CASER SALUD PRESTIGIO

Combined Healthcare and Expenses Reimbursement Insurance

General Conditions

CAJA DE SEGUROS REUNIDOS

Compañía de Seguros y Reaseguros, S.A.

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Pursuant to that established under Article 3, Law 50/80, dated 8 October, the Insurance Contract Act [*Ley de Contrato de Seguro*], the clauses limiting the rights of the Insured Parties contained in the General Conditions of the Policy are highlighted in bold print.

This contract is subject to Law 50/1980, dated 8 October, the Insurance Contract Act; Royal Legislative Decree 6/2004, dated 29 October, which approved the Redrafted text of the Spanish Private Insurance Classification and Supervision Act [*Texto Refundido de la Ley de Ordenación y Supervisión de los Seguros Privados*] and its implementation regulations.

Control of insurance activities corresponds to the Spanish Ministry of the Treasury, through its Department of Insurance and Pension Funds [*Dirección General de Seguros y Fondos de Pensiones*].

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GENERAL CONDITIONS

PREAMBLE

This insurance contract is governed by that established under Law 50/1980, dated 8 October, the Insurance Contract Act (published in the Official Gazette on 17 October 1980), by Royal Legislative Decree 6/2004, dated 29 October, which approved the Redrafted Text of the Spanish Private Insurance Classification and Supervision Act and its implementation regulations (Royal Decree No. 2486/98, dated 20 November), and by the General, Specific and Special Conditions of this contract. The control of insurance activities in Spanish territory corresponds to the Spanish Ministry of the Treasury, through its Department of Insurance and Pension Funds.

The Policyholder, upon signing the application, the Specific Conditions or, as appropriate, the Insurance Certificate, specifically accepts the clauses limiting the Insured Party's rights, which are highlighted in "bold print".

ARTICLE 1 - DEFINITIONS

For the purposes of this contract:

ACCIDENT: shall mean bodily injury derived directly from a violent and sudden, external cause beyond the volition of the Insured Party.

ATS/DUE: shall mean a professional legally capacitated and qualified to carry out nursing activities.

CALENDAR YEAR: shall mean the period between the 1 January and the following 31 December.

CASER HEALTH CARD: shall mean the document belonging to the Insurer that is issued and delivered to each Insured Party included in the policy, the personal and non-transferrable use of which is necessary to receive the services covered under the policy.

CHILDBIRTH: Normal childbirth at term shall mean that which takes place between the 37th and 42nd week from the date of the last menstruation.

CLAIMABLE EVENT: shall mean an event, the results of which require the use of the healthcare services that are fully or partially covered under the policy.

CONGENITAL ILLNESS, INJURY, DISABILITY, OR DEFORMITY: shall mean that which exists at the time of birth, as a result of hereditary factors, or a condition acquired during the pregnancy and up until the moment of birth. A congenital condition may appear and be diagnosed immediately following the birth, or be discovered later, at any time during the life of the Insured Party.

DISPUTABILITY PERIOD OR DEADLINE: shall mean the interval of time counted from the date of entry into effect of the policy for each Insured Party included therein, during which the Insurer may reject coverage of services or challenge the contract alleging the existence of a prior illness of the Insured Party, which was not declared in the Health Questionnaire. Once this period has elapsed, the Insurer's rejection must be based on the existence of wilful concealment by the Insured Party.

DOCTOR: shall mean a professional legally qualified to practise medicine.

EMERGENCY: shall mean a circumstance of the Insured Party that requires immediate medical assistance in order to prevent irreparable damage to said party's health.

EXCESS: Amount that the Policyholder has to pay the Insurer for each healthcare service used by the Policyholder or the Insured Parties included in the Policyholder's policy. This amount varies depending on the different kinds of healthcare services and/or medical specialities and their amounts, which is established in the Specific Conditions. It may be updated annually.

For the purposes of this policy, hotels, asylums, rest and convalescent homes, spas, facilities devoted mainly to internment and/or treatment of drug addicts or alcoholics and similar institutions will not be considered hospital.

HEALTH QUESTIONNAIRE: shall mean the document that contains all the necessary data of which the Insurer must be aware to evaluate the risk and which the Policyholder and/or the Insured Party must fill in completely and accurately and sign.

HOSPITAL: shall mean any establishment legally authorised to provide medical or surgical treatment of illnesses or bodily injuries, whether to outpatients or hospitalised patients. Said establishments must have a doctor permanently on duty and will only accept admission of patients with illnesses or injuries.

HOSPITALISATION:

- General Hospitalisation: shall mean the situation in which a person registered in a hospital as a patient spends the night or has a main meal there.

- Day Hospital: shall mean the situation in which a person is registered as a patient in the hospital units thus specifically named, whether medical, surgical or psychiatric, to receive specific treatment or due to having been under the effects of anaesthesia, without this meaning spending the night, and regardless of whether or not a main meal is taken in said unit.

ILLNESS: shall mean any alteration of the Insured Party's health that is not the result of an accident, diagnosed by a doctor, which requires healthcare services and of which the first symptoms appear during the term of validity of the policy.

INSURED PARTY: shall mean the individual or entity holding the interest covered by the insurance and which, in absence of the Policyholder, assumes the obligations derived from the contract. Unless it is expressly stated otherwise in the Specific Conditions, the Policyholder and the Insured Party shall be one and the same.

INSURER: shall mean the incorporated entity that assumes the contractually agreed risk; in this policy, CAJA DE SEGUROS REUNIDOS, Compañía de Seguros y Reaseguros, S.A., hereinafter, the Insurer.

LIMITS ESTABLISHED IN THE SPECIAL CONDITIONS: shall mean the maximum amounts that the Insurer undertakes to reimburse for each type of specified medical action.

LIST OF PRACTITIONERS OR MEDICAL PANEL: shall mean the published list of healthcare professionals and establishments belonging to or contracted by the Insurer in each province, with their addresses, telephone numbers and timetables. Each provincial list

of practitioners will include, apart from the professionals and establishments in the province, the information services and Insured Party Helpline telephones for the entire national territory.

MEDICAL PROCESS: shall mean the healthcare that comprises the diagnosis and treatment of an illness or injury, including patient hospitalisation and rehabilitation, as appropriate.

POLICY: shall mean the document or documents that contain the clauses and agreements regulating the Insurance Contract. The following form an integral and inseparable part of the policy: the Insurance Application, the Health Questionnaire, the General Conditions, the Specific Conditions that individualise the risks and the Special Conditions, if any, as well as the supplements or appendices that include, as appropriate, the modifications agreed during the term of the contract.

POLICYHOLDER: shall mean the individual or entity that, together with the Insurer, signs this contract and to which the obligations derived therein correspond, with exception to those that, due to their nature, have to be fulfilled by the Insured Party.

PRE-EXISTING ILLNESS: shall mean that which the Insured Party suffers prior to the effective date of incorporation (subscription) of said Party in the policy.

PREMIUM: shall mean the price of the insurance. The premium payment slip will include, furthermore, the legally applicable surcharges, taxes and levies. The insurance premium is annual, even if payment is carried out in instalments.

PRE-TERM OR PREMATURE BIRTH: shall mean that which occurs between the 28th and 36th week of gestation.

PROSTHESES, IMPLANTS AND GRAFTS: shall mean any element of any nature that replaces, temporarily or permanently the absence of an organ, tissue, organic fluid, limb or any part of these.

REHABILITATION: shall mean all actions directed by a practitioner with specialist qualifications, aided by physiotherapists and carried out in a centre suitable for rehabilitation and which are designed to functionally restore the parts of the motor system affected as a result of an illness occurred or accident caused during the term of the policy.

SERVICE: shall mean the healthcare assistance derived from the occurrence of a claimable event.

SPECIAL CONDITIONS: shall mean the document forming an integral part of the policy in which the insured amount and the quantitative limits of the expenses reimbursement cover are specified.

SPECIAL HEALTHCARE IN THE HOME: shall mean attention by a general practitioner or family doctor and a nursing assistant [ATS] or registered nurse [DUE] provided to the Insured Party in the home that appears on the policy, when the course of the illness requires special care without requiring hospitalisation and always with prior prescription by the Insurer's practitioner.

SPECIALIST DOCTOR OR SPECIALIST: shall mean a doctor that has the necessary qualifications to practise the profession within one of the legally recognised medical specialities.

SPECIFIC CONDITIONS: shall mean the document forming an integral part of the policy in which the aspects of the insured risk are specified and detailed.

SURGICAL OPERATION: shall mean any operation carried out through an incision or any other means of internal entry, by a surgeon in an authorised centre and which normally requires the use of an operating theatre.

WAITING PERIOD OR DEADLINE: shall mean the period of time during which some of the cover included within the policy guarantees are not effective. This period is calculated by months, counted as from the date of entry into effect of the policy for each one of the Insured Parties therein.

ARTICLE 2 - PURPOSE OF THE INSURANCE

This health insurance is a combined insurance for reimbursement of healthcare expenses and healthcare provided by the Insurer's list of practitioners. The insurance provides cover in two complementary modalities.

Modality I: Healthcare provided by the Insurer's list of practitioners

The Insurer will provide the corresponding medical, surgical and hospital healthcare for all illnesses or injuries included in the description of the cover, provided that the Insured Party uses the healthcare resources on the Insurer's list of practitioners.

Modality II: Healthcare obtained by other means (expenses reimbursement)

The Insurer will reimburse the reasonable and usual expenses incurred by the Insured Party for medical, surgical and hospital healthcare for all illnesses or injuries included in the description of the cover, provided that the Insured Party uses healthcare resources other than those on the Insurer's list of practitioners, whether in Spain or abroad. Reimbursement will be subject to the maximum amounts and excesses specified in the policy.

ARTICLE 3 - COVER DESCRIPTION

The specialities, healthcare services and other services covered by this policy are the following:

1. FAMILY MEDICINE

General medicine/family doctor: Assistance in surgery or the home. In this last case, provided the patient cannot travel due to medical reasons.

Paediatrics - Child Care: For children up to the age of 16 years old. It includes preventive and child development checks.

ATS/DUE [nursing] Service: In surgery and at home. In this last case, provided the patient is unable to travel due to medical reasons and with prior prescription from the Insurer's doctor.

2. EMERGENCIES

Healthcare assistance for emergencies will be provided in the permanent emergency centres (24 hours) indicated in the Insurer's contracted practitioners and medical centre's

list. Healthcare will be provided by the Insurer's general practitioner and/or ATS/DUE (nurse) at home whenever necessary due to the patient's condition.

3. SPECIALITIES

Healthcare assistance as out-patient or hospitalised (depending on the criterion of the Insurer's doctor), in the following specialties:

3.1. Allergology. Vaccinations will be to the account of the Insured Party.

3.2. Anaesthesiology and reanimation.

3.3. Pathological anatomy. Determination of the following Therapeutic Targets as a preliminary study prior to personalised oncologic treatment and based on the type of tumour and its status is expressly included:

Therapeutic target	Tumour type/status	Treatment
HER2	Breast cancer Advanced gastric cancer(metastatic)	HER2 inhibitors
EGFR	Lung cancer	EGFR inhibitors
KRAS	Advanced colon cancer (metastatic)	anti-EGFR monoclonal antibody
BRAF	Advanced melanoma (metastatic)	BRAF inhibitors
c-Kit	gastro-intestinal stromal tumour	c-Kit inhibitors
ALK	Lung carcinoma	ALK inhibitors

Only the Therapeutic Targets specified in the drug's specifications will be covered and they must be determined as a prior step to its administration based on the therapeutic approach in each case, with demonstrated clinical proof and relevance. They will only be considered for drugs marketed in Spain that have the corresponding indication and approval issued by the Spanish Medicines and Health Products Agency.

3.4 Angiology and vascular surgery. Surgery of symptomatic varicose veins will be included for grades III to VI in the CEAP Classification (which assesses and classifies venous insufficiency for the treatment or suppression of reflux in the saphenous axes) using endolaser thermal ablation techniques (endovascular laser), using radiofrequency (endovascular radiofrequency fibre) or applying sclerosing treatment, at centres that have agreements with the Insurer for said treatment.

3.5. Digestive system.

3.6. Cardiology. Cover includes cardiovascular risk prevention for people over the age of 45.

3.7. Anal-rectal surgery. Proctology.

3.8. Cardiovascular surgery.

3.9. General surgery and digestive system surgery.

3.10. Maxillofacial surgery.

3.11. Paediatric surgery.

3.12. Plastic and reparatory surgery. Includes solely and exclusively breast reconstruction following breast surgery of neoplastic origin, provided it has been carried out within the term of the policy. Breast prostheses are included.

3.13. Thoracic surgery.

3.14. Medical-surgical dermatology and venereology.

3.15. Endocrinology and nutrition.

3.16. Geriatrics.

3.17. Haematology and hemotherapy. Including autologous bone marrow transplants, **exclusively for treatment of tumours of haematological origin**.

3.18. Immunology.

3.19. Infectious and tropical diseases.

3.20. Internal medicine.

3.21. Nuclear medicine.

3.22. Nephrology.

3.23. Neonatology.

3.24. Pneumology.

3.25. Neurosurgery.

3.26. Clinical neurophysiology.

3.27. Neurology.

3.28. Obstetrics and gynaecology

a) Healthcare/Control during pregnancy and childbirth: Pregnancy control by an obstetrician who will attend births/Caesar sections.

b) Family planning: Control of treatment with anovulatories, IUD implants and control, including the cost of the intrauterine device. Tubal ligations.

c) Preventive medicine: Annual gynaecological checkups oriented towards early diagnosis of mammary and cervical neoplasias. This cover also includes diagnosis of infertility and sterility, as well as gynaecological laparoscopic surgery.

d) Control and treatment of the menopause.

e) Assisted Reproduction: For the treatment of sterility in couples. This cover includes the study, diagnosis (with the habitual and documented tests) and treatment of infertility of the couple, up to the limit of **3 cycles of artificial insemination and 1 cycle of in-vitro fertilisation**, including ICSI (sperm microinjection), when necessary. **The age limit for application of the different techniques is established at 40 years old. The treatment is excluded when the sterility has been produced voluntarily or it is the result of a natural physiological process.**

This cover does not include freezing / unfreezing and maintenance of embryos, oocytes, ovarian tissue and spermatozoids or the expenses incurred in oocyte donation.

To benefit from this cover it will be an essential condition that both members of the couple are insured. A waiting period of 24 months is established.

Treatments will be carried out at the medical and hospital centres and by the practitioners designated for this purpose by the Insurer, which may not necessarily be located in the province of the Insured Party's address.

Application of the assisted reproduction techniques will be compliant with prevailing legislation.

Under no circumstances will the Insurer reimburse the Insured Party for the costs of invoices issued by practitioners or centres not included in the Insurer's practitioners list.

3.29. Odontology and dentistry. Includes solely extractions, dentistry treatments derived from the former, simple intra-oral x-rays and one annual scale and polish, prescribed by a dentist on the Insurer's list of practitioners.

3.30. Ophthalmology. Includes laser photocoagulation and cornea transplant; the Insured Party will be responsible for the cost of the cornea to be transplanted.

3.31. Medical oncology. Cover includes implantable reservoirs for intravenous perfusion (port-a-cath type).

3.32. Radiotherapy oncology. Except for tomotherapy treatments and radioembolisation with Yttrium 90 spheres.

3.33. Otorhinolaryngology. Cover includes radiofrequency, for the treatment of turbinate hypertrophy.

3.34. Clinical psychology. Cover includes individual and temporary out-patient psychological treatment, prescribed by a psychiatrist on the Insurer's medical panel, for the purposes of treating conditions that benefit from psychological treatment, up to a maximum of 20 sessions per Insured Party and year.

This cover includes **Child psychology:** Includes 20 session per year with a specialist included in the Insurer's medical panel, for Insured Parties under the age of 16 years.

Authorisation from the Insurer will be required prior to treatment.

Under no circumstances will the Insurer reimburse the Insured Party for the costs of invoices issued by practitioners or centres not included in the Insurer's practitioners list.

3.35. Psychiatric treatment

3.36. Rehabilitation and Physiotherapy. Cover only includes out-patient treatment for motor system pathologies with prior prescription from one of the Insurer's doctors, specialist in the area. Lymphatic drains following oncologic breast surgery carried out during the term of the policy are included.

Authorisation from the Insurer will be required prior to treatment.

3.37. Rheumatology.

3.38. Pain Treatment. Cover includes **exclusively implantable reservoirs (port-a-cath type).**

3.39. Orthopaedics and Orthopaedic Surgery.

3.40. Urology. Includes vasectomy, diagnosis of impotency (not its treatment) as well as study and diagnosis of infertility and sterility. **Green laser** is also included **exclusively for treatment of benign prostrate hyperplasia and in centres that have prior agreements with the Insurer for said treatment.**

4. DIAGNOSTIC MEANS

In all cases, diagnostic tests will be carried out with prior written prescription from one of the Insurer's doctors. This cover includes all the usual diagnostic means recognised by medical practice at the time of taking out the policy, **except for any diagnostic studies or tests related to research or of a scientific nature or tests derived from plastic surgery.** The contrasts and radiopharmaceuticals used are included in the cover.

Clinical analysis: biochemical, haematological, microbiological, parasitological, surgical anatomic pathological, cytopathological.

Conventional radiology: Includes the usual diagnostic techniques such as simple radiology (head, trunk, limbs, special cranium and dental radiology), special non-invasive radiology (digestive, urological and gynaecological), nuclear magnetic resonance (NMR), computerised axial tomography (CAT/scan), bone densitometry, ecography.

Surgical visceral and vascular radiology.

Others:

1. **Nuclear medicine:** Radioactive isotopes, Gammagraphy**.**
2. **Positron emitting tomography (PET),** in cases of oncology and epilepsy resistant to drugs.
3. **Endoscopies: If endoscopic capsules are used, only those indicated for the small intestine will be covered.**

Cardiologic diagnostics: Electrocardiogram, stress tests, echocardiogram, conventional Holter, events Holter, Doppler and hemodynamic and electrophysiological studies and

coronary CAT scans.

Clinical neurophysiology: Electroencephalogram, electromyography and evoked potentials. Polysomnography, exclusively for studying obstructive sleep apnoea syndrome.

Triple screening, amniocentesis and foetal karyotype study in high risk pregnancies.

Digital dermatoscopy: Upon prescription from one of the Insurer's doctors in the speciality to be treated and at centres that have an agreement with the Insurer. In the early detection of malignant melanoma in persons with family and/or personal history of melanoma, in dysplastic nevus syndrome and/or when there are multiple nevi/moles (more than one hundred lesions).

Sentinel gland detection: For mammary pathology and melanoma.

Early detection of deafness in children: Includes consultation and examination, ear acoustic emissions and brainstem auditory evoked potential.

5. HOSPITALISATION

Hospitalisation will be upon indication of a practitioner, the patient occupying an individual room with bathroom and bed for companion (unless clearly impossible) with exception to the expressly excluded cases. The Insurer will be responsible for the operating theatre expenses, anaesthetic products and drugs used both during surgery and during hospitalisation, as well as dressings and materials and patient's board whilst hospitalised.

5.1. Medical hospitalisation (without surgery): The duration of the hospitalisation will be determined by the Insurer's doctor in charge of the healthcare, and will last until the doctor considers it convenient to transfer the patient home. Day hospitalisation is included.

5.2. Paediatric hospitalisation: Includes conventional hospitalisation and incubator (in this last case a bed for a companion is not included). Cover includes hospitalisation of premature babies or newborns with pathologies in a specialised centre (Neonatology).

5.3. Hospitalisation for maternity: Attended by an obstetrician and midwife. Cover includes anaesthesia (including epidural anaesthesia) as well as nursery and incubator for the newborn.

5.4. Surgical hospitalisation: Includes day hospitalisation (mayor out-patient surgery)

5.5. Hospitalisation in the Intensive Care Unit (ICU): In centres designated by the Insurer, ordered by a doctor in said centre, in the appropriate facilities. The head of the Intensive Care Unit will indicate how long the patient will stay in the unit. **Due to the nature of this hospitalisation a bed for a companion is not included.**

5.6. Psychiatric hospitalisation: Exclusively for patients previously diagnosed by a specialist for treatment of acute episodes that may be reversed, with hospital stay or as an out-patient, **with a limit of 60 days per calendar year. Due to the nature of this hospitalisation a bed for a companion is not included.**

5.7. Special home care: When the Insurer's doctor considers that the Insured Party requires hospital-type care covered by the policy but does not require admission to hospital, medical and nursing care may provided at the Insured Party's home stated on the policy.

Expenses generated due to social care, hostelry, linen, food, medication, healthcare materials, non-specific care of general practitioners and ATS/DUE nursing assistants, or continuous permanence of healthcare professionals in the Insured Party's home are excluded.

6. PROSTHESES, GRAFTS AND IMPLANTS

This cover includes fixed internal prostheses of a temporary or permanent nature, such as: cardiac valves, vascular by-pass, pacemakers, stent, orthopaedic prostheses, osteosynthesis material, intraocular lenses and mammary prostheses following surgery of neoplastic origin, provided the surgery takes places during the term of the policy.

7. SPECIAL TREATMENTS

In all cases, these treatments will be carried out with prior written prescription from one of the specialists included in the Insurer's medical panel, in the centre designated by the Insurer and related to the pathology. **Access to any of these treatments will require prior authorisation from the Insurer.**

- **Aerosol Therapy - Ventilotherapy**. **In any case, medication will be to the account of the Insured Party.**

- **Oxygen therapy**. Whether hospitalised or as an out-patient. Includes out-patient oxygen therapy for patients who require oxygen treatment during at least 16 hours a day.

- **Dialysis (Haemodialysis and Peritoneal Dialysis)**. Exclusively for treatment, on the necessary days, of acute renal failure, **with express exclusion of chronic conditions.**

- **Speech therapy**. **Exclusively as rehabilitation following major larynx surgery,** up to a maximum of 60 sessions.

- **Laser therapy.** Included **only** for **ophthalmological treatments, skeletal muscle rehabilitation, urological Green Laser, as established in Article 3, Point 3.40 and for symptomatic varicose veins, as established in Article 3, Point 3.4**.

- **Chemotherapy and Oncologic Radiotherapy, with exception to tomotherapy. treatments and radioembolisation with Yttrium 90 spheres**, and hospitalised or in day hospital, except for intravesical BCG instillations for the treatment of bladder surface carcinoma, which may be provided under out-patient regime. **The Insurer will only bear the costs of specifically cytostatic drugs dispensed on the domestic market and duly authorised by the Ministry of Health, applied following the indications that appear in the product specification**s.

- **Extracorporeal renal lithotripsy**.

8. OTHER SERVICES

- **Ambulances:** The insurance covers **exclusively the Insured Party's journeys from his or her home to the hospital or vice versa and only for hospital admissions or emergency healthcare.** An order from the Insurer's doctor will be required, except in the case of emergencies.

Transport, in any case will be on land and will be carried out provided the doctor gives a written order and there are special circumstances of physical impossibility that prevent the

Insured Party from using ordinary transport services (public services, taxi or private vehicle).

This service does not include transfers required for rehabilitation and physiotherapy treatments, dialysis or out-patient diagnostic tests.

- **Podiatry: Chiropody, only in doctors' surgery.**

- **Prenatal course.** Includes a series of techniques applied to ensure that the mother to be is physically and psychologically prepared for the birth. Addressed to pregnant women as from their sixth month of pregnancy.

ARTICLE 4 - EXCLUDED RISKS

a) Physical damages resulting from wars, mutinies, revolutions and terrorism; those caused by officially declared epidemics; those related direct or indirectly with radiation or nuclear reaction and those originating from cataclysms (earthquakes, floods and other seismic or meteorological phenomena).

b) Pharmaceuticals and medicaments of any kind outside the hospitalisation regime, as well as vaccines of all kinds and parapharmacy products.

c) Healthcare derived from chronic alcoholism or drug addiction of any kind.

d) Healthcare for injuries produced by inebriation, fighting (except when in legitimate defence), self-injury or suicide attempts.

e) Healthcare required as a result of injuries suffered while engaging in high risk activities such as bullfighting and fighting bull running; dangerous sports, such as scuba diving, speleology, boxing, martial arts, climbing, rugby, motor vehicle racing, quad, paragliding; aerial activities not authorised for public passenger transport, sailing activities or activities in white waters, bungee jumping, canyoning and any other manifestly dangerous activity, as well as healthcare derived from the professional practice of any sports.

f) Healthcare for all kinds of diseases, injuries, accidents and their after effects, defects or deformities either congenital or pre-existing diagnosed prior to the effective date of incorporation of each Insured Party in the policy, as well as the healthcare for any symptoms that could be considered as the initiation of an illness, or which would have required previous studies, diagnostic tests or treatments of any kind, unless said illnesses, injuries, accidents, symptoms, defects or deformities were declared by the Policyholder or Insured Party in the health questionnaire and their cover is expressly accepted by the Insurer in the Specific Conditions. This exclusion will not affect the Insured Parties incorporated in the policy since their birth, pursuant to Article 10, Point 1.e).

g) Alternative medicines. Treatments in asylums, residences, spas and similar.

h) General medical check-ups or general medical examinations of a preventive nature, unless expressly included in Article 3, Point 3.

i) Treatment for sterility or infertility (with exception to that expressly included in Article 5, Point 3.28), voluntary interruption of pregnancy in any circumstances, as well as diagnostic tests related with said interruption, and treatment

(including surgery) for impotence.

j) The following are expressly excluded from cover: surgical operations, infiltrations and treatments, as well as any other type of operations of a purely cosmetic nature. Likewise, the following are expressly excluded from cover: any pathology or complication that could appear at a later time and which is directly and mainly caused due to the Insured Party having undergone a purely cosmetic operation, infiltration or treatment.

k) Everything related to psychology, out-patient narcolepsy treatment, sophrology, neuropsychological and psychometric tests, psychoanalytical psychotherapy, as well as psychosocial rehabilitation or neuropsychiatry, psychoanalysis, hypnosis, individual or group psychotherapy, psychological tests and rest and sleep therapy, with exception to that specifically included in Article 3, Point 3.34.

l) Organ transplants, with exception to autologous bone marrow and cornea transplants (the Insurer will not bear the cost of the cornea to be transplanted).

m) Healthcare for AIDS and diseases caused by the human immunodeficiency virus (HIV).

n) Hospital healthcare and treatment for social or family reasons, as well as that which may be substituted by home or out-patient healthcare

o) In odontology and dentistry specialities, fillings, root canals, fitting of dental prostheses, orthodontics, periodontics and implants are excluded, as well as other odontology treatments not included under Article 3, Point 3.29.

p) Surgical correction of myopia, hypermetropy or astigmatism and presbyopia and any other refractive ocular pathology. Likewise, intracorneal segment / rings transplants are also excluded as are intravitreal injections for macular oedema treatment.

q) All the surgical and/or therapeutic techniques that use laser, except as expressly included in Article 3, Point 7.

r) Travelling and displacement costs, except for ambulances in the terms set out in Article 3, Point 8.

s) Chronic dialysis treatment.

t) Physiotherapy and rehabilitation treatments when functional or the maximum possible recovery has been achieved, or when it becomes occupational maintenance therapy or is thus ordered by the specialist in charge of the treatment. Educational therapy is excluded. Rehabilitation of the pelvic floor and lymphatic drains or rehabilitation due to a neurological pathology is excluded.

u) Generic tests are excluded when they are for the purpose of discovering the predisposition of the Insured Party or the descendents of the Insured Party, present or future, to suffer certain diseases related to genetic alterations, with the sole exception of those that are expressly included in the cover, such as amniocenteses (except for in situ hybridisation techniques) and karyotype (except for karyotype of abortion remains).

v) The diagnostic and/or therapeutic techniques not usually applied and accepted within the national health system.

Incorporation of new diagnostic and therapeutic procedures and new technologies in the policy cover will be carried out applying the principles of evidence based medicine, once they have demonstrated their effectiveness and safety, and there is sufficient availability to carry them out in the Entity's contracted facilities.

w) Any sleep disorder diagnostic means, except for those specified in Article 3, Point 4, is expressly excluded.

x) Obesity surgery and implant/fitting of intragastric balloons.

y) Robotic surgery is excluded.

z) Implantable pumps for drug infusion and medullar stimulation electrodes are expressly excluded.

aa) This cover does not include any type of orthopaedic material, ortheses, external fixings, biological or synthetic materials, grafts (except bone grafts), osteo-integrating dental and cochlear prostheses and implants, penis or scrotum prostheses, skin expanders and/or auditory prostheses and intraocular multifocal lenses, or implantable automatic defibrillators. Infiltrations with Autologous Growth Factors (plasma rich in growth factors) and/or platelet concentrates are excluded.

ab) Breast reduction surgery is excluded.

ac) Cytoreductive surgery in intraperitoneal chemotherapy is excluded.

ARTICLE 5 - HOW THE SERVICES ARE PROVIDED

1. ASSISTANCE GUIDANCE

Insured Parties have an Assistance Guidance Service at their disposal, the purpose of which is to facilitate Insured Parties' access to the healthcare services, informing on the procedures and facilitating said procedures as much as possible.

2. MODALITY I: HEALTHCARE PROVIDED BY THE INSURER'S LIST OF PRACTITIONERS

The healthcare covered under this policy will be provided in all towns in which the Insurer has offices or has a list of contracted practitioners. When any of the services in the policy are not available in any of these population centres, said services will be provided in another population centre where they are available, at the choice of the Insured Party.

2.1. Free choice of doctors

Insured Parties may go freely and directly to the primary healthcare and specialist practitioners on the Insurer's list of practitioners prevailing at any given time.

The Insurer recommends that each Insured Party has a general practitioner or paediatrician in charge of the family's healthcare. Each Insured Party may choose their general practitioner or paediatrician and ATS [nursing assistant] from among the practitioners that appear on the Insurer's practitioners list, for which notification to the Insurer of their choice

or modification thereof will be sufficient. When the Insured Party's address is not within the chosen practitioner's territorial scope of practice, the Insurer will not be obliged to provide healthcare in the home.

2.2. Home visits

Home visits by the general practitioner or ATS [nursing assistant] will be carried out following a telephone request made to the practitioner between 09:00 and 17:00. **Home visits will be carried out solely at the home address stated in the policy**. Any modification to said address will be notified to the Insurer at least 8 days prior to the request for any service.

In the event of emergencies the Insured Party should go to the permanent emergency services established by the Insurer or contact the telephone helpline included for this purpose in the documentation provided to Insured Parties.

2.3. Participation of the insured party in the service costs

The Insured Party will pay the amount that is established in the Specific Conditions in concept of excess or participation in said costs and for each medical assistance received.

For these purposes, from time to time the Insurer will send the Policyholder a comprehensive extract of the services used by the Insured Parties included in the policy, together with the amount of excess corresponding thereto.

Collection of the resulting total amount will be carried out by direct debit in the bank account designated by the Policyholder for the premium payment.

The excess amounts may be updated by the Insurer, pursuant to that established under Article 13 (ANNUAL UPDATING OF THE POLICY'S FINANCIAL TERMS).

2.4. Authorisation for services

In general, prior express authorisation from the Insurer will be required for hospitalisation, surgical operations, special treatments, rehabilitation treatments, physiotherapy and psychology, as well as diagnostic tests.

Documentation to be submitted in the case of services that require authorisation:

For healthcare services that require express authorisation from the Company and at the request of the Company, the Insured Party will provide a medical report that includes all the history, date of commencement, date of diagnosis, causes and origin and evolution of the condition suffered.

The Insured Party must obtain prior confirmation of the service from the Insurer, which will give said confirmation unless it deems that it is a service not covered by the policy, or it is related to or preparatory for a service not covered. Once written confirmation has been given, the Insurer will be bound financially.

In the case of an emergency, order from the Insurer's doctor will suffice, although the Insured Party will have to obtain confirmation from the Insurer within the seventy-two hours following hospital admission or from the start of the healthcare service. The Insurer will be financially bound up to the moment at which it declares its objection to the doctor's order in the event of deeming that the policy does not cover the medical attention or hospitalisation.

2.5. Emergencies

Emergency services will be requested by telephone or by going directly to the Permanent Emergency Centre established by the Insurer, the address and telephone of which appear in the practitioners list.

2.6. Temporary displacements

The Insurer undertakes to provide healthcare to Insured Parties who are temporarily displaced from their habitual residence to anywhere within national territory. For this purpose they must use the services belonging to the Insurer or those contracted by the Insurer as indicated in the documentation delivered to Insured Parties.

2.7. Healthcare in facilities not contracted by the insurer

The Insurer will not be liable for the fees of practitioners not on its practitioners list, or the hospitalisation expenses and services they may prescribe.

2.8. Insured parties' accreditation

When requesting the healthcare services, Insured Parties must show the individual Caser Salud health card, which the Insurer will give them for said purpose. The Insured Party must sign the certificate of having received the service.

The doctor or the centre providing the service may also request, when they deem appropriate, the National Identity Document from persons obliged to have them.

3. MODALITY II: HEALTHCARE OBTAINED BY OTHER MEANS (EXPENSES REIMBURSEMENT)

When the Insured Parties requires healthcare included in the covered specialities and services under the cover described in Articles 3 and 4, and they decide to receive it in a hospital or clinic and/or from practitioners not on the Insurer's practitioners list, the Insurer will reimburse the Insured Party the expenses for the treatment, in accordance with the percentage and limits indicated in the Special Conditions of the policy.

3.1. Notification of claimable events

Insured Parties, or any person on their behalf, must notify the claimable event to the Insurer within the following deadlines:

a) In cases of emergency healthcare, within five (5) working days following the date on which the medical or surgical healthcare or hospital admission took place.

b) In the event of programmed surgery or hospital admission, within seven (7) working days following the date of the surgery or hospital admission.

The aforementioned deadlines will be deemed without prejudice to that established under Section 16 of the Insurance Contract Act.

Additionally, the Insured Party must comply faithfully with the attending practitioner's instructions and prescriptions and provide the Insurer with whatsoever information regarding the circumstances and results of the claimable event.

3.2. Formalities for reimbursement of expenses

To obtain reimbursement of healthcare expenses, the Policyholder or, as appropriate, the

Insured Party must provide the Insurer with the following documentation:

a) Expenses reimbursement application form, in accordance with the insurer's template, duly filled in and signed by the Insured Party.

b) Original invoices for the healthcare expenses incurred and of **the receipts** or documents that prove payment of their amounts to the corresponding healthcare establishments and professionals.

- The invoices will include:
  - Name and surnames or corporate name of the individual or incorporated entities that issue them, their address, telephone, society member number and speciality, as appropriate, and tax number [NIF or CIF].
  - Suitable breakdown of the different healthcare concepts and their nature (types of actions/doctor/and their dates).

c) Original justification or proof of payment of the invoices by the Insured Party.

d) Original medical instructions or prescriptions, in the case of diagnostic means, special treatments, hospitalisation and other services.

e) In the case of hospitalisation, clinical report containing the medical history, date of initiation, cause, origin and evolution of the illness or injury, as well as the healthcare provided to the Insured Party.

For reimbursement of the healthcare expenses incurred it will essential that the documents identify by name and surnames the patient receiving the healthcare.

Apart from all the aforementioned, the Insured Party undertakes to provide the Insurer with all the collaboration it may request to complete its information regarding the claimable event and its consequences, allowing the medical visit of the medical professionals and specialists designated by the Insurer, who will not only ensure precise fulfilment of the insurance contract, but will also give support, with their know-how, to the medical team attending the patient.

The Insured Party undertakes to provide the Insurer with official translations of any documents drawn up in a language other than those that have official language status in Spain.

3.3. Liquidation and payment

Once the required documentation has been received and the appropriate verifications and calculations have been made to establish the compensation amount, the Insurer will have **ten working days** to reimburse or deposit said amount, based on the known circumstances.

In the event that the process extends for more than three months, the Policyholder or, as appropriate, the Insured Party will send the Insurer the invoice(s) for the expenses incurred in the previous three-month period.

In the event that the medical and/or hospital healthcare is provided abroad, assessment of the expenses or amount to be reimbursed by the Insurer will be made in euro at the official purchaser's exchange rate on the currency market corresponding to the currency in which

the Policyholder or Insured Party made the payment for the healthcare received on the date the Policyholder or the Insured Party paid the invoice for the medical and/or hospital expenses corresponding to the reimbursement in question.

Though, in principle, the Insurer will pay the compensation established in the policy to the Insured Party, it expressly reserves the rights to make the payments directly to the professionals and healthcare centres that issue the corresponding invoice.

ARTICLE 6 - GENERAL LIMITS

1. Geographical limits

The policy cover is valid worldwide, provided the Insured Party's permanent residence is in Spain. If this residence is transferred outside Spain, the policy cover will be automatically terminated and the non-consumed portion of the premium will be returned to the Policyholder or Insured Party. This limitation is also applicable to any of the parties incorporated in the policy.

2. Quantitative limits

If the Insured Party uses the Insurer's list of practitioners to obtain healthcare (Modality I), the Insurer will bear the costs corresponding thereto without any quantitative limit whatsoever.

If the Insured Party uses any of the cover included under Modality II, the following quantitative limits will be applicable:

a) Annual insured amount: All the amounts reimbursed for healthcare services during a calendar year will count for the purposes of calculating the insured amount.

Once the insured amount limit in the Special Conditions has been reached, the Insurer's obligations in the Reimbursement Modality will be deemed as finalised until the next calendar year.

In order to unify policy term maturities at 31 December, in the event that the insurance comes into effect after 1 January, the insured amount established in the Special Conditions, for the first year will be proportional to the fraction of the year subscribed. Likewise, proportionality will be applied to the year in which the policy is terminated, if this occurs before 31 December.

b) Partial limits: These are the limits established in the Special Conditions for the different types of medical actions. They are the maximum amounts that the Insurer will be reimbursed for each type of medical actions for which they are specified. They will only count and be applied in the Expenses Reimbursement Modality.

3. Healthcare not controlled by the Insurer

As regards the healthcare the Insured Party receives from healthcare professionals, centres and establishments not on the Insurer's Practitioners List, the Insurer will not assume any obligations other than those set out in Article 5 of the Special Conditions.

4. Combined use of both modalities

Combined use of both modalities for a single medical process will only be possible if it is allowed under the Insurer's agreements with the professionals, centres and establishments

on its medical panel that intervene in the process.

5. Newborns

Newborns may be insured pursuant to Article 11, Point 1 e) and will have the cover specified in the policy.

In the modality of healthcare services provided by outside means (Modality II) and when the healthcare is due to congenital diseases, **reimbursement will be granted only during the first year of life of the newborn** and with the maximum financial limit established in the Special Conditions in the policy. This limit will be deemed as the insured sum of the cover in the policy for the newborn.

Nevertheless, the mother must have been included in the policy at least ten (10) months prior to the birth, and the newborn must be included in the policy within 15 calendar days following it birth.

ARTICLE 7 - WAITING PERIODS

The services that require fulfilment of the waiting periods specified below for them to be covered by the Insurer are:

Six months waiting period:

- **Family planning.**
- **Surgery and hospital admission for medical treatments or surgery. This waiting period will not be applicable in the case of life-threatening emergencies.**
- **Oncologic and cardiovascular treatments, lithotripsy, dialysis and oxygen therapy.**

Eight months waiting period:

- **Assistance during childbirth: This waiting period will not be applicable to premature births.**

24 months waiting period:

- **Assisted reproduction**

ARTICLE 8 - CONTRACT BASES, LOSS OF RIGHTS, RESCISSION AND INDISPUTABLE NATURE

1. The declarations of the Policyholder and Insured Party in the Questionnaire-Insurance Application regarding their state of health constitute the basis for acceptance of the risk in this contract and form an integral part thereof.

2. The Insured Party will lose the right to the guaranteed service:

a) In the event of any reserve or inaccuracy when completing the state of health questionnaire (Article 10 of the Act).

The Insurer may rescind the contract via declaration addressed to the Policyholder of the insurance within a period of one month, as from the date on which it becomes aware of the

Policyholder or Insured Party's reserve or inaccuracy. The Insurer, except in the case of wilful misconduct or gross negligence on its part, will retain the premiums for the period current at the time said declaration is made.

If the claimable event occurs before the Insurer makes the declaration referred to in the preceding paragraph, the services provided by the Insurer corresponding to said event will be reduced proportionally in accordance with the difference between the agreed premium and the premium that would have been applicable had the true entity of the risk been known. If there was wilful misconduct or gross negligence on the part of the Policyholder or Insured Party, the Insurer will be released from the obligation to pay for the service.

b) In the case of aggravation of the risk, when the Policyholder or the Insured Party fail to notify the Insurer and have acted in bad faith (Article 12 of the Act).

c) When the claimable event covered occurs before the premium has been paid, unless otherwise agreed (Article 15 of the Act).

d) When the claimable event has been caused due to bad faith on the part of the Insured Party (Article 19 of the Act).

3. The Policyholder may rescind the contract when the list of practitioners corresponding to his or her province is modified by more than 50% or the primary services are affected; said decision must be notified to the Insurer by any justifiable means. This rule will not be applicable in the case of temporary substitutions for justified reasons or which refer to doctors who carry out special surgery techniques, as well as odontologists, analysts and electro-radiologists.

4. If a medical examination was carried out or all the rights were recognised, the policy may not be disputed based on the state of health of the Insured Party or Parties and the Insurer may not refuse to provide its services arguing the existence of prior illnesses, unless any express exception was included in the policy's Specific Conditions as a result of the aforementioned examination.

If no medical examination was carried out or all the rights were not recognised, the policy will be indisputable once one year has elapsed following contract perfection, unless there was wilful misconduct on the part of the Policyholder.

5. If the Policyholder, upon requesting the insurance, had made any inaccurate statements as regards the date of birth of any of the Insured Parties, the Insurer may only rescind the contract if the true age of the aforementioned, on the date of entry into effect of the policy, exceeded the limits for acceptance established by the Insurer.

In the event that, as a result of an inaccurate declaration of the date of birth, the premium paid was below that which would have had to be paid, the Policyholder will be obliged to pay the Insurer the difference between the amount actually paid in concept of premium and that which, pursuant to the rates, would have had to be paid based on the true age.

If, on the other hand, the premium paid was higher than that which should have been paid, the Insurer will be obliged to refund the Policyholder the excess premium received, without interest.

ARTICLE 9 - INSURANCE TERM

The insurance is taken out for the period established in the Specific Conditions and, unless

otherwise agreed, the policy term will be a calendar year. Upon maturity, and pursuant to Article 22 of the Insurance Contract Act, it will be tacitly renewed for annual periods.

Notwithstanding the aforementioned, any of the parties may oppose renewal by way of written notification to the other party given at least two months prior to the end of the insurance period in effect at the time. Notification from the Policyholder must be made to the Insurer.

Whilst an Insured Party is undergoing hospitalised treatment, the Insurer may not terminate the policy until said party has been discharged, unless the Insured Party waives continuing with the treatment.

In respect of each Insured Party, the insurance will be terminated:

1. Upon death.

2. When, if the policy includes family members who live with the Policyholder, these cease to live habitually at the address of the latter, circumstance that must be notified to the Insurer. If these people take out another insurance policy before one month has elapsed from the aforementioned notification, the Insurer will maintain all their acquired rights, provided they take out the same cover.

Unless otherwise agreed, minors may only be included in the insurance policy when the person or persons who are legally responsible for them or hold their legal guardianship are also insured.

The cover taken out will not come into effect until the first premium has been paid.

ARTICLE 10 - PREMIUM PAYMENTS

Pursuant to Article 14 of the Act, the Policyholder will be obliged to pay the premiums.

1. The first premium or instalment thereof will be payable, pursuant to Article 15 of the Act, upon signing the contract; if it is not paid due to causes attributable to the Policyholder, the Insurer will be entitled to rescind the contract or demand payment of the premium due via enforcement proceedings based on the policy. **In any case** and unless otherwise agreed, **if the premium is not paid before a claimable event occurs, the Insurer will be released from its obligation in this respect**.

2. In the event of non-payment of the second or successive premiums or instalments thereof, the cover will be suspended a month after the day the premium amount becomes due, and if the Insurer does not demand payment within the six months following said due date, the contract will be deemed terminated. If the contract had not been resolved or terminated pursuant to the aforementioned conditions, the cover will become effective again at twenty-four hundred hours on the day on which the Policyholder pays the premium. In any case, while the contract is suspended the Insurer may only demand payment of the premium for the period current at the time.

3. The Insurer will only be bound by virtue of the receipts issued by its legally authorised representatives.

Payment of premium amounts made by the Policyholder to the broker will not be deemed as made to the Insurer, unless the broker delivers to the Policyholder and in exchange, the premium receipt issued by the Insurer.

4. The Specific Conditions will establish the bank account designated by the Policyholder for payment of the premium payment slips, applying the following rules:

a) The Policyholder will deliver to the Insurer a letter addressed to the bank or savings bank, giving the corresponding order.

b) The premium will be deemed as paid on its due date unless, having attempted collection within a period of thirty calendar days, there were insufficient funds in the Policyholder's account. In this case, the Insurer will notify the Policyholder that the premium is at its disposal at the address of the aforementioned, and the Policyholder will be obliged to make the payment at said address.

c) If the Insurer allows the aforementioned period to elapse without presenting the payment slip for collection, and upon doing so there were not sufficient funds in the Policyholder's account, the former must notify said circumstance to the latter by letter or any other unequivocal means, granting a further period of thirty calendar days for the Policyholder to notify the manner in which the amount will be paid. This period will be counted as from the date of receipt of the aforementioned letter or notification at the last address notified to the Insurer.

ARTICLE 11 - OTHER OBLIGATIONS, DUTIES AND POWERS OF THE POLICYHOLDER OR INSURED PARTIES

1. The Policyholders and, as appropriate, the Insured Parties have the following obligations:

a) To declare to the Insurer, pursuant to questionnaire the Insurer has them complete, all circumstances known to them that could affect assessment of the risk.

They will be exempted from this obligation if the Insurer does not have them fill in the questionnaire or when, even if it does, the circumstances in question, even when they could affect the risk assessment, were not included in the questionnaire.

The Insurer may rescind the contract by declaration addressed to the Policyholder within a period of one month, counted as from the date on which it became aware of the reserve or inaccuracy of the Policyholder or Insured Party. Unless there is wilful misconduct or gross negligence on its part, the Insurer will retain the premiums related to period in effect at the moment at which said declaration is made.

If the claimable event occurs before the Insurer makes the declaration referred to in the preceding paragraph, the service provided by the Insurer will be reduced proportionally to the difference between the agreed premium and that which would have been applied had the true entity of the risk been known. If there was wilful misconduct or gross negligence on the part of the Policyholder, the Insurer will be released from payment of the service.

b) To notify the Insurer, during the term of the contract and as soon as possible, of all circumstances that, pursuant to the previously submitted Insured Party's state of health questionnaire, aggravates the risk and are of such a nature that had they been known by the Insurer, the contract would not have been entered into or it would have been granted with more burdensome conditions.

c) To notify the Insurer, as soon as possible, of any change of address.

d) To notify the Insurer, as soon as possible, of the incorporation or withdrawal of Insured

Parties during the term of the policy, the incorporations taking effect on the first day of the month following that of the date of notification made by the Policyholder and withdrawals on 31 December of said year, adapting the amount of the premium to the new situation.

e) Newborns may be incorporated, as insured parties and without a health questionnaire, in the policy of the mother, provided she has been a CASER Insured Party for a minimum of the eight months, the birth took place under a CASER insurance and incorporation of the newborn is requested within a maximum period of 15 days following its birth, via the corresponding insurance application.

Otherwise, acceptance of the newborn will be subject to fulfilling the conditions established by Caser and the ordinary waiting periods and the corresponding exclusions may be applicable and the requested incorporation may be refused.

In any case, Caser will cover the healthcare for the newborn provided it has been incorporated as an Insured Party.

f) Recently adopted children may be incorporated, as insured parties and without a health questionnaire, in the father or mother's policy, provided one or the other has been a CASER Insured Party for at least the last eight months, and incorporation of the recently adopted child is requested within a maximum period of 15 days from its registration in the Family Book, via the corresponding insurance application.

Otherwise, acceptance of the recently adopted child will be subject to fulfilment of the conditions established by Caser and the ordinary waiting periods and the corresponding exclusions may be applicable and requested incorporation may be refused

g) To reduce the consequences of the claimable event, employing the methods at their disposal for rapid recovery. Breach of this duty, with clear intention of causing damage to or deceiving the Insurer, will release the latter from all services derived from the claimable event.

h) To grant and facilitate the subrogation by the Insurer established under Article 82 of the Act.

2. The Caser Salud health card, which belongs to the Insurer and which it will give to each Insured Party, is a non-transferrable document for personal use. In the event of loss, theft or deterioration, the Policyholder and the Insured Party are obliged to notify this to the Insurer within a period of seventy-two hours.

In such cases, the Insurer will issue and send a new card to the address of the Insured Party that appears on the policy, cancelling the lost, stolen or deteriorated card.

Additionally, the Policyholder and the Insured Party undertake to return to the Insurer the cards corresponding to Insured Parties that are withdrawn from the policy.

The Insurer will not be liable for any improper or fraudulent use of the Caser Salud health card.

3. The Policyholder may demand, within a period of one month following delivery of the policy, that the Insurer corrects any discrepancies between the policy and the insurance proposal or the agreed clauses, pursuant to that established under Article 8 of the Act.

ARTICLE 12 - OTHER OBLIGATIONS OF THE INSURER

Apart from providing the contracted healthcare, the Insurer will give the Policyholder the insurance policy or, as appropriate, the provisional cover document or that which corresponds pursuant to Article 5 of the Act, as well as a copy of the health questionnaire and other documents signed by the Policyholder.

Likewise, it will give the Policyholder a Caser Salud health card, the personal and non-transferrable document, corresponding to each one of the Insured Parties included in the policy.

At the time of subscribing the policy, the Insurer will also provide a copy of the list of practitioners corresponding to the Insured Parties' province of residence, specifying the permanent medical and surgical emergency centre or centres, the permanent outpatients service, the hospitals and clinics, the addresses and surgery hours of the practitioners and the information, emergency and permanent outpatient services in all the capitals of the other provinces.

The Insurer may update the list of practitioners annually, adding or removing practitioners, professionals, hospitals and other establishments listed therein. The Policyholder and/or Insured Parties will be obliged to use the services of the healthcare providers registered at the date of requesting the healthcare. For these purposes they may request an updated list of practitioners in the offices of the Insurer.

ARTICLE 13 - ANNUAL UPDATING OF THE POLICY'S FINANCIAL TERMS

The Insurer may update annually the premium amount and the amounts corresponding to the excess or participation of the Insured Party in the costs of the services, referred to under Article 5, Point 2.3 of these General Conditions. It may also modify the limits and percentages of the expenses reimbursements established in the Special Conditions.

These premium and excess updates, which will include the necessary adjustments to guarantee that the premium rate is sufficient, are based on the technical-actuarial calculations carried out, which in turn are based on the increase in the cost of the healthcare services, the increase in the frequency of the services covered by the policy, the incorporation of technological innovations that appear or are used after contract perfection and which are incorporated in the guaranteed cover, or other events of similar characteristics.

The premiums to be paid by the Policyholder will vary depending on the age of each one of the Insured Parties and the geographic zone corresponding to the service address, applying the current rates of the Insurer at the date of each renewal.

The Policyholder, upon receipt of the notification of these updated premiums and/or excesses for the following annual term may choose between renewing the insurance contract, which means acceptance of the new financial terms, or its rescission at the end of term in progress, by way of the corresponding written notice addressed to the Insurer.

ARTICLE 14 - NOTIFICATIONS

1. Notifications to the Insurer will be carried out at the address stated in the policy.

2. Notifications and premium payments carried out at the branches and offices of the Insurer or to the broker in the contract will have the same effect as if they had been made directly to the Insurer.

ARTICLE 15 - PRESCRIPTION

The actions derived from this contract prescribe in **five years** counted from the date on which they can be exercised.

ARTICLE 16 - JURISDICTION

This contract is subject to Spanish jurisdiction and, within this, the judge competent to hear actions derived from said contract will be that corresponding to the address of the Insured Party in Spain.

This insurance contract includes in an inseparable manner the above General Conditions, the Specific Conditions, the Special Conditions, if any, and the Appendices that set out the modifications referring to all the aforementioned agreed by the parties.

HEALTH INSURANCE SUPPLEMENTARY COVER

SECOND MEDICAL OPINION COVER

1. Purpose of the service

The purpose of this service is to guarantee the persons designated as Insured Parties the services of Second Medical Opinion, as defined herein below.

Second Medical Opinion service will consist in evaluation, by experts of recognised national or international prestige in the pathology in question, of the diagnosis and treatment the Insured Party is undergoing in the process or illness suffered, issuing the corresponding report thereon.

2. Insured Parties

The Insured Parties are the Policyholder and the beneficiaries of the policy included at the time the services are requested and during all the time the service lasts.

3. Description

This cover must be requested during the term of this Healthcare Insurance and in accordance with the following definitions:

a) Second medical opinion regarding the pathologies described within this contract under **Conditions Subject to Second Medical Opinion**. The service consists of:

- Second medical opinion from specialists of maximum national and international prestige.
- Without having to travel and with reply within ten working days, as from the date the Insured Party sends the Second Medical Opinion request form duly filled in, together with the corresponding documentation.
- Patient support, if considered appropriate, following processing of the Second Medical Opinion.

b) Selection of experts and hospital:

- Selection and reference of national and international medical experts and hospitals.
- Advice on the medical care that will be provided in national and international hospitals.

c) When the Insured Party considers that any medical services not included in the Insurer's list of practitioners and contracted centres are appropriate, an expenses management service will be provided, consisting in:

- Appointment management with national and international doctors not on the Insurer's list.
- Obtaining quotes and estimated hospitalisations costs.
- Admission formalities in national and international hospitals.

- Coordination of patient transfer (reservations, air and land ambulance, translation services).

Under no circumstances will these services be provided without prior authorisation from the Insurer.

4. Conditions subject to Second Medical Opinion

The Second Medical Opinion service will be supplied when the Insured Party has already received a first diagnosis of the following serious conditions:

- Cancer
- Cardiovascular diseases
- Neurological and neurosurgical diseases, including cerebrovascular accidents
- Chronic kidney failure
- Idiopathic Parkinson's disease (paralysis agitans)
- Multiple sclerosis
- Diabetes in children
- Tropical diseases

5. Other conditions

The services included in this Healthcare Insurance policy will be provided only when the Insured party, directly or via the Insurer's attending doctor, requests the Second Medical Opinion service by calling the telephone established for said purpose.

Once the telephone request has been made, the Insurer will provide the Insured Party with a questionnaire to be returned, duly completed, together with the medical/clinical records relating to the case, the laboratory tests, medical reports, x-rays, biopsies and any other medical documents held by the Insured Party, corresponding to the first diagnosis made, as well as any reports and supplementary tests that the Insurer may request, depending on the condition.

The Second Medical Opinion service includes the fees and expenses derived directly from the aforementioned medical consultancy and second diagnosis, provided they have been requested as described above. **Any other expenses, costs and fees derived from medical consultancy or treatment, tests and analyses, drafting of reports, x-rays and any other type of examination will be to the account of the Insured Party if said party uses resources not included in the Insurer's practitioner's lists, even when these are related to the illness or clinical condition for which the Second Medical Opinion has been requested.**

6. Use of the service

This service provides medical information, given by an expert, supplementary to the information the Insured Party receives from the attending doctor and it does not seek, under any circumstances, to offer an independent medical diagnosis or therapeutic

decision.

The reply obtained via the Insurer will be conditioned on the veracity and accuracy of the data provided.

The reply the Insured Party receives should not be used to substitute the attending doctor, as a clinical decision requires personalisation that can only be achieved with a personal interview.

7. Request for Second Medical Opinion

Requests for the Second Medical Opinion services may be made by calling telephone **901 33 22 33**. Insured Parties must provide the identification data requested to accredit their right to the service.

HEALTH INSURANCE SUPPLEMENTARY COVER

TRAVEL ASSISTANCE ABROAD

The Insurer guarantees cover under this supplementary guarantee to the Insured Party and other beneficiaries on the policy during the term thereof, which will provided via SMASA, Sociedad Mundial de Asistencia, S.A.

The following definitions will apply:

INSURED PARTY: the individual, resident in Spain and holder or beneficiary of the policy. None of the Insured Parties' rights will be modified or impaired when they travel separately.

RISK TO PEOPLE: this cover is valid in any country in the world, with exception to Spain.

VALIDITY: in order to receive the guaranteed services, Insured Parties must have their address in Spain, which must be their permanent residence and they must not spend more than 90 days travelling or away from this residence.

SERVICE PROVIDER: SMASA, Sociedad Mundial de Asistencia, S.A. with registered address at C/ Albacete 5, 28027 - Madrid.

For the Insurer to assume its obligations, it will be an essential condition that the claimable event is immediately notified to SMASA, Sociedad Mundial de Asistencia, S.A., by calling the telephone indicated in this document.

Cover

1. Repatriation of deceased Insured Parties and their companions

In the event of death of an Insured Party, the Insurer will organise and bear the costs for transporting the body from the place of death to the place of burial in Spain, as well as the return to their homes of the other people accompanying the deceased and who are Insured Parties.

Additionally, the expenses of post-mortem treatment and preparation (such as embalming expenses and the mandatory transfer casket), pursuant to the legal requirements, will be covered **up to a limit of €601.01**.

In any case, the costs of the normal casket and the burial and ceremony costs will not be to the account of the Insurer.

2. Medical repatriation of the injured or sick from abroad

Depending on the urgency or seriousness of the case and at the criteria of the attending doctor, the Insurer will bear the transfer costs of Insured Parties, even under medical surveillance, if necessary, until their admission in a hospital in Spain close to their residence, or to their permanent residence when hospitalisation is not necessary. If hospitalisation is not possible close to the party's home, the Company will bear the costs, when the time comes, of the transfer to their residence.

Transport means:

- Special ambulance aircraft for Europe and countries bordering the Mediterranean Sea
- Scheduled airline flights, rail or ships
- Ambulance

In the event of benign conditions or minor injuries that do not justify repatriation, transfer will be carried out by ambulance or any other means, to a place where suitable care can be provided.

Under no circumstances will the Insurer replace the emergency rescue organisations and nor will it bear the costs of these services.

In all cases, the decision on whether or not to carry out the transfer will correspond to the doctor designated by the Insurer in each case, in agreement with the doctor attending the Insured Party and, as appropriate, the party's family.

Additionally, the Insurer will bear the transfer costs of up to two people travelling with the Insured Party and who are also Insured Parties, up to their place of origin or destination, provided these costs do not exceed those of their return to their home address.

3. Payment and reimbursement of medical, surgical, pharmaceutical and hospitalisation costs abroad

Under this cover the Insurer will bear the costs, **up to a limit of €15,000.00**, of the expenses incurred by each Insured Party outside Spain as a result of an accident or an illness of an unforeseeable nature, occurred during the trip and within the term of this cover.

In any case, **emergency dental costs are limited to €120.20**.

The expenses reimbursements mentioned herein are, in any case, supplementary to any other benefits that both Insured Parties and their successors are entitled to, whether for Social Security benefits or those of any other insurance scheme to which they may be affiliated.

Therefore, the Insured Party undertakes to take the necessary steps to recover the expenses from these organisations and to reimburse the Insurer any amount that it may have advanced.

4. Travel expenses for a family member to accompany the Insured Party hospitalised abroad

If the sick Insured Party's condition prevents repatriation and if hospitalisation in the location of the Insured Party exceeds five days, the Insurer will bear the following costs:

- A return rail (first class) or aircraft (tourist class) ticket for a member of the Insured Party's family, or the person the latter designates, to travel to the place of hospitalisation.
- Additionally, the Insurer will pay, upon presentation of the corresponding supporting documents, the bed and board expenses of the aforementioned person, **up to €66.11 per day and a total of no more than €661.11**.

5. Extension of the hotel stay abroad

In the event that the sick or injured Insured Party, in the opinion of the attending doctor and in agreement with the doctor designated by the Insurer, is unable to return home, the Insurer will pay the expenses arising from the Insured Party's extended stay in a hotel and board, **up to €66.11 per day and a total of no more than €661.11**.

6. Sending medicines abroad

The Insurer will deal with locating and sending any possible medicines that are of vital importance and which cannot be found in the country where the Insured Party is hospitalised.

Sending these medicines will be subject to the legislation of the country from where they are requested.

Nevertheless, the Insurer will cease to be liable if the Spanish Pharmaceutical Ministerial Department or Pharmaceutics Board reports that the required product does not exist in the Spanish domestic market.

7. Transmission of urgent messages derived from the cover

The Insurer will place a 24-hour telephone helpline at Insured Parties' disposal, to transmit urgent messages related to incidents derived from the Travel Assistance cover.

8. Repatriation or transfer of family members under the age of fifteen

If minors under the age of 15 travelling with the Insured Party are left without assistance and unable to continue their journey due to an accident, illness or transfer of the Insured Party covered by the policy, the Insurer will organise their return to their home address or residence given, sending a family member or providing a steward to accompany them, if necessary, on the transport means and date determined by the Insurer.

9. Interpreter in the event of accident or illness

If, as a result of an accident covered by the policy or serious illness occurred abroad, the services of an interpreter are required in the place of occurrence the Insurer will provide one to the Insured Party as soon as possible.

The expenses covered by the Insurer will be limited to €30.05 per day, with a maximum total of €180.30.

10. Advance of procedure bonds and expenses

If, as a result of judicial proceedings initiated due to a vehicle accident occurred outside the country of the address or residence stated on the policy, the Insured Party is required to pay a bond in a criminal case to achieve provisional release or is required to give a fees retainer to settle legal defence costs, the Party may request, after giving a formal undertaking to reimburse the amounts given within a period of sixty days, an advance from the Insurer of **up to a maximum amount of €6,010.12 for the bond, and €601.01 for the procedural costs.**

With a view to guaranteeing the advanced amount, the Insurer reserves the right to demand, prior to the making the advance, that a person in Spain designated by the Insured Party gives written undertaking to reimburse the advance by way of the corresponding recognition of debt.

In any case, this cover does not include the Insured Party's legal defence.

11. Support in administrative formalities for hospitalisation

The Insurer will collaborate in carrying out any administrative formalities that may be required for the Insured Party's admission to hospital.

12. Deposits for hospitals

If, due to accident or serious illness covered by the policy, the Insured Party needs to be admitted to hospital, the Insurer will bear the costs of the deposit that the centre may require to admit the Insured Party, **up to a maximum limit of €601.01**.

13. Advance of cash in the event of accident, larceny or serious illness abroad

Should the Insured Party urgently require cash as a result of an accident covered by the policy or due to larceny of property, or serious illness, the Insurer will advance the corresponding amount, **up to a maximum amount of €1,502.53**.

With a view to guaranteeing the advanced amount, the Insurer reserves the right to demand, prior to the making the advance, that a person in Spain designated by the Insured Party gives written undertaking to reimburse the advance by way of the corresponding recognition of debt.

This advance will be subject to the legislation of the country from which it is requested.

The Insured Party undertakes to reimburse the amount advanced by the Insurer within a period of 10 days as from the finalisation of the trip, and in any case, within two months as from the date on which the advance was made.

14. Accompaniment of mortal remains

In the event that there is no-one to accompany the mortal remains of the Insured Party, the Insurer will provide the person designated by the successors with a return train (first class) or aircraft (tourist class) ticket, to accompany the body.

15. Expenses for the person accompanying the mortal remains

When the aforementioned cover is applicable, if the companion has to stay at the place of death, due to formalities related to the transfer of the mortal remains, the Insurer will bear the bed and board costs of the stay **for an amount of €60.10/day and for a maximum of three days**.

16. Early return due to death of a family member

When Insured Parties travelling have to interrupt their trip due to the death in Spain of their spouse, ascendant or descendant in first degree, or sibling, the Insurer will provide them with a train (first class) or aircraft (tourist class) ticket, from the place the Insured Parties are at the time to the place of burial of the deceased family member in Spain, together with a ticket to return to the place they were located at the time of the event; or two tickets to their permanent place of residence, provided they are Insured Parties.

17. Aid in locating and sending luggage

In the event of delay or loss of luggage, the Insurer will collaborate in the claim and the search, location and sending of luggage to the Insured Party's address.

18. Sending and/or resending objects forgotten and/or stolen during the trip

The Insurer will organise and bear the costs of resending to the Insured Party's address any object that the Insured Party may have been forgotten in the place or places visited during the trip.

GENERAL EXCLUSIONS TO THE TRAVEL ASSISTANCE ABROAD COVER

The following cover is excluded from the policy:

- **Relapse of illnesses with risk of sudden aggravation of which the Insured Party was aware upon commencing the trip.**
- **Pathological conditions known by the Insured Party and with medical history and which could be worsened by travelling.**
- **Pregnancy. Nevertheless, up to the sixth month, unexpected complications will be covered.**
- **In cases of acute dental problems, these being deemed as those caused by infection, pain or trauma, which require urgent treatment, the expenses will be limited, in any case, to a maximum of €120.20.**
- **Rescue of people on mountains, sea or deserts.**
- **Services derived from participation in high risk sports, such as mountain climbing, climbing, motocross, gliding, hang-gliding and similar.**
- **Accidents occurring whilst skiing.**
- **Expenses relating to a chronic illness, prostheses of any kind and thermal cures.**
- **Any medical expense below €9.02.**
- **Suicides, self-injury and drug or alcoholic intoxication.**
- **Under no circumstances will the Insurer replace the emergency rescue organisations and nor will it bear the costs of these services.**
- **Acquired Immune Deficiency Syndrome (AIDS), as well as all the problems derived from alcohol and drug addiction.**
- **Vaccinations and checks of previously known diseases.**
- **Thermal cures and UVA ray treatments.**
- **Physiotherapy and massage therapy.**
- **Mental diseases and psychoanalysis and psychotherapy.**

ADDITIONAL CONDITIONS TO THE TRAVEL ASSISTANCE ABROAD COVER

1. This cover is supplementary to the Healthcare Insurance policy, and will not be valid unless accompanied by the latter.

2. The Insurer declines all responsibility for any delays or failures due to circumstances of force majeure.

3. As regards travel expenses for the insured people, the Insurer will only bear the costs of excess expenses, over and above those they would normally have foreseen (train, aircraft tickets, fares, maritime voyages, vehicle fuel, etc.).

4. The Travel Assistance cover is provided via SMASA, Sociedad Mundial de Asistencia, S.A., which has the sole function of providing the service.

5. For the Insurer to assume its obligations, it will be an essential condition that the claimable event is immediately notified to SMASA, Sociedad Mundial de Asistencia, S.A., by calling the telephone indicated in this document.

6. To use the indicated services, it will be sufficient to call the following number, which may be done reversed charge:

Assistance abroad:
34 91 595 50 49

INSURED PARTIES OMBUDSMAN SERVICE

1. CAJA DE SEGUROS REUNIDOS, Compañía de Seguros y Reaseguros, S.A. (CASER) places at its customers' disposal an Insured Parties Ombudsman Service (Complaints and Claims) at Avenida de Burgos 109, 28050 Madrid and at the electronic mail address: *defensa-asegurado@caser.es*.

2. This Service will deal with and resolve, pursuant to prevailing regulations and within a maximum period of two months as from their filing, any complaints and claims submitted directly or via a duly accredited representative, by any individuals or incorporated entities that are CASER insurance users and participants in or beneficiaries of CASER employment pensions plans and CASER associates, when these refer to their legally recognised interests and rights related to their insurance transactions and pension plans, whether derived from the policies themselves, the regulations on transparency and customer protection or best practices and customs, and in particular, the principle of equity.

Complaints and claims will be submitted in writing to any office of the entity or the central office of CASER GESTIÓN TÉCNICA, A.I.E. (Avenida de Burgos, No. 109, 28050, Madrid), by post or by computerised, electronic or online means, provided these enable their reading, printing and conservation and meet the legal requirements and characteristics established in the Regulations.

3. Once a decision has been issued and the claims procedure with the Insured Parties Ombudsman Service has been exhausted, should claimants still disagree with the decisions announced or if two months elapse following receipt without said Service issuing a decision in the matter, claimants may address their claim to the *Servicio de Reclamaciones de la Dirección General de Seguros Fondos de Pensiones* [Pension Plan Insurance Department's Claims Office], Paseo de la Castellana, 44, 28046 Madrid; however, the decisions of this body are not binding. Likewise, they may submit them to the competent courts and tribunals.

4. Both at CASER offices and on its web page www.caser.es, our customers and users, as well as injured parties, will find a claims form, the CASER Insured Parties Ombudsman Service Regulations, which govern the activities and operation of this Service, and the characteristics and requirements for submitting and resolving complaints and claims.

5. The decisions reached will take into account the obligations and rights established in the policies' General, Specific and Special Conditions, as well as in the regulations that govern the insurance sector and those on transparency and customer protection in financial services (Insurance Contract Act [*Ley de Contrato de Seguro*]; Redrafted text of the Private Insurance Classification and Supervision Act and Regulations [*Texto Refundido de la Ley y Reglamento de Ordenación y Supervisión de Seguros Privados*]; the Financial System Reform Act [*Ley de Reforma del Sistema Financiero*]; the Collective Investment Entities Act [*Ley de Instituciones de Inversión Colectiva*]; Royal Decree 303/2004, dated 20 February; Order ECO 734/2004, dated 11 March, the Consumers and Users' Defence Act and Regulations, [*Ley y Reglamento para la Defensa de Consumidores y Usuarios*], and the General Contracting Conditions Act [*Ley de Condiciones Generales de la Contratación*])