- ✓ Accidents resulting from acts of terrorism when the Insured participated in them actively.
- ✓ Accidents suffered by the Insured Person in a state of sudden illness or unconsciousness when resulting from an established chronic illness that has resulted in serious and/or permanent disability.
- ✓ Accidents resulting from the driving of any motor vehicle or vessel, if the Insured Person is driving without a suitable and valid licence or is in a state of alcohol or psychotropic drug abuse or has taken hallucinogenic drugs for nontherapeutic use.
- ✓ Attempted or consummated suicide, acts of self-harm;
- ✓ AIDS, HIV; Congenital abnormalities or physical defects that medical literature indicates are among the direct causes of one of the critical illnesses covered by the guarantee;
- ✓ Failure to consult or disregard professional advice from a licensed medical specialist;
- ✓ Any pre-existing condition;
- ✓ Events caused by the use of psychotropic drugs or t h e non-therapeutic use of narcotics and hallucinogens.

Prescription terms

The rights of the Insured towards Insurers will expire 2 years after the claim date; the prescription term will be interrupted when the Insured claims a reimbursement included in policy conditions.

What to do in the event of a claim

Fill in the 'INJURY ACCIDENT REPORT' form with a clear and concise indication of how the accident occurred, attaching the following documentation:

- ✓ medical certificates on the course of injuries and/or first aid
- ✓ definitive medical certificate and/or medico-legal expertise (upon definitive recovery)
- ✓ copy of full medical file (in case of hospitalisation)
- ✓ copy of driving licence (in case of road accident as driver)

Send the form to Aon at the address below:

Spa
Health & Benefits Division
V. Calindri, 6 – 20143 – Milano
Sig.ra Gloria Lorenzi

Spett. le Aon S.p.A.
Via Calindri,6 Milano
CAP 20143

DENUNCIA DI SINISTRO INFORTUNI

Claim specialist: *Gloria Lorenzi*
Send via e-mail: Gloria.lorenzi@aon.it
Phone + 39 0245434.086
Claims Department Employee Benefits

Employer	
Last name and name	
Fiscal code	
Date and place of birth	
Address	
E-mail address	
Phone number	
Category	
CBA	
Place of work	

☐ OCCUPATIONAL
☐ NON - OCCUPATIONAL

Date and place of the event	
Description of the accident	

DOCUMENTATION TO ATTACH

o certificate issued by the emergency room
o reports of initial instrumental examinations performed
o copy of driving licence (in the event of a road accident as driver)

We ask you to access the following link in order to read the information notice and give your privacy consent:

https://aon-privacy.my.onetrust.com/hosted-webform/consent/3f996699-ab81-49df-b284-e640e5fe59d5/9f0ed5ce-ecf9-484b-ae90-e6cf01bf32d1

Date…… Signature of Employee.....

Medical Plan

Coverage Scope

The plan covers the reimbursement of medical expenses due to accident or sickness, for insurance covers specified in the benefit schedule.

Beneficiaries

The coverage is extended to Insured family:

- Employee;
- Cohabiting more uxorio;
- Cohabiting and non-cohabiting tax dependent children of the employee and the cohabiting partner.

Persons in temporary pre-adoptive foster care with an express order of direct assignment from the Tutelary Judge to the Employee shall be considered equivalent to children. Included in the cover without any age limit are children who are fiscally dependent according to the relevant laws in force, and who, due to physical or mental infirmity, are absolutely and permanently unable to devote themselves to gainful employment.

Territorial limits

Insurance applies worldwide, 24 hours a day

Main Exclusions

Cover does not include expenses incurred for:

- ✓ Routine checks and/or check-ups, except as provided for in section "Preventive Medicine
- ✓ Direct consequences of accidents, illnesses, malformations, and pathological states that gave rise to treatment or examinations or diagnoses, prior to the stipulation of the agreement, which were fraudulently concealed at the time the cover was signed. This exclusion does not apply with respect to Assisted Persons previously covered by other health coverage for whom benefits are operative without interruption with the effectiveness of this agreement
- ✓ Admission to unauthorised facilities or fees of unauthorised practitioners
- ✓ Psychotherapeutic treatments unless necessary as a result of injury or oncological/infirmative diseases
- ✓ Treatment of intoxications resulting from alcohol abuse, use of hallucinogens, nontherapeutic use of psychotropic drugs or narcotics
- ✓ Benefits for aesthetic purposes (with the exception of reconstructive plastic surgery necessitated by an indemnifiable neoplasm or accident), slimming and phytotherapeutic
- ✓ Physical defects or congenital malformations pre-existing at the commencement of cover(the exclusion does not apply to births under contract, if the cover includes them)
- ✓ Therapeutic and/or surgical services aimed at sex change
- ✓ H.I.V. seropositivity
- ✓ Accidents resulting from being drunk or under t h e influence of hallucinogens, narcotics or psychotropic drugs taken for non-therapeutic purposes
- ✓ Admissions made necessary solely by the Insured Person's state of non-self-sufficiency and/or long-term care
- ✓ Non-therapeutic voluntary abortion
- ✓ Accidents occurring during the practice of air sports in general, participation in motor races - other than pure regularity races - and related trials, as well as from the practice of motoring and motorcycling during free access to circuits; mental illness, psychic disorders in general (including neurotic illnesses, anxious and/or depressive syndromes, those attributable to nervous breakdown), acts of self-harm(including attempted suicide), manic depression, eating disorders, personality disorders and their consequences; psychotherapy and psychoanalysis; unless foreseen in the reference limit/guarantee sheet
- ✓ Purchase, rental, repair and maintenance of prosthetic or medical devices (except as provided for in the General Policy Conditions)
- ✓ Occupational diseases under Presidential Decree No. 336/94 and subsequent amendments and supplements

- ✓ Cures and therapies carried out with the use of stem cells, which have not passed the clinical trial stages, except in cases ordered by the Judicial Authority
- ✓ Therapies and treatments not covered by protocols recognised by the World Health Organisation
- ✓ Refractive surgery and excimer laser treatments unless they are performed :
  - In the case of anisometropia greater than three dioptres
  - In the case of visual impairment of 5 dioptres or more in each eye

Consequences of :

- Malicious acts committed or attempted by the Insured
- Participation in undertakings of an exceptional nature (exploratory or Arctic, Himalayan or Andean expeditions, ocean races, extreme skiing and the like)
- Acts of recklessness performed not out of human solidarity or selfdefence)
- Energy transformations or settlements of the atom (natural or caused) and accelerations of atomic particles, except those suffered as a patient for radiotherapeutic applications)
- Wars and insurrections; volcanic movements and eruptions in Italy, the Republic of San Marino, the Vatican State

Warranties scheme – TOP UP to FONDO FASDAC

WARRANTIES	MAXIMUM LIMIT PER FAMILY/YEAR Deductibles/Co-payments
Hospitalization with or without surgery: ▪ Fees of health professionals (medical and non-medical); ▪ Operating room fees and operating material, including endoprostheses and the like applied during surgery; ▪ Hospitality fees ; ▪ Accompanying person's fee (in case there is no hospital availability, in a hotel with a limit of € 50 per day max. 30 days); ▪ Medical and nursing services, medical consultations, physiotherapy and rehabilitation treatments, medicines, vaccines, examinations and diagnostic tests; This includes expenses incurred in the 90 days preceding and 90 days following hospitalisation,surgery or caesarean section, provided they are related to the event in question; specialist visits and diagnostic tests	**€ 1.000.000** **In network** **€ 500.000** **Out of network**
Parto naturale	**€ 7000**
Oncological care Out-patient therapies related to oncological and/or neoplastic diseases (such as, but not limited to: full courses of radiotherapy, chemotherapy, cobalt therapy and the like) including medically prescribed drugs.	**€ 6.000**
Transport by ambulance, plane or train	**€ 800 in Italy** **€ 1.600 abroad**
Substitute Daily Benefit	**125 € max 300dd – 200 € in case of childbirth**
Non-Hospitalization **High Diagnostics** Dialysis, Electrocardiography, Nuclear Magnetic Resonance Imaging, Echocardiography, Cobalt Therapy, Echocolordoppler, Electroencephalography, Scintigraphy, Urography, Echography, Coronarography, T.A.C., Bronchography, Endoscopy, Radionephrogram, Angiography, Phlebography, Artography Electrocardiography, Mammography, Colonoscopy, Cystography, Myelography. **Pregnancy** Amniocentesis, amnioscopy, chorionic villus biopsy, cardiocentesis, fetoscopy, specialist examinations, laboratory tests, diagnostic tests	**€ 7.000**
Specialist fees Medical fees, provided that the specialists are duly registered in the medical register ; ▪ Physiotherapeutic rehabilitation treatments, osteopathic treatments provided they are carried out by an osteopathic physician, chiropractic treatments provided they are carried out by a chiropractor registered with the Italian Chiropractic Association; ▪ Diagnostic Assessments ; ▪ Spa treatment, all-inclusive daily allowance par € 80 max. 20 days ▪ Application of plaster casts or equivalent braces ; ▪ Homeopathic treatment: the cover includes outpatient visits and examinations including	**€ 2.500**

medicines (max. € 150 per year/household). ▪ Nursing care This includes pool therapy sessions for children up to 10 years of age following dyslexia, • dyscalculia, autism, Touretta disorder (€ 500) Assistenza infermieristica Sono comprese le sedute piscoterapiche per bambini fino a 10 anni a seguito di dislessia, discalculia, autismo, disturbo di Touretta (€ 500)	
Preventive care (Only for employee) - Laboratory examinations (venous sampling, ALT, AST, gamma GT, blood glucose, total cholesterol, HDL, triglycerides, urea, creatinine, partial prothrombin time, PTP, total prothrombin time PTT, ESR, urine examination) ; - Resting and exercise electrocardiogram ; - Chest X-ray ; - PSA for men ; - Pap test and mammography for women.	**They must be done in a single payment at a affiliated facility once a year, either directly or reimbursed. (100% reimbursement)**
Dental care Dental treatment/visits/therapies (also related to periodontal disease); extractions, dentures, orthodontic appliances/therapies, dental hygiene (tartar ablation, once a year)	**€ 3.000**
Lenses Including contact lenses, but excluding frames following a change in visual acuity certified by an optician/optometrist. Including eye replacement prostheses	**€ 1.000 per person**
Prosthetics Orthopaedic and hearing aids, braces and the like (including orthopaedic insoles), orthopaedic wheelchairs and the hire of haemodialysis equipment	**€ 1.500**
Infertility treatment, to be understood as infertility investigations and medical practices aimed at artificial insemination	**€ 2.000**
Psychotherapeutic care	**€ 500**
Reimbursement of expenses for transporting the body from abroad	**€ 1.500**

Sublimits

Hospitalization Guarantee

The hospitalisation cover also includes natural childbirth.
Only benefits during the period of hospitalisation are provided, such as: hospital fees, diagnostic tests, medical and nursing care, specialist and non-specialist care, medicines Non caesarean section: € 7,000

Specialist visits

This includes pool therapy sessions for children up to 10 years of age following dyslexia, dyscalculia, autism, Touretta disorder € 500

Co-payments and deductibles

Insured covered by the funds
For guarantees not provided by the fund or in the event of non-utilisation of the fund by of the Insured:
Hospitalization : No deductible/co-payments
Lenses : 20% deductible with a minimum of € 50
Other warranties : 25% deductible

Insured not covered by the funds
Hospitalization : No deductible/co-payments
Pregnancy : Co-payment 20% with a minimum of € 55
High diagnostics : 20% Co-payment with a minimum of €50
Specialists : 20% Co-payment with a minimum of €50
Dental treatment: 20% Co-payment with a minimum of € 100
Lenses: co-payment 20% with a minimum of € 50

Direct Payments

In the case of the use of health facilities and doctors both affiliated with OneNet, the Insured must contact - with at least 3 working days' notice (raised to 5 working days for hospitalisation) before the date of hospitalisation or provision of the service
Since agreements with surgeons and healthcare facilities may change over time, it is essential - in order to obtain the service in direct form - that the insured person has access to the affiliated healthcare facilities and surgeons, in the absence of which the service does not operate.
At the time of access to the healthcare facility, the Insured Person shall make himself known and sign the "request for benefits", which constitutes the first report of the claim.
At the time of discharge, the Insured Person shall bear any expenses for which he/she is responsible himself/herself (uncovered, deductible, benefits not covered by the guarantee).

“Convenzionamento Misto“

If the Insured uses doctors who are not affiliated to a contracted medical facility, OneNet will pay the medical facility directly (subject to the provisions of the previous point), while the Insured must pay the expenses relating to the payment of the medical-surgical team, which will be reimbursed in accordance with the rules set out in the following point and subject to the application of the deductibles/ deductibles provided for in the Cover Options.

The mixed-form settlement referred to in this point shall not apply to out-patient services.
In the event that the Insurant uses non-contracted doctors at a contracted healthcare facility, the expenses incurred, both for the doctors and the facility, shall be reimbursed in accordance with the provisions for non-contracted doctors.

Refunds

Without prejudice to the provisions of Articles 1910 (insurance with different insurers), 1915 (breach of duty to warn or rescue) and 2952 (statute of limitations on insurance) of the Civil Code, the Insured must - once the service has been rendered - send a report to OneCare, to which the medical and expense documentation must be attached.
In particular, the Insured must provide OneCare with:

- copy of complete medical records, results of diagnostic tests, medical prescriptions,therapies and treatments, with relevant diagnoses;
- copies of tax-registered and receipted invoices and cost statements,
-

The reimbursement of expenses incurred abroad in currencies other than the euro will be made by applying the exchange rate against the euro, as recorded by the European Central Bank and deduced from the publications in the main economic newspapers with national circulation or, failing this, the exchange rate against the US dollar.
Reimbursement will be made at the average exchange rate of the week in which the expenditure was incurred.
The diagnosis of the pathology must always be provided, on pain of forfeiture of the right to compensation, in relation to out-patient services (with the exception of preventive medicine).
In any event, the cost of any revenue stamps shall be borne by the Insured.
affixed to expenditure invoices.

If the policy has been activated by the Policyholder on a first risk basis and the Insurant obtains reimbursement of the expenses incurred through other insurance cover, the Insurer shall guarantee the reimbursement of the excess expenses incurred, provided that the insured party is eligible for reimbursement under the terms of the policy, within the maximum limit and subject to the application of the deductibles/ deductibles - to be applied
to the excess expenses for which reimbursement is requested - as per the chosen Cover Option. To this end, the Insured Person shall submit the claim accompanied by medical and expense documentation with evidence of the amounts already paid by another Institution in favour of the Insured Person.

Vademecum of Key Benefits

Admission - expenses for admission must be submitted with a complete medical record (the administrative costs of which are not reimbursable) and all expenses related to admission prior to 30 days from the date of admission and after 120 days from the date of discharge are reimbursable (i.e. without deductible). Hospitalisation for check-ups **is not covered**. The benefit is convertible into a daily allowance if ALL EXPENSES DURING HOSPITALISATION are paid by the National Health Service and in an overnight stay;

Pregnancy and natural childbirth - pregnancy-related expenses, if subject to a specific ceiling, must be submitted in a lump sum (in order to avoid double application of the deductible) and accompanied by a certificate of pregnancy status;

Caesarean section - subject to the same rules as hospitalisation;

Specialist examinations - specialist examinations are specialist examinations if they are carried out by a specialist doctor. The doctor must therefore have completed, in addition to a degree in medicine and surgery, the specialisation that follows the degree course and ends with the award of a specialisation diploma (orthopaedics, gynaecology, otorhinolaryngology, etc.).
These expenses are recognised:
if prescribed by a doctor (even a general practitioner, e.g. a general practitioner) with an indication of the pathology certain and/or presumed; if the certain/presumed pathology is indicated on the invoice issued by the specialist;

Laboratory examinations, diagnostic tests - these expenses must be prescribed by a doctor (including the treating doctor) and accompanied by a medical prescription indicating certain and/or presumed pathology. The prescription for blood tests must be detailed and contain the pathology certain and/or presumed;

Dentistry - dental expenses are indemnified without the need for a prescription, but must be detailed with individual amounts per service. Expenses for oral hygiene and preventive dentistry are not indemnifiable;

Physiotherapy - services must be performed in specialised medical centres or by freelancers provided that they are performed by registered physiotherapists, a copy of whose diploma is requested. It is not necessary for the practitioner to be a doctor, but it is indispensable that he or she has a diploma as a physiotherapist (also abroad as long as it is recognized in Italy). The therapies must be prescribed by a specialist doctor (orthopaedist and/or physiatrist) and the prescription must indicate the diagnosis that makes it necessary to use a physiotherapist;

Speech therapy - speech therapy treatments are regulated in the same way as physiotherapy treatments. The speech therapist must hold a recognised diploma. Expenses related to "mental" illnesses are not eligible for reimbursement, only those related to physical defects. Every related to the mental sphere is excluded from the policy;

Acupuncture - expenses are only reimbursable for services performed by a specialised doctor (e.g. orthopaedist...), as specialisation in acupuncture is not recognised in Italy. The
therapy prescription indicating the certain or presumed pathology is indispensable.
Lenses - in order to obtain compensation for lenses (excluding the cost of frames, which are not indemnifiable), it is essential to enclose the visus change issued by an ophthalmologist or optometrist. Contact lenses are subject to the same rules as traditional lenses, so they will be indemnified if accompanied by a prescription relating to the change in visus;
Supplementary form-All expenses submitted for reimbursement of expenses not recognised by the institution must be accompanied by a doctor's prescription attesting to a certain and/or presumed pathology.
Claim forms must be accompanied by:

- copy of reimbursement letter from the institution;
- copies of individual invoices not recognised (if included in the policy
- guarantees);
- copies of invoices recognised only in part (invoices paid in full need not beattached);
- copy of performance prescriptions;
-

The limitation period for the right to compensation, in cases where reimbursement is made in supplementary form, runs from the date of the relevant invoice/receipt(two years);

Drugs - drugs are only included following hospitalisation with or without surgery, in the 120 days following and related to the surgery;

It is important to remember that:
Certifications - expenses relating to certificates for insurance use, licence renewal, sports use
or any other type of certification **are not indemnifiable**.
Prescription of the right to compensation - the limitation period (two years pursuant to Article 2952 of the Civil Code as amended by Article 3 - Law 166 of 27 October 2008) runs from the day on which the expense was incurred.
If there are several invoices relating to the same pathology/service, the reference date will be the date indicated on the first invoice issued.

Deductibles - deductibles are applied per policy year (effective date and expiry date of the contract) per individual patient, per pathology, and per individual type of expense (specialist, high diagnostic, dental, etc.). The expenses of the same person who undergoes several visits for the same pathology shall be burdened by a single deductible;

Physiological states (menopause, andropause, post-partum, etc.) - expenses relating to physiological states related to the nature of the subject and therefore without the character of pathology, are not indemnifiable. However, expenses incurred for pathologies caused by physiological states are indemnifiable;

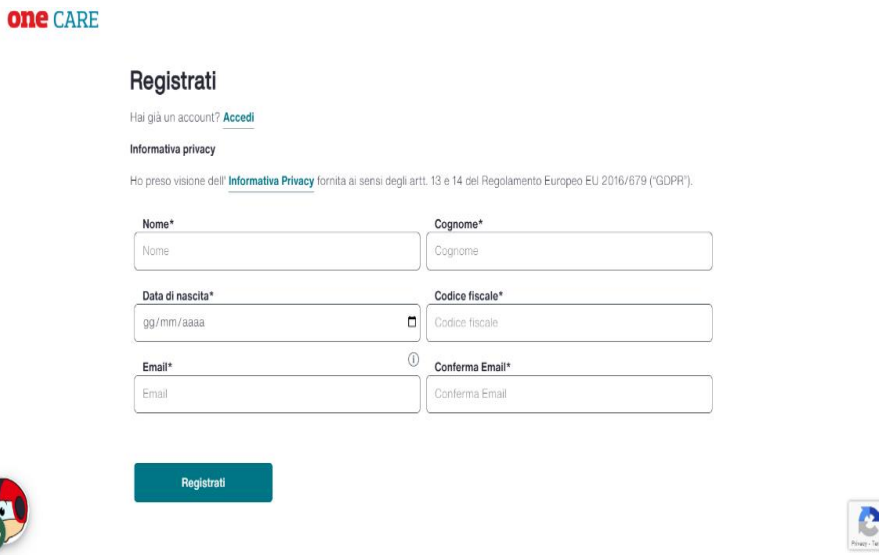
It is understood that the foregoing is merely a vademecum for understanding the manner in which expenses are to be submitted and does not form an integral part of the contract or in any way replace its contents.

OneCare

User manual

Registration

The caregiver through the ONEcare® portal, https://www.onecare.aon.it/ will be directed directly to the Registration/Login page.



If the user is not already registered, he/she can do so through the “REGISTER” function by entering his/her master data and submitting the registration request. It is necessary to enter the e-mail address provided at the service activation request.

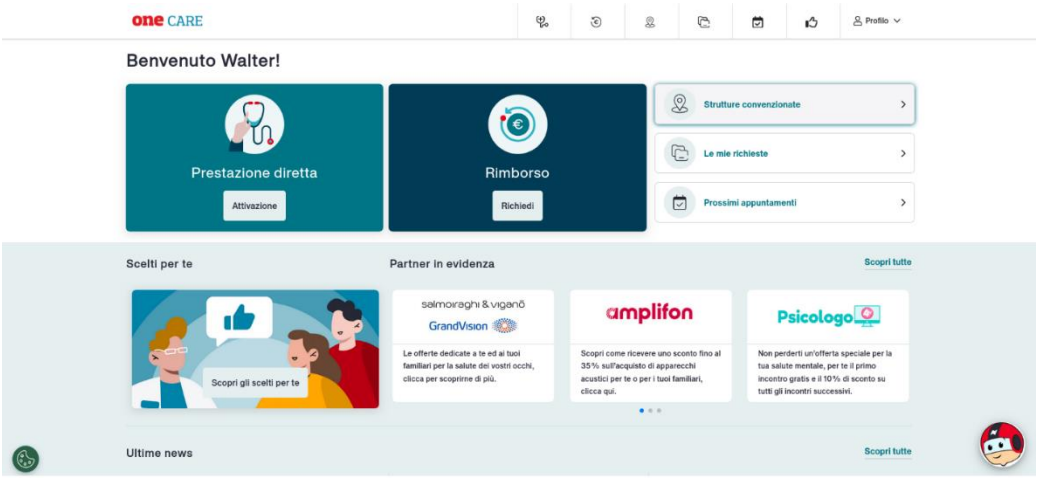
Then the assisted person will receive a communication containing the Ticket Number that must be entered on the “Account Activation” page, which is accessed directly from the link indicated in the e-mail. At this point he will receive two e-mails: in the first the username and in the second the password.

After entering the temporary credentials you will be asked to change your password. You are also advised that a guide with instructions for registration is available on the portal.

Homepage

From the homepage it will be possible to:

- Apply for a direct medical service by choosing from contracted facilities
- Enter a claim for a medical service
- View a map of contracted facilities
- Check the status of requests for direct agreement or reimbursement
- Consult the list of reservations made
- Consult tips on services, featured facilities and news



Assisted profile

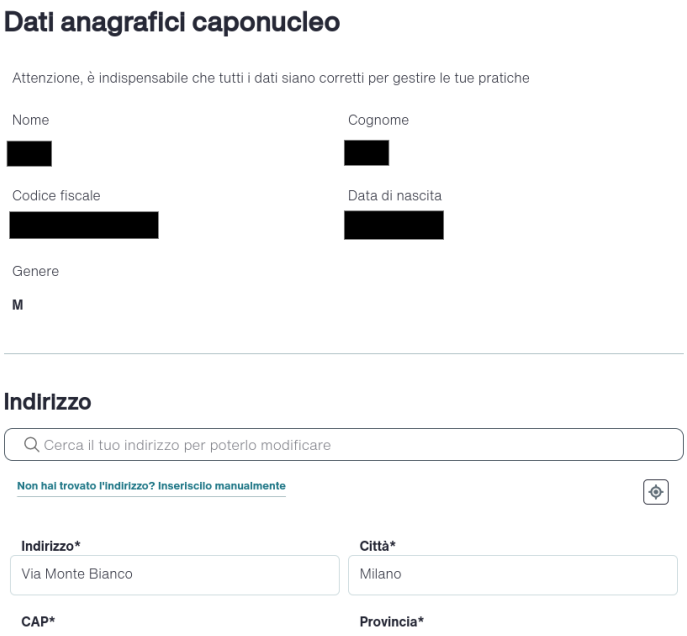
From the homepage, at the top right, the Profile menu can be accessed, which contains, among others, the following sections:

- My Registry
- My health plan

My biography

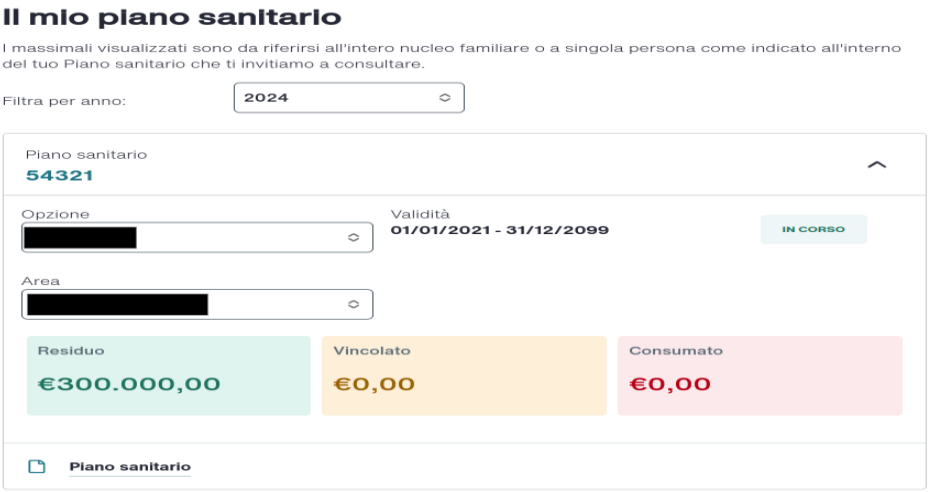
By clicking on “My Master Data” you can check, enter, and if necessary modify, according to the settings defined on your OneCare account, your master data: First Name, Last Name, Social

Security Number, date of birth, gender, address, contact information and bank details.



My health plan

The “My Health Plan” section displays a list of active and expired health plans that can be filtered by year .



For each health plan in your insurance coverage, you can view the relevant options and corresponding areas, each with its own maximum amounts.

For each selected area, you can view the corresponding ceiling values:

- Residual;

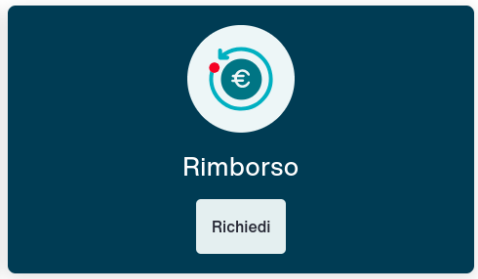
- Bound;

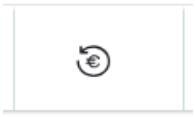
- Consumed.

In the section, if any, documents related to one's health plan can also be viewed and downloaded.

Request for reimbursement

To request reimbursement for a medical expense, click on the “Request Reimbursement” box or the corresponding icon in the header portion of the portal

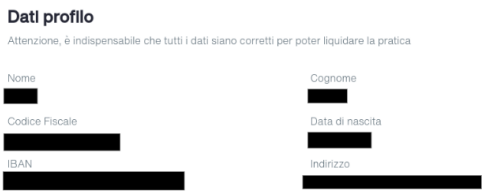




Introductory page

In the Claim a Reimbursement section you can enter reimbursements for yourself and your household, to do so you need to:

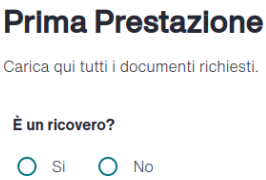
1. Be in possession of the required documentation: expense/medical records
2. That all biographical data are complete
3. Agree to the privacy clauses, if not already accepted
4. Select the patient who performed the service for which reimbursement is requested



Benefit insertion

Within a claim, multiple services can be entered for the same person, for the same condition, each with its own expense documents.

For each benefit, the first step is always the choice between Hospitalization YES / NO. With this choice, you indicate whether the benefit for which you are claiming reimbursement is a hospitalization or a medical service (e.g., an examination).

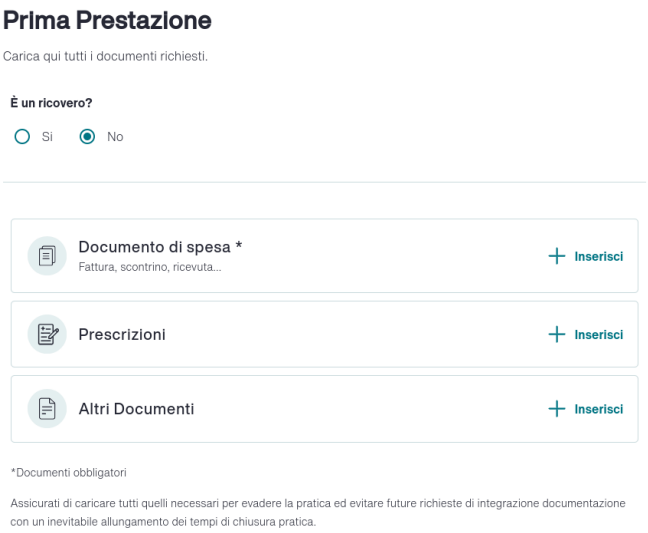


In case of Hospitalization NO the list of documents to be uploaded is displayed, which are:

- Expense document (mandatory)

- Medical prescription (if required by the health plan)

- Other documents



In case of Hospitalization YES the inclusion of the medical record is mandatory. If it is a request for Inpatient Per Diem, the inclusion of the medical record only will be mandatory, if it is a paid hospitalization, the inclusion of the expense document will also be mandatory.

Uploading documents

Clicking Insert on the “Expense Document” or “Medical Record” will open the page for uploading the expense document and related data, you will be able to enter:

- a single PDF type file (even of multiple pages)

- or a single TIFF image file (also of more than one page)

- or more than one image type file JPEG, PNG, BMP

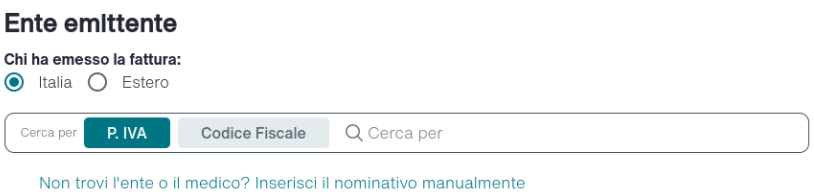
Documents larger than 15 MB in size are not allowed to be uploaded.

Issuing entity

It is required to indicate the nationality of the issuing entity, whether it is a doctor/professional or a medical clinic. The choice is between Italian/Foreign

If you choose Estero because the invoice was issued by an entity or doctor/professional operating outside of Italy, you will not need to enter additional information.

If, on the other hand, the entity is Italian, you will have to proceed to enter its name. This can be done using the appropriate search field by VAT number for facilities or Codice Fiscale for professionals.



In case the institution or doctor/professional is not present in the system, it will be possible to add it through the function “Can't find the institution or doctor? Enter the name manually” by filling in the required mandatory fields.

Expenditure document data

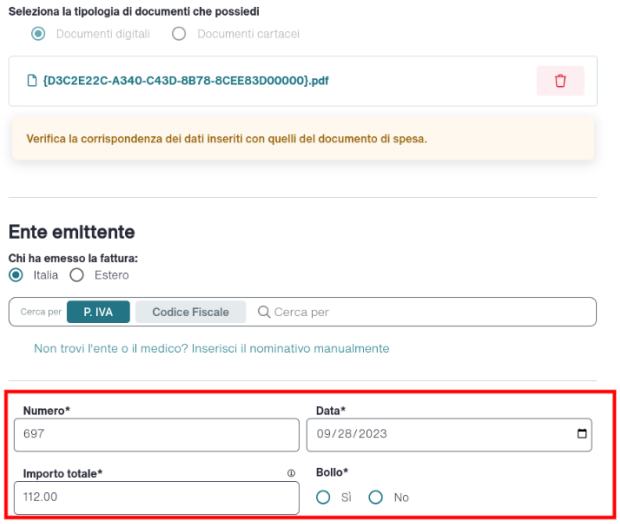
Completion of the following data is required:

- Expense document number (e.g., invoice number, receipt number, etc.).

- Date of the expense document

- Amount of the expense document (including the stamp, if it is included)

- Presence of stamp in the expense document, with YES / NO choice



In the case of digital documents, the system will intelligently attempt to automatically fill in the data listed above (excluding the vignette), reading the information from the file that has been uploaded. It is advisable, however, in the case of automatic compilation to check the data entered and, if necessary, correct and/or supplement them (if absent).

In case of entering the medical record, it will be necessary to indicate start and end date of hospitalization.

Medical prescription - Other documents

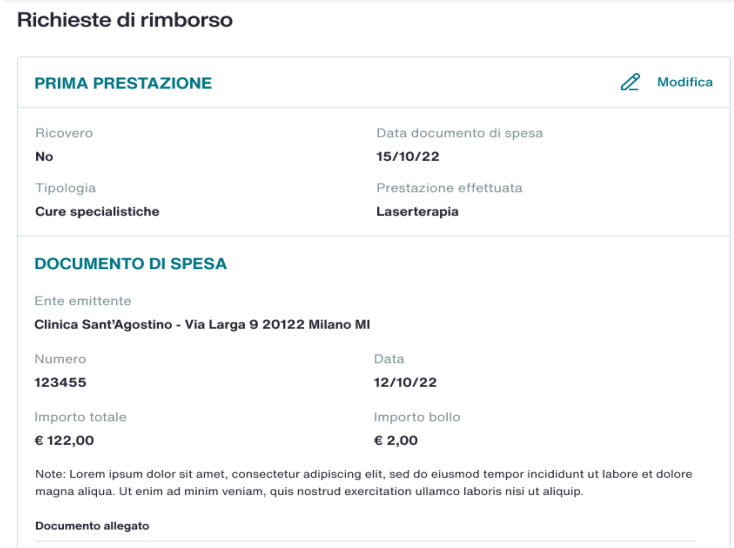
In the upload box provided, you are asked to upload any prescription or additional documentation you have. You can also upload multiple files, one at a time, in the different formats supported (PDF, TIFF, JPG, BMP, JPEG), each with a maximum size of 15MB.

Additional benefit insertion

After completing the entry of the first service, it is possible to enter other services for the same patient for the same condition by choosing YES to the question “Do you have other expense documents to upload for the same patient and the same condition?” A mini-summary of what is already entered is always shown on the left side of the page, with the option to edit it at any time (by clicking on pencil icon).

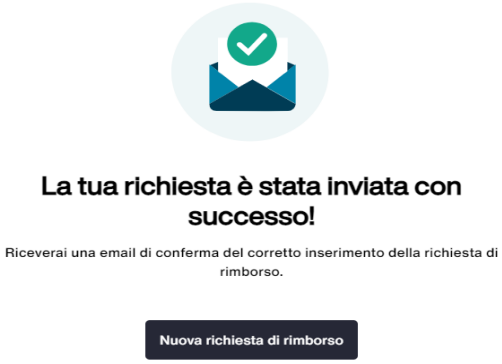
Summary and submission of request

The final summary page displays all the choices, files uploaded, and data entered that have been successfully completed up to that point.



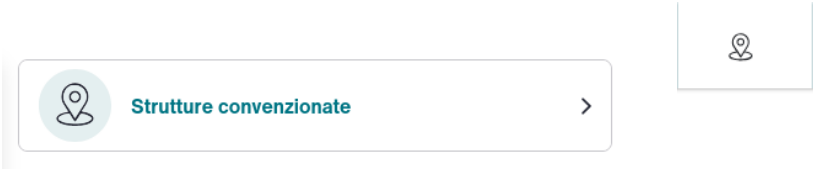
If after a data check you want to change something, you can click on the edit button next to the section containing the data to be changed and you will be taken to the specific page where you can implement the change. If everything is correct, however, you can proceed to submit the request. If

the request has been entered correctly a message that it has been sent successfully will appear.



Affiliated facilities

On the homepage, there is a link to the “Affiliated Facilities” page; the same link is also available in the header part of the portal.



Clicking on the above link or icon brings up the page with:

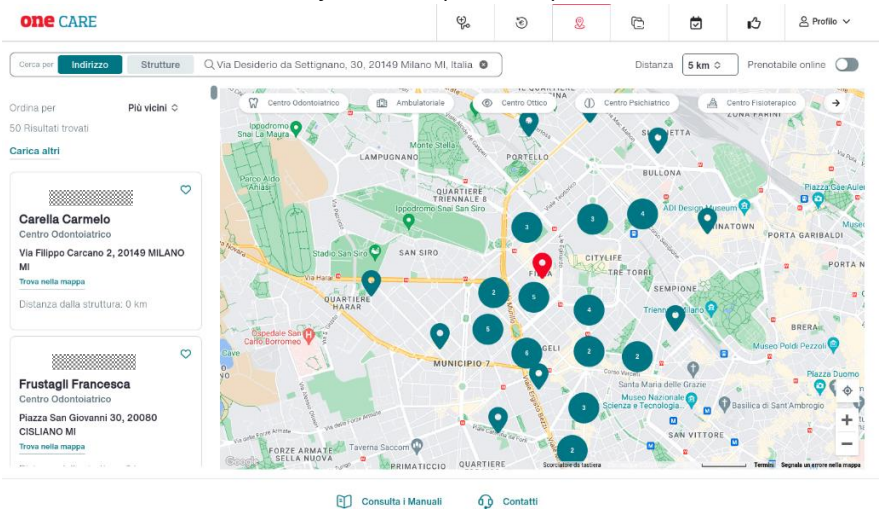
- a map containing filters by category (e.g., “Dental Center,” “Optical Center,” etc.);

- a search bar with a filter that proposes the items “address,” “facility.”

- a distance filter that proposes various distances;

- a manually activated filter “Bookable online” that provides the possibility to book directly from the portal the service with the facility, viewing their actual calendar;

- sidebar on the left that lists the facilities/doctors results of the search, sortable alphabetically from A to Z and vice versa, or by distance (“Closest”), which is the default filter.



By choosing the “Address” filter and filling it in, a list of the facilities found appears in the left sidebar, whose placeholders are shown on the map. Each search produces 50 results by default; you can increase the results by scrolling through the list or by clicking on “Load more.” Results will be increased as long as they are available, within the limits of the search input parameter (e.g., when there are no more facilities included of the set distance).

By choosing the “Facility” filter and entering the name of the facility (even partially), a list of facilities whose placemarks appear on the map appears in the left sidebar.

The facilities resulting from the search can be marked as “favorites” by clicking on the heart next to their name.

Clicking on a placeholder in the map displays summary information about the facility and a button to open its detail page.

Clicking on a facility's tab in the list on the left opens the page dedicated to the chosen facility, which contains its information (e.g. PP - pickup point only etc.). If the facility is bookable online, this information is marked in the upper right corner with a “Bookable online” badge.

Reservation request

To access Direct Arrangement, you must make a reservation for the service at one of the Health Facilities affiliated with ONEnet®.
Through the ONEnet® Network, you will be able to access the affiliated facilities, subject to authorization from the Onecare Operations Center, without advancing any amount related to the service, with the exception of any fees charged to you under the policy conditions.
Before requesting authorization from our Onecare Operations Center, the patient must book the service directly with the ONEnet® Network Health Facility. The list of affiliated facilities can be consulted within the Onecare® portal. For some facilities, the reservation can be made online directly on the portal.

Next, the Attendant must finalize the procedure by providing Aon with the information about the service booked by entering the request in the Direct Service box.

A minimum notice period of 2 working days for outpatient services, 5 working days in the case of hospitalization, is required to request a direct service.

Medical documentation indicating the prescribed service and diagnosis is required for out-of-patient services, except in cases where coverage does not provide for it (e.g., Dental Care, Preventive Medicine). In case of outpatient service, the Operation Center, after evaluating the request, in case of acceptance will send the “taking in charge” to the patient and the facility/professional, in the document will be reported the data of the appointment, the service, the amount of the invoice and any overdraft charged to the insured to be paid to the facility at the time of acceptance.

For dentistry, please note that the activation is provided for the examination and/or ablation only, if further treatment is needed, it will be the responsibility of the dental office, after having carried out the examination, to enter and send the necessary treatment plan to the OneCare Operations Center. The latter will be handled within the 10 working days from the date of receipt of the treatment plan.

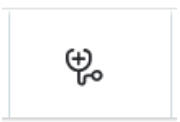
In the case of hospitalization services, in addition to the doctor's prescription indicating surgery and pathology for which it is requested, the cost estimate with the facility's AON rates and the name of the primary caregiver (doctor who will perform the surgery) must be attached. In case of urgent hospitalization, attach the certificate of urgency issued by the doctor.

In the case of hospitalization, even if urgent, the Operations Center, having concluded the preliminary investigation of the file, which includes the receipt of the internal medical evaluation and approval by the Company/Fund, will notify the outcome of the evaluation of the request by e-mail, if the evaluation is positive, it will send the “taking in charge” that will specify the services allowed and authorized, any limitations related to exclusions, deductibles and uncovered.

Please note that incidental expenses, such as telephone, bar, secretarial fees, etc., are not included in the benefits and, therefore, must be paid by the Assisted Person upon discharge from the Health Facility.

In the event that the Facility requires a modification of the intake received, it is necessary that the request for correction be sent directly by the Facility

To request activation of a direct agreement, access the “Direct Benefit” box or on the corresponding icon in the header part of the portal.



Introductory page

In the Direct Performance section, it is possible to enter a direct booking request; to do so, it is necessary to:

1. Be in possession of the required documentation: doctor's prescription with diagnosis (in case of outpatient and inpatient services) and cost estimate of the facility and name of the first practitioner (in case of inpatient)
2. That all biographical data are complete
3. Agree to the privacy clauses, if not already accepted
4. Select the patient for whom the service is requested

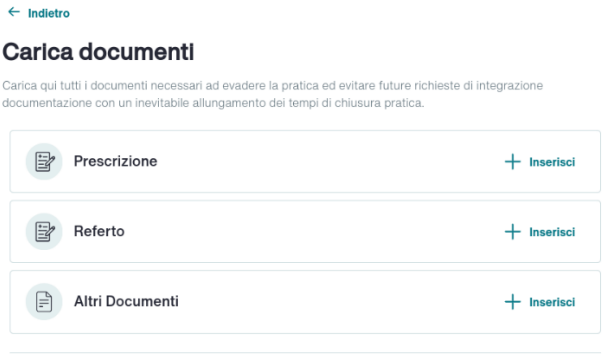
Service request entry with existing reservation

If you already have a reservation obtained directly through the medical facility, when asked “Do you have a reservation?” answer YES and fill in the reservation information.

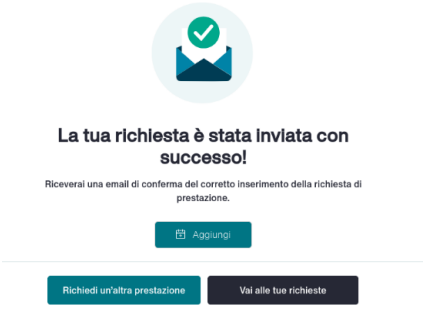
You select the facility and the service from the facility's list in the appropriate search fields. The fields work in suggestion mode, when you type, suggestions appear related to the name you are looking for. In each field you must select a result offered by the system in order to continue.

Once the facility and specific service booked have been found, the doctor/professional is requested, if listed in the reservation. In case of a reservation with a specific doctor/professional, the list of available doctors is displayed. If the doctor/professional, with whom you have the reservation, does not appear in the list of doctors, you can enter it by filling in first and last name.

After filling in the previous fields, you move on to entering the day and time of the appointment. On the next page, you can upload any documents needed to complete the request.



You enter any notes and go to the final summary page, where you can activate a reminder (e-mail notification) of the appointment. Once the request has been submitted, the outcome of the request is displayed on a confirmation page.After completing the previous fields, you move on to entering the appointment day and time. On the next page, you can upload any documents needed to complete the request.

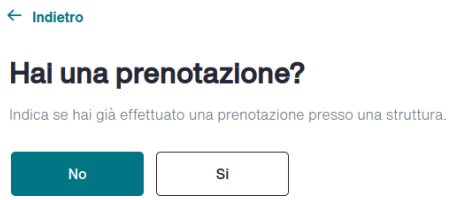


Entering a request for direct activation without a reservation made at the facility

A request to activate a direct service can only be sent when an appointment has been scheduled. However, there are some health facilities on the portal that for specific services (no hospitalizations) allow online booking from OneCare.

Please note: If online booking is not available for your chosen facility and/or for the specific service, you must make the appointment in advance through the facility's channels.

When asked “Do you have a reservation?” answer NO.



It is always necessary to indicate whether the service being claimed is an inpatient or not.

Search criterion selection

The available search criteria are:

- Search by Performance

- Search by Facility

- Search by Doctor

Search Criterion by Performance

In the search criterion by Performance, it is required to enter the type of performance and the detail performance.

Once both values are selected, clicking Proceed lands you on a map with the facilities in the network that provide the requested service. From the map, you can search and select the facility of your interest.

Search criterion by Structure

Selecting the search criterion for Structure displays a search field with active suggestions as you type in the name of the structure.

You can proceed to the next step only by choosing a result from those proposed.

If the results are not satisfactory, you can perform the advanced search using the facilities map by clicking on the “Advanced Search” link. The map works as described in the section “Affiliated Facilities.”

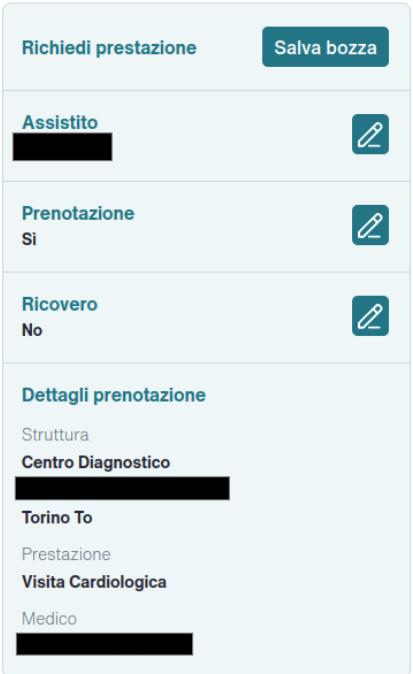
Search criterion for doctor

Selecting the search criterion for doctor displays a search field with active suggestions as you enter the name of the doctor/professional.

You can proceed to the next step only by choosing a result from those proposed.

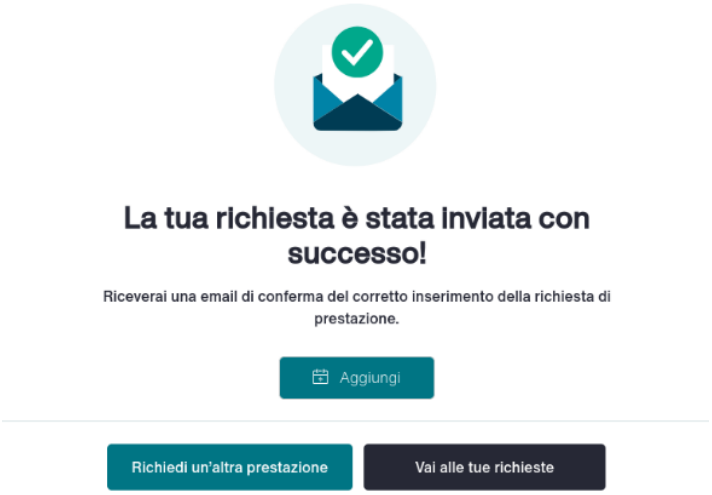
If the results are not satisfactory, one can perform the advanced search using the doctors map by clicking on the “Advanced Search” link. The map works as described in the section Affiliated Facilities.

After making an appointment with the facility and proceeding to enter the request, you will see the summary page. From the summary you can edit any data entered during the entry process, using the Edit link.



At the bottom of the summary you can activate a booking reminder by selecting how many hours in advance you want to be notified by e-mail with the reminder.

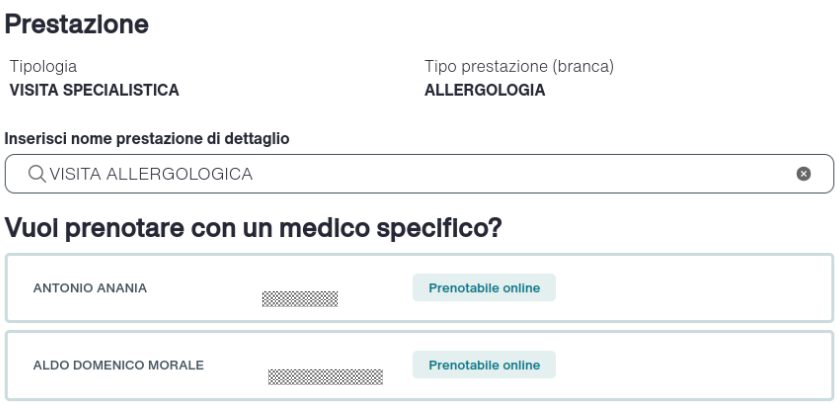
Clicking on Send reservation request, if the reservation is successful, will display a confirmation page.



Booking at a facility Bookable online

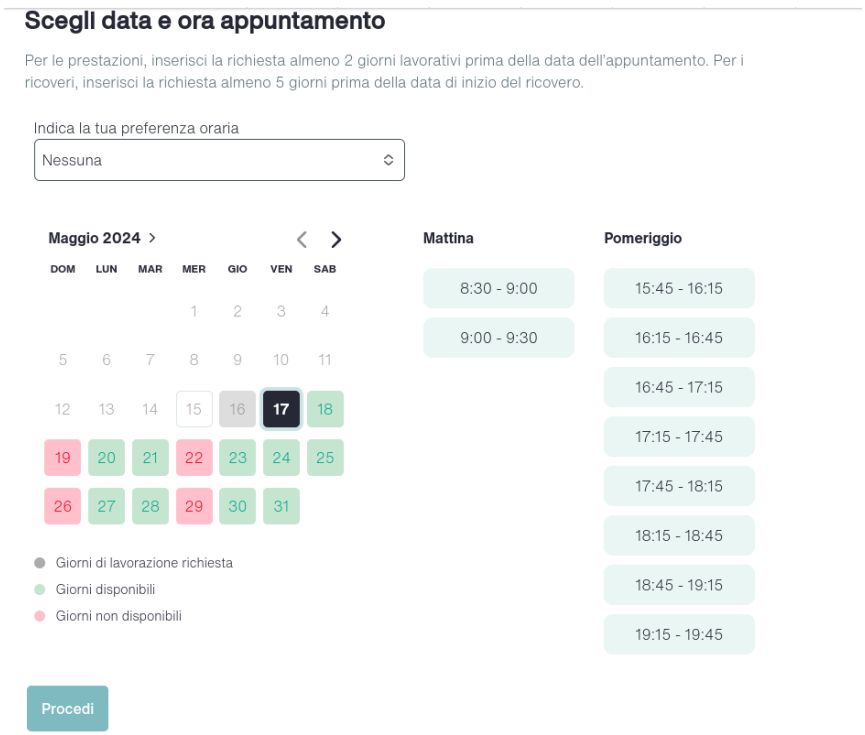
After choosing a medical facility using one of the search criteria described in the previous paragraphs, if the desired facility is bookable online, a specific service must be chosen from the facility's list of services. Based on the chosen service, a list of doctors is then presented, some of

whom may be labeled “Bookable online.”



If the doctor/professional selected from those proposed by the system does not bear the words BOOK ONLINE, it will not be possible to proceed with the online booking, and an information section will appear asking you to contact the facility directly to book the desired service.

If, on the other hand, a doctor/professional is selected from those presented by the system that carries the words “BOOK ONLINE,” a calendar will be displayed with the availability of the doctor/professional at the selected facility and for the indicated service.



Days required for processing the request (in dark gray) or those for which there is no availability (in red) cannot be selected. Clicking on green days proposes available time slots to the right of the calendar. It is possible to further filter availability by time slot to show only days when there is morning (6 a.m. to 2 p.m.) or afternoon (2 p.m. to 9 p.m.) availability. By default, all-day availability is shown.

After selecting a green (available) day and a preferred time slot, you proceed to the next page, where you can upload any documents (no documents among those listed are required), view the summary page, and activate a reminder.

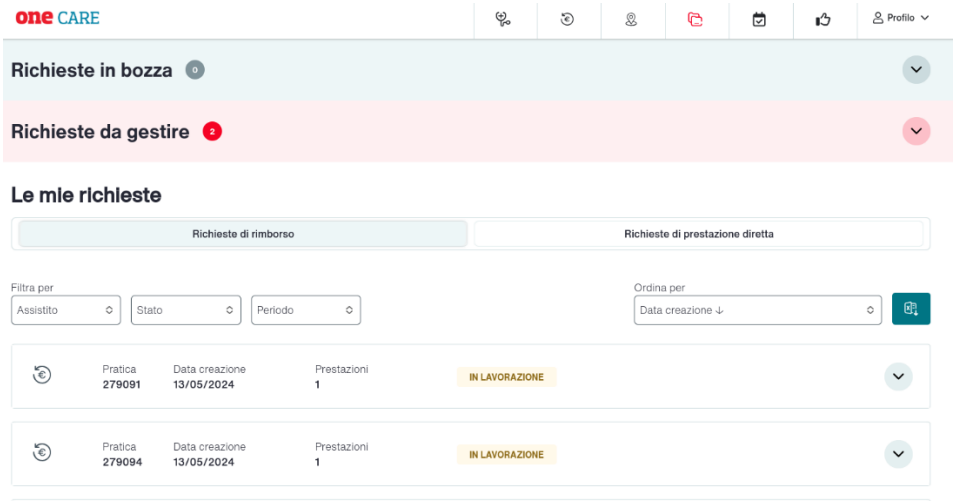
Clicking on Send reservation request, if the reservation is successful, will display a confirmation page.

My requests

There is a “My Requests” link on the homepage or among the service icons on the navigation bar at the top of all pages.

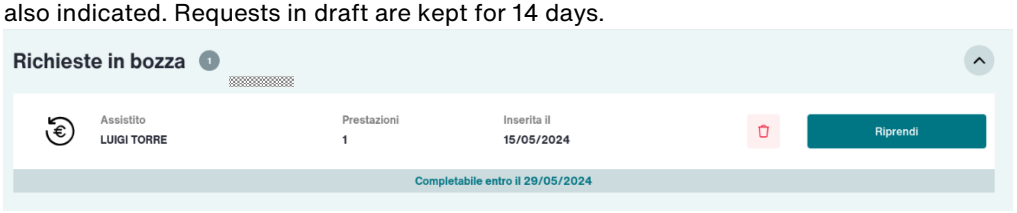
Clicking on the “My Requests” link takes you to a page divided into 3 sections:

- Requests in draft;
- Requests to be handled.
- My requests for reimbursement and/or direct service



Draft Requests

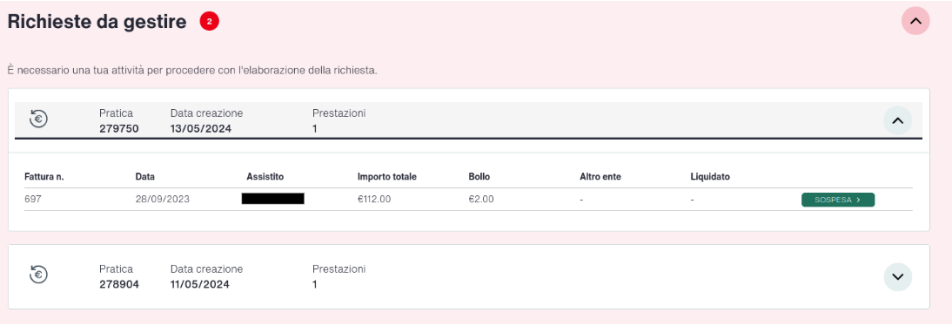
Contains all requests saved as drafts through the “Save Draft” feature. A draft can be deleted or retrieved for completion. The date until which the request is kept in draft and can be completed is also indicated. Requests in draft are kept for 14 days.



Requests to be handled

Contains all requests for which user action is required in order to continue the claim or direct benefit request process.

To be able to manage the claim, you must expand the box with the up and right arrow and click on the claim detail status. You will land on the detail page where the directions needed to unlock the claim (e.g., uploading additional documentation) are provided.



My requests

Contains all claims, both reimbursement and direct benefit, depending on which service is enabled on the account.

In “Reimbursement Requests” you can view all reimbursement requests, which can be in status:

- Open

- In process

- Closed

Each claim can contain multiple rows, each representing a service for which reimbursement has been requested, and for which an expense or hospitalization document has been submitted. Each row has its own information and status, which can take the following values:

- Entered the request has been entered into the system and is waiting to be processed

- Denied the request does not meet contract terms so it cannot be cleared

- Suspended the request is incomplete, awaiting additional documentation

- Processing the request has been taken in and is being handled by the claims office

- Settled the claim has been processed and placed in settlement

Selecting the status displays detailed information about the claim.

Search filters can be applied for Attendant, Status, and Date, either separately or together.

Any change in the status of claims is notified by a statement to the census e-mail address.

In “Benefit Requests” you can view all benefit requests, which can be in status:

- Open

- In process

- Managed

Each request can contain multiple rows, each of which has its own information and status, which can take the following values:

- Pending Authorization the Operations Center has received the documentation to be evaluated and processed

- Reservation confirmed the Ops Center has received the request for direct agreement and will need to verify that it has all the necessary data and documents to evaluate and process

- Direct authorized the Operations Center has authorized the service requested

- Directed in processing the Operation Center has taken over the direct agreement request to be processed and evaluated

- Direct denied Central Operations has denied the direct agreement request

- Direct canceled the Operation Center has canceled the request

Selecting the status displays the detailed information of the request.

Contacts

For any needs, problems or requests for information and assistance, the Customer Care Customer Care dal lunedì al venerdì dalle 9.00 alle 18.00.

Phone number: **02.45422617**

E-mail support requests: **info.onecare.isa@aon.it**

Direct convention reservations: **prenotazioni.onecare@aon.it**

NOA: LiveChat! active in service hours (Monday to Friday from 09:00 to 18:00) and ChatBot active 24h/24h

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Published by Aon S.p.A.