CASER SALUD ACTIVA

Health insurance policy

General Conditions

CAJA DE SEGUROS REUNIDOS

Compañía de Seguros y Reaseguros, S.A.

Registered address: Avenida de Burgos, 109 - 28050 Madrid

caser.es

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Pursuant to Article 3 of the Insurance Contracts Act 50/80 of 8 October, the clauses limiting the rights of the insured parties in the general conditions of the policy are highlighted in bold print.

This contract is subject to the Insurance Contracts Act 50/1980 of 8 October, and to Act 20/2015 of 14 July on the Classification, Supervision, and Solvency of Insurers and Underwriters and its implementation regulations.

The company´s insurance activities are supervised by the Spanish Ministry for the Economy and Competition, through its Directorate-General of Insurance and Pension Funds.

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GENERAL CONDITIONS

PREAMBLE

This insurance contract is regulated by the provisions of the Insurance Contracts Act 50/1980 of 8 October, (published in the Official Gazette of 17 October, 1980), by Act 20 /2015 of 14 July on the Classification, Supervision, and Solvency of Insurers and Underwriters and its implementation regulations (Royal Decree No. 1060/2015 of 20 November), and by the general, specific and special conditions of this contract. The company´s insurance activities in Spain are supervised by the Spanish Ministry for the Economy and Competition, through its Directorate-General of Insurance and Pension Funds.

By signing the application, the specific conditions or, as applicable, the insurance certificate, the policyholder specifically accepts the clauses limiting the rights of the insured that appear in bold print.

ARTICLE 1 - DEFINITIONS

For the purposes of this contract, the following definitions apply:

ACCIDENT: means an event resulting in bodily injury occurring while this policy is in force, where the injury is caused by a violent, sudden, and external event beyond the control of the insured.

CASER HEALTH CARD: means the health card which is issued to each insured party included in the policy by the Insurer, and which is the property of the Insurer. This card may only be used by the holder, who should show it whenever s/he wants to receive the services covered under the policy.

CLAIMABLE EVENT: means an event suffered by the insured after which s/he requires healthcare services that are fully or partially covered under the policy.

CONGENITAL DISORDER, DEFECT, DISABILITY OR ABNORMALITY: means any condition that exists at birth as a result of hereditary factors, or has been acquired during the development of the foetus. A congenital condition may appear and be diagnosed at birth, or be discovered later at any time during the life of the insured.

DEDUCTIBLE OR COPAYMENT: means the amount the policyholder has to pay the Insurer for a healthcare service used by him/herself or by the insured parties in his/her policy. The amount can vary depending on the type of healthcare service and/or medical speciality provided, and is established in the specific conditions. It may be updated annually.

DOCTOR: means a health professional who meets the legal requirements to practice medicine.

EMERGENCY: means a situation where the insured requires immediate medical assistance in order to prevent irreparable damage to his/her health.

HEALTH QUESTIONNAIRE: means the document which the policyholder and/or insured party should fill in completely and accurately, sign, and return to the Insurer so that it has all the information it needs in order to assess the risk.

HOSPITAL: means any institution that is legally authorised to provide medical and surgical treatment to outpatients or inpatients for illnesses or injuries. These institutions must have a doctor permanently on duty, and will only admit patients who are sick or injured.

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

HOSPITALISATION:

- General hospitalisation: means the situation where a person is registered as a patient at a hospital, and either spends the night or has a main meal there.

- Day hospital: means the situation where a person is registered as a patient at one of the medical, surgical or psychiatric day units of a hospital in order to receive specific treatment, or because they have received an anaesthetic, but when they do not stay overnight, and may or may not have a main meal in the unit.

ILLNESS: means any change to the insured party's health which is not the result of an accident, that is diagnosed by a doctor, which requires healthcare services, and where the first symptoms appear while this policy is in force.

INCONTESTABILITY PERIOD: means the period of time, starting from the effective date of the insurance policy for each of the insured parties, during which the Insurer may refuse to provide coverage of services, or challenge the contract, on the grounds that the insured has a pre-existing illness which s/he did not declare in the health questionnaire. Once this period has elapsed, the Insurer may only refuse to provide coverage if there has been wilful concealment by the insured party.

INSURED: means the natural or legal person who is a beneficiary of the insurance policy and who is responsible for assuming the obligations arising from the contract, except for those that the policyholder is responsible for. Unless it is expressly stated otherwise in the specific conditions, the policyholder and the insured shall be one and the same.

INSURER: means the legal person that assumes the contractually agreed risk. In this policy the insurer is CAJA DE SEGUROS REUNIDOS, Compañía de Seguros y Reaseguros, S.A., hereinafter referred to as "the Insurer".

LIST OF MEDICAL PRACTITIONERS: means the list of healthcare professionals and institutions belonging to or contracted by the Insurer in each province, with their addresses, telephone numbers and opening hours. The list of medical practitioners for each province will include, in addition to the healthcare professionals and institutions in the province, the information services and customer helplines that insured parties can call for the whole of Spain.

NURSING ASSISTANT/ REGISTERED NURSE: means a healthcare professional who meets the legal requirements and has the qualifications needed to practice nursing.

POLICY: means the document or documents that contain the clauses and agreements that regulate 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 specify the risks; the special conditions, if any; and the supplementary documents or appendixes that contain any modifications agreed upon during the term of the contract.

POLICYHOLDER: means the natural or legal person who enters into this contract with the Insurer, and who must comply with the obligations arising from the contract, except for those which, due to their nature, must be met by the insured party.

PRE-EXISTING ILLNESS: means any medical condition that started before the effective date of insurance.

PREMIUM: means the price of the insurance. The total amount of the premium will include the legally applicable surcharges, taxes and fees. Insurance premiums are annual, even though they may be paid in instalments.

PROSTHESES, IMPLANTS AND GRAFTS: means any element of any kind that replaces, either temporarily or permanently, all or part of an organ, tissue, body fluid, or limb (valves, artificial skin, intraocular implants, biological material, gels, synthetic or semisynthetic fluids that replace bone or body fluids and drug reservoirs, among others).

REHABILITATION: means all the therapy provided by a rehabilitation specialist, with the help of physiotherapists, which is carried out in a rehabilitation centre and whose purpose is to restore functionally to the parts of the insured´s musculoskeletal system which have been affected by an illness or accident that occurred during the term of the policy.

SERVICE: means the healthcare assistance provided as a result of a claimable event.

SPECIAL HOME MEDICAL ASSISTANCE SERVICES: means medical assistance provided by a GP or family doctor, nursing assistant, or registered nurse to the insured in the home that appears on the policy, when s/he is suffering from an illness that requires special health care but not hospitalisation. This service must always be pre-authorised by a specialist doctor who is on the Insurer´s list of medical practitioners.

SPECIALIST DOCTOR OR SPECIALIST: means a doctor who has the qualifications required to practise one of the legally recognised medical specialities.

SPECIFIC CONDITIONS: means the document that sets out and specifies the insured risks, and which forms an integral part of the policy.

SURGICAL OPERATION: means any operation carried out through an incision or any other means of internal entry by a surgeon, and which normally takes place in an operating theatre.

WAITING PERIOD: means the period of time that must pass before some of the insured´s healthcare coverage comes into effect. This period is calculated by months, and starts from the effective date of the insurance policy for each of the insured parties.

ARTICLE 2 - PURPOSE OF THE INSURANCE

The Insurer undertakes to provide the insured, in Spain, with the medical, surgical and hospital healthcare that s/he requires for illnesses and injuries that are covered by this insurance policy, subject to the limits and conditions stipulated in the policy, and payment of the premium and applicable deductibles. All healthcare services will be provided by the medical practitioners with whom the Insurer has entered into an agreement at the time when the service is provided.

The Insurer undertakes to provide any emergency assistance required in accordance with the policy conditions, and the terms of Article 103 of the Insurance Contracts Act.

Under the terms of this policy no cash payments in lieu of healthcare services will be made.

ARTICLE 3 - DESCRIPTION OF THE HEALTH INSURANCE COVER

The medical specialities, healthcare services, and other services covered by this policy are as follows:

1. FAMILY MEDICINE

General medicine/GP: healthcare provided at the doctor´s surgery or at home. The latter will only be provided when the patient cannot travel for medical reasons.

Paediatrics – child care: includes preventive and child development check-ups.

Nursing assistant/registered nurse services: healthcare provided at the doctor´s surgery or at home. The latter will only be provided when the patient cannot travel for medical reasons, and the visit has been pre-authorised by one of the Insurer´s doctors.

2. EMERGENCIES

If an insured requires emergency healthcare s/he should go to one of the 24/7 emergency health services centres that is in the Insurer´s list of contracted medical practitioners and medical centres. Emergency medical services will be provided at the insured´s home by one of the Insurer´s GPs and/or a nursing assistant when the patient´s state of health makes this necessary.

3. MEDICAL SPECIALITIES

Specialist healthcare will be provided to the insured either as an outpatient or inpatient (according to the medical criteria of the Insurer´s doctor) for the following specialities:

3.1. Allergology: the vaccinations will be paid for by the insured.

3.2. Anaesthesiology and resuscitation.

3.3. Anatomical pathology: determination of the following therapeutic targets in a preliminary study, prior to personalised cancer treatment based on the type and stage of tumour, is specifically included:

Therapeutic target	Tumour type/stage	Treatment
HER2	Breast cancer Advanced gastric cancer (metastatic)	HER2 inhibitors
EGFR	Lung cancer	EGFR inhibitors
KRAS	Advanced colon cancer (metastatic)	anti-EGFR monoclonal antibodies
BRAF	Advanced melanoma (metastatic)	BRAF inhibitors
c-Kit	Gastrointestinal stromal tumours	c-Kit inhibitors
ALK	Lung carcinoma	ALK inhibitors

Only the therapeutic targets which are listed in a drug's specifications and, depending on the therapeutic approach taken in each case, have to be determined before the drug is administered will be covered. The drugs must have demonstrated clinical effectiveness and importance, be marketed in Spain, and be authorised and approved by the Spanish Agency of Medicines and Medical Devices.

3.4. Angiology and vascular surgery: this covers grade III to VI symptomatic varicose vein surgery, in accordance with the CEAP classification, which assesses and classifies venous insufficiency for the treatment or elimination of saphenous vein reflux by means of endolaser for thermal ablation (endovascular laser), radiofrequency (endovascular radiofrequency fibre), or sclerotherapy. The treatment will be provided at the medical centres which have an agreement with the Insurer to this effect.

3.5. Digestive system.

3.6. Cardiology: this cover includes a cardiovascular risk prevention programme 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 reconstructive surgery: this insurance only covers breast reconstruction after surgery for breast neoplasms, where the surgery has been performed during 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: autologous bone marrow transplants are included **only for the treatment of haematological tumours.**

3.18. Immunology.

3.19. Tropical and infectious 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: this covers the neurophysiological intraoperative monitoring of the nervous system solely and exclusively for intracranial surgery, and for the fusion or arthrodesis of three or more levels of the spine.

3.27. Neurology.

3.28. Obstetrics and gynaecology.

a) **Birth preparation:** this includes a set of techniques that are practised in order to prepare the expectant mother physically and psychologically for birth. It is aimed at women who are at least three months pregnant.

b) **Pregnancy healthcare/monitoring:** the pregnancy is monitored by an obstetrician.

c) **Family planning:** this cover includes tubal ligation, hormonal contraception monitoring, and IUD insertion and monitoring. The **cost of the intrauterine device is included provided that the insured buys it at a chemist.** The Insurer will reimburse 100% of the cost after the insured has presented the doctor´s prescription and the corresponding invoice. **Hysteroscopic tubal occlusion, the insertion of Essure devices, or any other techniques are not covered**.

d) **Preventive medicine:** annual gynaecological check-ups for the early detection of breast and cervical neoplasms. This cover also includes the study and diagnosis of infertility and sterility.

e) **Diagnosis of infertility and assisted reproduction:** this cover provides infertility treatment for couples. The cover includes the study, diagnosis (through the most common standard complementary tests) and treatment of a couple´s infertility, up to a limit of **3 attempts at artificial insemination and 1 attempt at in-vitro fertilisation**. ICSI (sperm microinjection) is included, if necessary. **The maximum age limit for the application of the different techniques is set at 43 years for women. Treatment is excluded in the event of voluntary infertility or when it is the result of a natural physiological process. Furthermore, the diagnosis of one of the couple as infertile must be confirmed.**

   This cover is limited to one birth per policy.

   This cover does not include sperm FISH analysis, the sperm DNA fragmentation test, Embryoscope incubators, HBA sperm selection, vitrification, the freezing/thawing and storing of embryos, eggs, ovarian tissue and sperm, or the costs of egg donation or preimplantation genetic diagnosis (PGD). Immunoglobulin therapy is specifically excluded.

   In order to receive the treatment covered by this insurance it is essential that both of the couple are insured parties and beneficiaries of the cover. A waiting period of 24 months is established for each member of the couple.

   The treatment will be provided by medical practitioners designated by the Insurer, and at the medical centres and hospitals specified by the Insurer, which will not necessarily be located in the province where the insured lives.

   All assisted reproduction procedures will be performed in compliance with the legislation in force.

f) **Postpartum home services**.

3.29. Dentistry-oral medicine: this only includes tooth extractions at the dentist´s clinic, follow-up care, plain intraoral X-rays, and annual dental cleaning (tartar removal) **prescribed by a dentist–oral surgeon on the Insurer´s list of medical practitioners, and performed at a dental and oral-medicine clinic.** The conditions of this coverage are given in Annex I of this document.

3.30. Ophthalmology: this includes laser photocoagulation and corneal transplants; the insured will be responsible for the cost of the cornea to be transplanted.

3.31. Medical oncology: this cover includes implantable port-a-cath reservoirs for intravenous perfusion in chemotherapy.

3.32. Radiotherapeutic oncology: except for radioembolisation with spheres, and limited exclusively to cancers and arteriovenous malformations.

3.33. Otorhinolaryngology: this cover includes radiofrequency for the treatment of illnesses related to the respiratory system.

3.34. Clinical psychology: cover includes individual, short-term outpatient psychological treatment, prescribed by a psychiatrist on the Insurer's list of medical practitioners, in order to treat conditions that can benefit from psychological treatment, **up to a maximum of 20 outpatient sessions per insured and year.**

A prescription from one of the specialists on the Insurer's list of medical practitioners and authorisation from the Insurer will be required prior to treatment.

3.35. Psychiatric treatment.

3.36. Rehabilitation and physiotherapy: this cover **only includes outpatient treatment for disorders of the musculoskeletal system.** Lymphatic drainage after breast cancer surgery carried out during the term of the policy is included.

A prescription from one of the specialists on the Insurer's list of medical practitioners and authorisation from the Insurer will be required prior to treatment.

3.37. Rheumatology.

3.38. Pain treatment: this cover includes implantable reservoirs (port-a-cath type).

3.39. Traumatology and orthopaedic surgery.

3.40. Urology: this includes vasectomies, diagnosis of impotency (not treatment) as well as a study and diagnosis of infertility and sterility. It also includes Holmium surgical laser for endourological surgery, lithiasis, stenosis and tumours, and the greenlight laser (KTP and HPS) for surgical treatment of benign prostatic hyperplasia. All treatment will be provided at centres that have prior agreements with the Insurer to this effect.

4. DIAGNOSTIC METHODS

This cover includes all the standard diagnostic methods recognised in medical practice at the time of taking out the policy, and in all cases the diagnostic tests will be only carried out with a **prior written prescription from a specialist listed in the Insurer's list of medical practitioners**. **Diagnostic studies and tests for research or scientific purposes, and plastic surgery tests, are not covered**. The contrast mediums and radiopharmaceuticals used are included in the cover.

4.1 Clinical analyses: biochemical, haematological, microbiological, parasitological, cytopathological, and those for surgical anatomical pathology.

4.2 Conventional radiology: this includes standard diagnostic techniques such as plain radiology (head, trunk, limbs, special skull X-rays and dental radiology), and special non-invasive radiology (digestive, urological and gynaecological), nuclear magnetic resonance (NMR), computerised axial tomography (CAT scan), bone densitometry, and ultrasound scanning.

4.3 Visceral and vascular interventional radiology.

4.4 Others:

1. **Nuclear medicine:** radioactive isotopes and gammagraphy.

2. **Positron emission tomography (PET):** in cases of cancer and drug-resistant epilepsy.

3. **Endoscopy: If endoscopic capsules are used, only those used for the small intestine will be covered.**

4.5 Cardiological diagnostics: electrocardiograms, stress tests, echocardiograms, conventional Holter monitor, Holter event monitor, Doppler, hemodynamic and electrophysiological studies, and coronary CAT scans.

4.6 Clinical neurophysiology: electroencephalograms, electromyography, evoked potentials, and polysomnography solely for studying the obstructive sleep apnoea syndrome.

4.7 Triple Screening, amniocentesis and foetal karyotyping in high-risk pregnancies.

4.8 Digital dermoscopy: this is for the early detection of malignant melanoma in people with a family and/or personal history of melanoma, dysplastic nevus syndrome and/or when the person has multiple nevi/moles. It must be prescribed by one of the Insurer's doctors related to the speciality to be treated, and performed at clinics that have an agreement with the Insurer.

4.9 Detection of sentinel lymph nodes in breast cancer and melanoma.

4.10 Early detection of deafness in children: this includes consultations and examinations, otoacoustic emissions, and brainstem auditory evoked potentials.

5. HOSPITALISATION

Insured parties will be admitted to a hospital either belonging to or contracted by the Insurer when a doctor at the hospital issues an admission order to this effect. The insured will have his/her own room with a bathroom and a bed for a companion (unless this is clearly impossible), except for those cases which are expressly excluded. The Insurer will be responsible for the operating theatre expenses, anaesthetic products and the drugs used during both surgery and hospitalisation, as well as the materials required for the post-operative care, and the insured´s board whilst hospitalised.

5.1. Medical hospitalisation (without surgery): the length of the insured´s stay in hospital will be decided by the Insurer's doctor in charge of the healthcare, and the insured will remain in hospital until the doctor considers that s/he can be sent home. Day hospitalisation is included.

5.2. Paediatric hospitalisation: this includes conventional hospitalisation and incubator (the latter does not include a bed for a companion). **It also includes the hospitalisation of premature or sick newborns in a specialist centre (neonatology), provided that the newborn is registered as an insured party in the policy.**

5.3. Maternity hospitalisation: the insured will be attended by an obstetrician and midwife. The cover includes anaesthesia (including epidural anaesthesia**) as well as a cot and incubator for the newborn, provided that s/he is registered as an insured party in the policy.**

5.4. Surgical hospitalisation: this includes day hospitalisation (major outpatient surgery).

5.5. Hospitalisation in the Intensive Care Unit (ICU): the insured will be admitted to the appropriate facilities of a hospital, designated by the Insurer, when an admission order has been issued by a doctor at said hospital. The head of the Intensive Care Unit will decide how long the insured has to stay in the Unit. **Due to the nature of this type of hospitalisation a bed for a companion is not included.**

5.6. Psychiatric hospitalisation: this is only for the treatment of acute episodes suffered by patients who have previously been diagnosed as having a reversible illness by one of the Insured´s specialists. The patient will be admitted as an inpatient or outpatient **up to a maximum of sixty days per**

calendar year. Due to the nature of this type of hospitalisation, a bed for a companion is not included.

5.7. Special home care: when the Insurer's doctor considers that the insured requires hospital-type healthcare which is covered by the policy, but does not have to be admitted to hospital, medical and nursing care may be provided to the insured at the home that appears in the policy.

Expenses incurred as a result of social care, accommodation and board costs, linen, food, medication, and healthcare materials are excluded, as are the general healthcare provided by GPs, nursing assistants and registered nurses, and the round-the-clock presence of healthcare professionals in the insured's home.

6. PROSTHESES, GRAFTS AND IMPLANTS

This cover includes fixed internal temporary or permanent prostheses, which should be provided by the suppliers designated by the insurer and implanted during the term of the policy, such as: cardiac valves (**except for valve endoprostheses (pulmonary and aortic), and METRACLIP and similar devices for percutaneous/transapical procedures using a catheter);** vascular bypasses; pacemakers; stents; orthopaedic prostheses; osteosynthesis material; monofocal intraocular lenses for cataract surgery **(except toric and bitoric lenses);** breast prostheses following surgery for breast neoplasms (provided that the surgery was performed during the term of the policy), although **the contralateral prosthesis will not be covered unless it is for a neoplasm;** and auditory prostheses **(except cochlear implants, Carina implants and similar devices)**. Testicular prostheses will only be covered after cancer surgery**, and the contralateral prosthesis will not be covered unless it is for a neoplasm.**

7. SPECIAL TREATMENTS

In all cases **these treatments will only be carried out after the insured has received a written prescription from one of the specialists in the Insurer's list of medical practitioners**, and will be performed at a medical centre designated by the Insurer which specialises in the illness. **The insured will require authorisation from the Insurer prior to receiving treatment.**

- **Aerosol and ventilation therapy: all medication will be paid for by the insured.**
- **Oxygen therapy:** this will be provided for both inpatients and outpatients. Outpatient oxygen therapy is provided for patients who require oxygen treatment for at least 16 hours a day.
- **Dialysis (haemodialysis and peritoneal dialysis):** this only covers the treatment of acute renal failure on the days that it is necessary. **Chronic conditions are expressly excluded.**
- **Phoniatrics: solely as rehabilitation following major larynx surgery, for up to a maximum of 60 sessions.**
- **Laser therapy:** this is only included for ophthalmological treatments, musculoskeletal rehabilitation, urology (in accordance with the terms of Article 3), and in varicose vein treatment (in accordance with the terms of Article 3).
- **Chemotherapy and radiotherapeutic oncology, except for radioembolisation with spheres and limited exclusively to cancers and arteriovenous malformations.** The patient will receive treatment as an inpatient or through day hospitalisation, although intravesical BCG instillations for the treatment of superficial bladder cancer will be provided at an outpatient clinic. **The Insurer will only pay the costs of cytostatic drugs that are available in the domestic market, duly authorised**

by the Ministry of Health, and used following the instructions given in the product´s technical data sheet.

- **<u>Extracorporeal renal lithotripsy.</u>**

8. OTHER SERVICES

- **<u>Ambulances:</u>** this insurance policy only covers **the insured´s urban and intercity journeys from his/her home to the hospital or vice versa, and only in the case of hospital admissions or emergency healthcare. An order from the insurer's doctor will be required, except in case of emergencies.**

  Ambulance transfers will always be made using land ambulances, and may be requested when the insured is physically unable to use ordinary transport services (public transport, taxi or own vehicle). All transfers will require a written order from a doctor indicating that the insured needs to be transferred by ambulance.

- **<u>Podiatry:</u>** chiropody, only at the doctor´s surgery, and biomechanical gait studies for under 15-year olds.

ARTICLE 4 - EXCLUDED RISKS

a) Injuries resulting from wars, uprisings, revolutions and terrorism; those caused by officially declared epidemics; those related directly or indirectly with radiation or nuclear reaction and; those caused by disasters (earthquakes, floods and other seismic or meteorological phenomena).

b) Pharmaceuticals, radiopharmaceuticals and medicaments of any kind that are prescribed when the insured is not hospitalised, as well as vaccines of all kinds and parapharmaceuticals.

c) Healthcare arising from the consumption of alcohol or drugs of any kind.

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

e) Healthcare required as a result of injuries suffered while: engaging in high risk activities such as bullfighting or running with bulls; the practice of dangerous sports such as scuba diving, pot-holing, boxing, martial arts, climbing, rugby, motor sports, quad vehicles, paragliding; aerial activities not authorised for public passenger transport, sailing activities or white water rafting, bungee jumping, canyoning, skiing, snowboarding, surfing and any other manifestly dangerous activity, as well as the healthcare required for the professional practice of any sport.

f) The healthcare required for all kinds of illnesses, injuries, or accidents, together with their long-term impacts or consequences, congenital defects or abnormalities, and pre-existing conditions which were diagnosed prior to the effective date of the policy for each insured party, as well as the healthcare for symptoms that may be the start of a medical condition and which appeared before such date, or for which the insured has undergone analyses, diagnostic tests or treatments of any kind prior to the effective date, unless such illnesses, injuries, accidents, symptoms, defects or abnormalities were declared by the policyholder or insured in the health questionnaire and the Insurer had specifically agreed to cover

them in the specific conditions. This exclusion will not affect insured parties who have been covered by the insurance policy since birth, pursuant to Point 1.e) of Article 10.

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

h) General preventative check-ups or examinations unless they are specifically included in Point 3 of Article 3.

i) Sterility or infertility treatments (except those that are specifically included in point 3.28 of Article 3), the voluntary termination of pregnancy in any circumstances as well as the diagnostic tests required for the termination, and treatment (including surgery) for impotence.

j) The following are expressly excluded from the insurance cover: surgical operations, filtrations, treatments, and any other type of medical intervention that is performed for purely cosmetic reasons; illnesses, complications and special diagnostic and/or therapeutic tests that are directly related or a consequence of the insured having undergone a surgical operation, infiltration or treatment for purely cosmetic reasons. In these cases the insurer will only be liable for the tests needed for gynaecological check-ups.

k) Everything related to psychology, ambulatory monitoring for narcolepsy, sophrology, neuropsychological and psychometric tests, psychoanalytic psychotherapy, psychosocial rehabilitation or neuropsychiatry, psychoanalysis, hypnosis, group psychotherapy, psychological tests, rest cures and sleep therapy is specifically excluded from the coverage, except when expressly included in Point 3.34 of Article 3.

l) Organ and organ tissue transplants, except for autologous bone marrow and corneal transplants (the insurer will not pay the costs of the cornea to be transplanted).

m) Healthcare for AIDS and diseases caused by the human immunodeficiency virus (HIV), as well as any type of treatment and healthcare for hepatitis C and its complications.

n) Hospital healthcare and treatment for social or family reasons, as well as the hospital healthcare and treatment which can be replaced by healthcare and treatment at home or at an outpatient clinic.

o) In the dentistry-oral medicine speciality the following are excluded: dental fillings, root canal treatment, insertion of dental prostheses, orthodontic treatment, periodontal treatment and implants as well as any dental treatment other than that listed in Point 3.29 of Article 3.

p) Treatments to restore functioning of the mouth and teeth, such as orthognathic, pre-implantologic or preprosthetic surgery.

q) Surgical correction of myopia, hypermetropy or astigmatism, presbyopia and any other refractive eye condition. In addition, intracorneal segment/ring implants are also excluded, as is crosslinking as a treatment for keratoconus.

r) All the surgical and/or therapeutic techniques that use laser, except for those expressly included in Point 7 of Article 3.

s) Transportation and travelling expenses, except for the ambulance expenses included in point 8 of Article 3. In addition, any transfers required for appointments, diagnostic or

therapeutic tests, rehabilitation, physiotherapy, phoniatrics, psychology, radiotherapy, cancer treatment, surgery and all the special treatments are excluded, irrespective of whether the treatment is provided as an inpatient or an outpatient.

t) Chronic dialysis treatments.

u) Physiotherapy and rehabilitation treatments when the insured has recovered functional use of the affected part or has made the fullest possible recovery, in the opinion of the specialist in charge of the treatment, or when it becomes occupational maintenance therapy. Educational therapy is excluded. Pelvic floor and lymphatic drainage rehabilitation are excluded, except that which is expressly included in point 3.36 of Article 3, as is the rehabilitation required as a result of a neurological disorder.

v) Genetic tests to determine whether the insured, or his/her present or future descendants have a genetic predisposition to diseases caused by genetic alterations are excluded, with the sole exception of those that are expressly included in the cover, such as amniocentesis (except for the in situ hybridisation technique), karyotyping (except for karyotyping of foetal tissue), and the therapeutic targets described in Article 3. Genetic counselling, paternity and kinship testing, cancer gene-mapping and pharmacogenetics, whether for preventive or predictive purposes, are also excluded, as is massive gene sequencing, molecular karyotyping, comparative genomic hybridisation techniques, microarray platforms with automated interpretation of results, and any other genetic and/or molecular biology testing that may be requested for prognostic or diagnostic purposes.

w) Diagnostic and therapeutic procedures that have not been scientifically proven are excluded, as are those that appear after the insured has signed the policy. In addition, procedures that have not gained widespread acceptance and are not well-established in standard clinical practice, those which have been replaced by other available procedures, experimental procedures, and those whose effectiveness in the prevention, treatment and curing of illnesses has not been clearly established are also excluded.

A diagnostic, surgical, or therapeutic procedure is considered to be safe and effective, for the purposes of this policy, when it has been approved by the European Medicines Agency and/or the Spanish Agency of Medicines and Medical Devices. A procedure is considered to have gained widespread acceptance and be well-established when it has been adopted as standard clinical practice at public hospitals which are not among the top-ranking public hospitals.

x) All sleep disorder diagnostic methods are specifically excluded, except for those specified in Point 4 of Article 3.

y) Metabolic and obesity surgery, and the implanting/fitting of gastric bands and intragastric balloons.

z) Robotic surgery and neuromonitoring for any diagnostic, surgical, or therapeutic procedures are excluded, except as specified for neurophysiology in point 3.26.

aa) Implantable drug-delivery pumps and spinal stimulation electrodes are expressly excluded.

bb) Any kind of orthopaedic material, orthotic devices, external fixators, biological or synthetic materials, grafts (except bone grafts), prostheses, dental osseointegrated implants and cochlear implants, valve endoprostheses (pulmonary and aortic), METRACLIP and similar devices for percutaneous/transapical procedures using a catheter

are excluded, as are implantable pumps, penile and testicular prostheses (except after cancer surgery) intraocular multifocal lenses, and implantable automatic defibrillators. The infiltration of autologous growth factors (plasma rich in growth factors) and/or platelet concentrates and cellular components is also excluded.

cc) Breast reduction surgery is excluded.

dd) Cytoreductive surgery and intraperitoneal chemotherapy are excluded.

ee) Health and social care and/or palliative care are excluded.

ARTICLE 5 - HOW THE SERVICES ARE PROVIDED

The healthcare covered under this policy will be provided in all the towns where the Insurer has centres or a list of contracted medical practitioners. If a service listed in the policy is not available in one of these towns, it will be provided in another town where it is available, in which case the town will be chosen by the insured party.

New diagnostic and therapeutic procedures, and new technologies, will be included in the policy in accordance with medical principles once their effectiveness and safety has been proven, and they are available at the centres that the Insurer has entered into an agreement. Treatment provided by healthcare professionals, appointments, and diagnostic or therapeutic methods prescribed by a doctor will not be covered by this policy unless they are included in the healthcare services covered by this policy.

1. HEALTHCARE ADVICE AND GUIDANCE

Insured parties have a Healthcare Advice and Guidance Service at their disposal, whose purpose is to advise the insured when s/he wants to use the healthcare services by explaining the procedures to be followed, and providing any other assistance that is required.

2. FREE CHOICE OF DOCTORS

Insured parties are free to choose the primary healthcare doctors and specialist practitioners that they want, provided they are on the Insurer's medical practitioners list that is in force at the time.

The Insurer recommends that each insured have a general practitioner or paediatrician to provide family healthcare services. Insured parties should choose their general practitioner or paediatrician and nursing assistant from the medical practitioners on the Insurer's list, and inform the Insurer of who they have chosen. They should also notify the Insurer if they change doctors. If the insured does not live in the catchment area of the practitioner s/he has chosen, the Insurer will not be obliged to provide medical home visits.

3. HOME VISITS

Home visits by the GP or nursing assistant will be made from between 09:00 and 17:00, and following a telephone request made to the practitioner. **Home visits will be made only to the address given in the policy**. The insured should notify the Insurer of any changes to his/her home address at least 8 days before any healthcare service is requested.

In the event of an emergency the insured should go to the 24/7 emergency health services centre established by the Insurer, or telephone the emergency helpline that is listed in the documentation given to insured parties.

4. COST-SHARING

In the case of healthcare services with a copayment amount, the insured will be required to pay a copayment for the service s/he has received. Caser will calculate the total amount of copays payable by the insured on the basis of the invoices it receives from the insured´s doctor. The copay amounts are listed in the specific conditions of the policy.

To this end, the Insurer will periodically send the policyholder a complete list of the services used by the insured parties in the policy, together with the amount of the copayments.

The total amount to be paid by the insured will be paid to the Insurer by direct debit from the bank account designated by the policyholder for the premium payments.

The copay amounts may be updated by the Insurer, in accordance with Article 12 (ANNUAL UPDATING OF THE POLICY'S FINANCIAL TERMS).

5. AUTHORISATION OF SERVICES

In general, hospitalisation, surgical operations, special treatments, rehabilitation and physiotherapy, psychological treatment, assisted reproduction treatment and diagnostic tests will require a written prescription from the Insurer's medical practitioner and prior express authorisation from the Insurer.

Documentation to be submitted for services that require authorisation:

When healthcare services have to be expressly authorised by the Insurer the insured will, at its request, provide the Insurer with a medical report which should include the history, date of commencement, date of diagnosis, causes, origin and evolution of the condition suffered.

The insured must obtain the Insurer´s prior authorisation before receiving any healthcare services, which will be given unless the Insurer considers that it is a service which is not covered by the policy, or is related to or preparatory to a service which is not included in the cover. After the Insurer has issued its written authorisation, it is responsible for paying its share of the costs of the healthcare service.

In the event of an emergency the only authorisation required will be that of the Insurer's doctor, although the insured must obtain the Insurer´s authorisation within the seventy-two hours following his/her hospitalisation or from the start of the healthcare service. The Insurer will be responsible for paying its share of the costs of the healthcare service up to the time when it challenges the doctor's authorisation on the grounds that the healthcare service or hospitalisation in question is not covered by the policy.

6. EMERGENCIES

In the event of an emergency the insured should telephone the emergency services, or by go directly to the 24/7 emergency health services centre of the Insurer. The address and telephone number of the emergency services centre are given in the Insurer´s list of medical practitioners.

7. TEMPORARY RELOCATIONS

The Insurer undertakes to provide healthcare to insured parties who are temporarily relocated away from their home throughout the whole of Spain. In this case they should use the healthcare services belonging to or contracted by the Insurer which are listed in the documentation given to insured parties.

8. HEALTHCARE IN MEDICAL FACILITIES NOT CONTRACTED BY THE INSURER

The Insurer is not liable for the fees of practitioners who are not on its medical practitioners list, nor for the costs of any hospitalisation or healthcare services they prescribe.

9. ACCREDITATION OF INSURED PARTIES

When requesting healthcare services the insured must show his/her Caser health card, which the Insurer will have given them for this purpose. The insured must sign the receipt for the healthcare services provided.

The doctor or the centre providing the service may also request, when they consider it appropriate, the national ID card of those persons who are legally obliged to have one.

ARTICLE 6 - WAITING PERIODS

The healthcare services for which a specific period of time must pass, as from the effective date of the policy, before some or all of the insured´s healthcare coverage begins are:

Six-month (6) waiting period:

- Family planning.
- Surgical operations and hospital admissions.
- Cancer and cardiovascular treatments, lithotripsy and dialysis.

Ten-month (10) waiting period:

- Hospitalisation and admittance to hospital for deliveries/caesarean deliveries. This cover will be provided for premature deliveries if the approximate due date of the baby, had it not been premature, is after the end date of the waiting period for this service.

Twenty-four month (24) waiting period:

- Assisted reproduction.

ARTICLE 7 - CONTRACT BASIS, LOSS OF RIGHTS, RESCISSION AND INCONTESTABILITY OF CONTRACT

1. The declarations made by the policyholder and insured in the questionnaire-insurance application regarding their state of health constitute the basis for the Insurer´s acceptance of the risk in this contract, and form an integral part of such contract.

2. The insured will lose the right to the insured healthcare services:

   a) In the event that s/he withholds or misrepresents information when completing the questionnaire about his/her state of health (Article 10 of the Act).

      The Insurer may rescind the policy through a statement addressed to the policyholder within a period of one month, as of the time it learns of said withholding or misrepresentation. As soon as the Insurer makes this statement it is entitled to keep the premiums corresponding to the period underway, unless there is wilful intent or gross negligence on its part.

If a claimable event occurs before the Insurer has sent the statement referred to in the previous paragraph, the service provided to the insured shall be reduced in the same proportion as that existing between the premium agreed in the policy and the premium that would have been applied if the Insurer had been aware of the true nature of the risk. If there is wilful intent or gross negligence on the part of the policyholder or insured, the Insurer shall be released from its obligations to pay for any of the healthcare services.

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

c) When the claimable event has been caused due to bad faith on the part of the insured party (Article 19 of the Act).

3. However, the Insurer undertakes:

a. In the event that the insured is being treated in hospital, not to terminate the policy until the insured has been discharged, unless s/he decides not to continue with the treatment.

b. Not to challenge the renewal of insurance contracts in which there are insured parties who have certain serious illnesses, provided that the illness was first diagnosed when the policy was in force. The illnesses for which insured parties may be receiving treatment during the term of the contract, and which are covered, are as follows:

· Active cancers.
· Cardiac diseases which require surgical or interventional treatment.
· Organ transplants.
· The ongoing evolution or current after the immediate high of surgery orthopedic surgery complex
· Degenerative and demyelinating diseases of the nervous system.
· Acute renal failure.
· Torpid chronic respiratory failure.
· Chronic liver diseases (except alcoholic liver diseases).
· Acute myocardial infarction with cardiac failure.
· Macular degeneration.

c. Not to challenge the renewal of insurance contracts in which there are insured parties who are over 65-years old when they can show that they have been an insured party for the last five years or more, and they have paid all of the insurance premiums.

The above undertakings given by the Insurer will not be applicable, or will cease to be valid, in the following circumstances:

a. The insured fails to comply with his/her obligations, or has withheld or misrepresented information when declaring the risk.
b. The policyholder fails to pay a premium, or does not accept an updated premium.
c. The policyholder does not accept the new conditions upon renewal of the contract.

4. The policyholder may cancel the contract when the list of medical practitioners for his/her province is changed by more than 50%, in which case s/he should formally notify the Insurer of his/her decision. This clause will not be applicable if the doctors are temporary replacements standing in for doctors who are officially off-work, are doctors who perform special surgical techniques, or dentists, analysts, electrologists and radiologists.

5. If any of the dates of birth of the insured parties in the application form filled in by the policyholder are inaccurate, the Insurer may only cancel the contract if the insured/s does/do not comply with the minimum or maximum age limits for applicants who want to enrol with the Company, on the effective date of the policy.

   If, as a result of an inaccurate declaration of the date of birth, the premium paid for an insured was less than that which should have been paid, the policyholder will be obliged to pay the Insurer the difference between the amount actually paid as the premium and the amount which, in accordance with the Insurer´s rates, should have been paid on the basis of the insured´s true age.

   However, if 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 8 - INSURANCE TERM

This insurance policy is taken out for the period established in the specific conditions. Pursuant to Article 22 of the Insurance Contracts Act, it will be automatically renewed for annual periods at the end of each insurance period.

Notwithstanding the terms of Article 7.3.c, either of the parties may decide not to renew the contract, in which case they should notify the other party in writing of their decision. In this case the policyholder should notify the Insurer at least one month before the end of the insurance period underway, while the Insurer should notify the Policyholder at least two months before the end of the insurance period underway. The notification from the policyholder must be sent to the Insurer.

The Insurer may not terminate the policy while the insured is in hospital for treatment, and must wait until he/she has been discharged, unless the insured decides not to continue with such treatment.

With respect to each insured party, the insurance will be terminated:

1. Upon death.
2. When, if the policy includes family members who live with the policyholder, they move out of the policyholder´s home, in which case the Insurer must be notified of the change in the situation. If a family member takes out another insurance policy with the Insurer within one month, starting from when the above notice was sent, the Insurer undertakes to maintain all their acquired rights, provided they take out the same cover.

Minors may only be included in the insurance policy when their parents or legal guardians are also insured in the same policy, unless there is a specific agreement to the contrary.

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

ARTICLE 9 - PAYMENT OF PREMIUMS

Under Article 14 of the Act, the policyholder is 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 shall be entitled to terminate the contract or initiate enforcement proceedings to demand payment of the outstanding premium, in accordance with the terms and conditions of the policy. **If the premium has not been paid prior to a claimable event the Insurer shall be released from its obligations,** unless there is an agreement otherwise.

2. In case of failure to pay the second or successive premiums or instalments thereof, the insured´s coverage will be suspended a month as from when the policy expired. If the Insurer does not request payment of the premium within the six (6) months subsequent to when the premium became due, the contract shall be considered to be terminated. If the contract has not been terminated or cancelled in accordance with the preceding conditions, the policy coverage will take effect again at midnight of the day on which the policyholder pays the premium. In any case, during the period that the contract is suspended, the Insurer may only request payment of the premium for the insurance period underway.

3. The Insurer will only be obliged to provide healthcare services when the insured parties have payment receipts issued by its legally authorised representatives.

   Premium payments made by the policyholder to the broker will not be considered to be payments to the Insurer, unless the broker gives the policyholder the premium payment receipt issued by the Insurer.

4. The bank account designated by the policyholder for payment of the premiums will be given in the specific conditions, and the following norm will apply. Premiums will be considered paid at renewal unless, having attempted collection during a period of thirty calendar days, there were insufficient funds in the policyholder's account.

ARTICLE 10 - OTHER OBLIGATIONS, DUTIES AND RIGHTS OF THE POLICYHOLDER AND INSURED PARTIES

1. The policyholder and, as applicable, the insured, have the following obligations:

a) To declare all the circumstances known to him/her that could affect the risk assessment when s/he completes the Insurer´s health questionnaire.

   S/he will be exempted from this obligation if the Insurer does not have him/her fill in the questionnaire or when, even if it does, the circumstances in question were not included in the questionnaire, even though they could have affected the risk assessment.

   The Insurer may rescind the policy through a statement addressed to the policyholder within a period of one month, as of the time it learns of any withholding or misrepresentation by the policyholder or insured. As soon as the Insurer makes this statement it is entitled to keep the premiums corresponding to the period underway, unless there is wilful intent or gross negligence on its part.

b) If a claimable event occurs before the Insurer has sent the statement referred to in the previous paragraph, the service provided to the insured shall be reduced in the same proportion as that existing between the premium agreed in the policy and the premium that would have been applied if the Insurer had been aware of the true nature of the risk. If there is wilful intent or gross negligence on the part of the policyholder, the Insurer shall be released from its obligations to pay for any healthcare services. While the contract is in force the policyholder or insured must notify the Insurer, as quickly as possible, of any circumstances that, pursuant to the health questionnaire s/he submitted, might aggravate a risk and are such that if the Insurer had been aware of them before entering the contract it would not have signed the contract, or it would have established conditions less favourable to the policyholder.

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

d) To notify the Insurer, as soon as possible, if any insured parties have to be removed from or added to the policy during the term of such policy. Any such additions or removals will come into effect on

the first day of the month following that of the date of notification made by the policyholder. The removal of an insured from the policy during the term of the policy will be accepted when it is a consequence of: the death of the insured, a change of residence abroad, the separation of the couple, the emancipation of one of the insured, or in the event that one of the insured is to be provided with insurance as an employee benefit.

e) Newborn and recently adopted children may be included as additional insureds in the policy of their parents, and do not need to have a health questionnaire, nor will the terms established for waiting periods or pre-existing illnesses apply, provided the parents have been CASER insured parties for a **minimum of eight (8) months** and the application is made within a maximum period of 15 days, starting from the day s/he was born in the case of newborns, and from the day s/he was registered in the family book in the case of recently adopted children.

   Once the 15 days have expired, newborns or recently adopted children will only be added to the policy if they meet the conditions established by the Insurer. In this case the ordinary waiting periods and exclusions will apply, and the Insurer will have the right to refuse applications.

   The Insurer will provide healthcare services for newborns when they have been included in the policy as an insured party.

f) To mitigate the consequences of a claimable event, taking all the measures at his/her disposal to ensure s/he recovers rapidly. If the policyholder or insured fails to comply with this obligation with the clear intention of trying to harm or defraud the Insurer, it will be released from all its obligations arising from the claimable event.

g) To grant and facilitate the subrogation by the Insurer established in Article 82 of the Insurance Contracts Act.

2. The Caser Salud health card, which belongs to the Insurer and which it will give to each insured, is a document which may only be used by the insured. If it is lost, stolen, or damaged the policyholder or insured should notify the Insurer within a period of seventy-two (72) hours.

   In these cases the Insurer will send a new card to the address of the insured party that appears in the policy, and cancel the lost, stolen, or damaged card.

   Additionally, the policyholder and insured undertakes to return the card of any insured parties that are removed from the policy to the Insurer.

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

3. If the content of this policy differs from the insurance proposal or from the agreed clauses, the policyholder may ask the Insurer to rectify the discrepancies within a period of one month, starting from when they received the policy, pursuant to Article 8 of the Insurance Contracts Act.

ARTICLE 11 - 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 or other document as described in Article 5 of the Insurance Contracts Act, as well as a copy of the health questionnaire and other documents signed by the policyholder.

The Insurer will also give the policyholder the Caser Salud health cards, which may only be used by the holder, for all the insured parties included in the policy.

On signing the policy the Insurer will give the policyholder a copy of the list of medical practitioners for the province where s/he lives, with the addresses and other necessary information of the 24/7 medical and surgical emergency centre or centres, the 24/7 outpatient clinic, the hospitals and medical clinics, and the addresses and surgery hours of the medical practitioners. It will also provide the addresses and other necessary information of the information services, and 24/7 emergency and outpatient services in all the capitals of the other provinces.

The Insurer may update the medical practitioners list annually, adding or removing medical practitioners, healthcare professionals, hospitals and any other institutions on the list, and these changes will come into effect on 1 January of each year. The policyholder and/or insured parties must use the services of the healthcare providers who are on the list when they request a healthcare service. To this end they may request an updated list of medical practitioners at the offices of the Insurer.

ARTICLE 12 - ANNUAL UPDATING OF THE POLICY'S FINANCIAL TERMS

The Insurer may update the premiums and the copayments for the healthcare services annually, as stipulated in Point 4 of Article 5 of the general conditions.

These premium and copay updates include the adjustments needed to ensure that the premium rate is high enough. They are based on technical-actuarial calculations which take into account increases in healthcare prices, increases in healthcare service utilisation, the appearance of new technologies after the contract has been entered into and which are available under the terms of the policy, and other similar events.

The premiums to be paid by the policyholder will vary depending on the age of each one of the insured parties and the region where the home of the insured is located. The rates of the Insurer that are in force at the date of each renewal will be applied.

When the policyholder receives the notice informing him/her of the updated premiums and/or copayments for the following annual insurance period, s/he may choose between renewing the insurance contract, which means accepting the new financial terms, or cancelling the contract when it expires, in which case s/he should send written notice to the Insurer.

ARTICLE 13 - NOTICES

1. All notices to the Insurer should be sent to the address given in the policy.

2. Notices and premium payments made at the branches and offices of the Insurer, or to the insurance broker, will have the same effect as if they had been made directly to the Insurer.

ARTICLE 14 - LIMITATION OF RIGHTS

Any legal proceedings that may arise from this contract will become statute-barred after **five (5) years,** starting from the date on which they could have been initiated.

ARTICLE 15 - JURISDICTION

This contract is subject to Spanish jurisdiction and, within this, the judge competent to hear any legal action arising from this contract will be the judge of the court that corresponds to the domicile of the insured party in Spain.

This insurance contract is made up of the above general conditions, the specific conditions, the special conditions, if applicable, and the appendixes with the contractual amendments that have been agreed upon by the parties. They all form an integral and inseparable part of the contract.

SUPPLEMENTARY HEALTHCARE INSURANCE COVER

ANNEX I: DENTAL ASSISTANCE COVERAGE

1. Purpose of the service

In addition to the dental healthcare covered by the policy, the Insurer undertakes to provide the insured with the outpatient dental healthcare described in this supplementary cover. This healthcare will either be provided free-of-charge, or will require the payment of the maximum amounts (deductibles) given in the corresponding coverages.

The dental healthcare will be provided only by the medical practitioners who are listed in the Insurer´s Services Guide which is in force for the year.

Under the terms of this policy, insureds cannot choose to receive cash payments in lieu of the services provided under this cover.

2. Description of the cover

This section contains a description of the oral medicine services available to the insured for the year that is underway. It includes the services which are **free-of-charge,** as well as the services for which a **maximum amount** (deductible) must be paid.

The list of services for which a **maximum amount** (deductible) must be paid for may be updated annually, if the prices of the service suppliers change and/or if the Insurer deems it necessary. The Insurer will always notify insured parties of any changes to the prices of the maximum amounts (deductibles) in advance.

The cover available and maximum amounts (deductibles) are available at our website: casersalud.es

3. Excluded risks

a. **Injuries resulting from wars, uprisings, revolutions and terrorism; those caused by officially declared epidemics; those related directly or indirectly with radiation or nuclear reaction and; those caused by disasters (earthquakes, floods and other seismic or meteorological phenomena).**

b. **Healthcare arising from chronic alcoholism or the addition to drugs of any kind.**

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

d. **Any other dental healthcare that is not expressly included in the special conditions of the policy, where the insurance cover and insured healthcare services are described.**

4. How the services are provided

The services included in this additional cover may be used by all the insureds, and do not require the authorisation of the Insurer.

When requesting this healthcare the insured must show the identification document that the Insurer will provide him/her with for this purpose.

The Insurer is not liable for the fees of practitioners who are not on its medical practitioners list, nor for the costs of any healthcare treatment they may prescribe.

For the purposes of this policy, it will be understood that the Insurer has been informed of the claim when the insured requests the services provided under this cover.

All the insured treatments and healthcare will be provided at an outpatient clinic, and therefore hospitalisation and general anaesthesia are excluded.

If there are alternative treatments for a procedure, the insured will decide which treatment s/he wishes to receive.

5. Structure and provision of the service

The Insurer will provide insureds with an extensive list of oral medicine professionals, who have the most advanced diagnostic methods and treatments. The cover is valid for the whole of Spain, and comprises two types of cover:

1. Covered healthcare: services which the insured may use free-of-charge.
2. Services with maximum amounts: services for which the insured must pay a special price. Insureds will be provided with a list of the services with **maximum amounts** (deductibles) so that they know what the maximum amounts are before requesting a quote.

6. Using the services

- **Choice of professional**: the insured may select the professional of his/her choice from the list of professionals who appear in the Services Guide.
- **Accessing the service:** in order to use the dental services and obtain the special prices (when applicable), the insured must present the health card which shows they are a CASER SALUD insured.
- **Diagnoses and quotes:** after making a diagnosis the healthcare professional will give the insured a quote, based on the maximum recommended prices in force (for services with an added charge), which should be accepted by the insured before the start of the treatment.
- **Treatments:** in the case of treatments with an added charge the insured must accept the quote before starting the treatment.
- **Payment of treatments:** in the case of treatments with an added charge, the insured should pay the medical professional or Centre where the treatment is provided directly.

ANNEX II: SECOND MEDICAL OPINION COVERAGE

1. Purpose of the service

The purpose of this cover is to provide the persons designated as insured parties with a second medical opinion, as described below.

The Second Medical Opinion service comprises an assessment of the diagnosis and treatment the insured is undergoing by recognised national and international experts in the field, who will then issue a report.

2. Insured parties

The policyholder and beneficiaries who are included in the policy when the service is requested and while the service is being provided will be considered to be insured parties.

3. Description

This healthcare service must be requested while the healthcare insurance contract is in force, and is as follows:

a) A second medical opinion for the illnesses listed in the **Illnesses for which the Second Medical Opinion service may be requested** section of this contract. The service consists of:

- Obtaining a second medical opinion from national and international highly-prestigious specialists.
- The insured will not have to travel, and will receive a reply within ten working days, starting from when s/he returns the completed second medical opinion request form, together with the corresponding documentation.
- Patient support, if considered appropriate, will be provided after the second medical opinion has been processed.

b) Selection of experts and hospitals:

- The insured will be advised as to the best national or international medical expert and hospital, and provided with a referral.
- The insured will be informed about the medical assistance that will be provided in national and international hospitals.

c) If the insured wants to contract medical services that are not included in the Insurer's list of medical practitioners and contracted centres, an expenses management service will be provided, which will:

- Manage appointments with national and international doctors who are not on the Insurer's list.
- Obtain quotes and estimated hospitalisation costs.
- Deal with the admission process to national and international hospitals.
- Coordinate patient transfers (reservations, air and land ambulance, translation services).

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

4. Illnesses for which the Second Medical Opinion service may be requested

The Second Medical Opinion service will be provided when the insured has already received a preliminary diagnosis for the following serious illnesses:

- Cancer.
- Cardiovascular diseases.
- Neurological and neurosurgical conditions, including strokes.
- Chronic kidney disease.
- Idiopathic Parkinson´s disease (paralysis agitans).
- Multiple sclerosis.
- Diabetes in children.
- Tropical diseases.

5. Other conditions

The services listed in this healthcare insurance policy will only be provided when the insured, or his/her doctor, requests the Second Medical Opinion service by calling the phone line set up for this purpose.

Once the telephone request has been made, the Insurer will send the insured a questionnaire which s/he should fill in and return, together with the medical/clinical records relating to his/her illness, laboratory tests, case history, x-rays, biopsies and any other medical documents s/he has about the preliminary diagnosis, as well as any complementary reports or tests that the Insurer may request, depending on the insured´s illness.

The Second Medical Opinion service includes the fees and expenses incurred directly from the medical consultancy and second diagnosis services described above, provided they have been requested in the way described above. **Any other expenses, costs and fees incurred from medical consultancy or treatment, tests, analyses, drafting of reports, x-rays and any other type of examination will be paid for by the insured if s/he decides to use the services of a medical practitioner or institution that is not in the Insurer's Services Guide, even when these are related to the illness or clinical condition for which the Second Medical Opinion was requested.**

6. Using the service

This service provides the insured with medical information, given by an expert, to supplement the information s/he has received from the doctor who is treating him/her. However, at no time will the doctor giving the second opinion offer an independent medical diagnosis or suggest therapeutic treatment.

In order to receive an accurate and reliable second medical opinion, via the Insurer, the information provided by the insured should be as true and accurate as possible.

The insured should not use the second medical opinion to substitute the doctor that is treating him/her, as any clinical decision requires person-specific information which can only be obtained by a clinical interview between doctor and patient.

7. Requesting a Second Medical Opinion

Insured parties who wish to request the Second Medical Opinion service should phone **901 33 22 33** and, when asked, must provide the information required to identify themselves to show they are entitled to use the service.

ANNEX III: TRAVEL ASSISTANCE ABROAD COVERAGE

The Insurer guarantees that the policyholder and other policy beneficiaries will be eligible for this supplementary cover for the term of the insurance period. It will be provided by CASAVI Asistencia en Viaje S.L. **with a maximum insured amount of €15,000 per insured and annual insurance year, at all times.** The following definitions will apply:

INSURED: the natural person, resident in Spain, who is the policyholder and other policy beneficiaries. None of the insured parties' rights will be modified or impaired if they travel separately.

RISK TO PEOPLE: this cover is valid in any country in the world, except for Spain.

VALIDITY: in order to use the services provided under the cover, the insured must have a home in Spain which is his/her habitual residence, and must not spend more than 90 days away from this home.

SERVICE PROVIDER: CASAVI Asistencia en Viaje, S.L., whose registered office is at Av/ de Burgos, 109, 28050, Madrid.

In order for the Insurer to comply with its obligations, it is essential that the insured immediately notify CASAVI Asistencia en Viaje, S.L., of the occurrence of a claimable event by calling the telephone number given in this document.

PARTIAL REIMBURSEMENT LIMITS

Notwithstanding the preceding section, any reimbursements paid by the Insurer will not exceed the limits that are established below for each type of cover:

Coverage

1. Repatriation of deceased insured party and their companions

In the event of the death of an insured party, the Insurer will organise and pay the costs of transferring the body to its place of burial in Spain. The Insurer will also pay for the return of any other insured parties who were with the deceased to their home.

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

However, the cost of the burial coffin and the burial and ceremony expenses are not included in this cover.

2. Medical repatriation of the injured or sick from abroad

Depending on the urgency and seriousness of the case, and according to the medical criteria of the doctor in charge of the case, the Insurer will organise and pay for the transfer of the injured or sick insured party, under medical supervision if necessary, to a hospital in Spain close to his/her home, or to his/her home if hospitalisation is not necessary. If it is not possible to have the insured admitted to a hospital close to his/her home, the Company will pay the costs of transferring the insured to his/her home, when s/he is discharged from hospital.

Means of transport:

- Special ambulance aircraft for Europe and countries bordering the Mediterranean Sea.
- Commercial airline flights, train and ship.
- Ambulance.

If the insured is suffering from a benign condition or minor injury that does not call for repatriation, s/he will be taken by ambulance, or any other means of transport, to a place where s/he can receive suitable healthcare.

Under no circumstances will this service replace the emergency or assistance services of the country in question, nor will the Insurer accept such costs.

In all cases the decision as to whether or not to transfer the insured party will be taken by the doctor appointed to the case by the Insurer, in agreement with the doctor attending the insured and, as appropriate, his/her family.

Additionally, the Insurer will pay the travel expenses of up to two other insured parties who were travelling with the sick or injured insured party to take them to the place where they started their journey, or were due to end it, provided that these expenses do not exceed the travel expenses of returning them home.

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

Under this cover the Insurer will pay, **up to a limit of €15,000.00**, the expenses incurred by each insured outside Spain as a result of an accident or unforeseeable illness which occurs during a journey and the term of the insurance policy.

Emergency dental expenses are limited to €120.20.

The reimbursement of expenses will supplement any other amounts that the insured parties and their successors, either through Social Security payments or any employment insurance scheme they may belong to, are entitled to.

The insured therefore undertakes to take the steps necessary to recoup the expenses from the aforementioned entities, and to reimburse the Insurer any advance payments it has made.

4. Travel arrangements for a family member to accompany the insured if s/he is hospitalised abroad

If the condition of the injured or sick insured party means they cannot be repatriated, and they are hospitalised for more than five days in the place where they are, the Insurer will:

- Provide a family member, or another person chosen by the insured, with a return train (first class) or plane (tourist class) ticket so that they can accompany the insured in hospital.
- The Insurer will also pay the accommodation and meal expenses for the companion, provided they present the pertinent receipts, for an amount of **up to €66.11 per day, and for a maximum amount of €661.11.**

5. Extension of a hotel stay abroad

If, in the opinion of the doctor treating the insured and with the agreement of the Insurer's doctor, the sick or injured insured party cannot return home to Spain and must extend his/her stay in the hotel, the Insurer will pay the accommodation and meal expenses incurred due to the extended stay for an amount of **up to €66.11 per day, and for a maximum amount of €661.11.**

6. Sending medicines abroad

The Insurer will find and send any essential medicines which cannot be found in the country where the insured party is hospitalised.

The shipment of any medicines will be subject to the legislation of the country from which they are requested.

Nevertheless, the Insurer will cease to be liable if the Spanish Directorate of Pharmaceutical Products or the National Pharmaceutical Council reports that the required product is not available in the Spanish domestic market.

7. Transmission of urgent messages related to the insurance coverage

The Insurer will provide the insured parties with a 24-hour telephone helpline which they can call to send any urgent messages they need to send as a result of an incident that is covered by the travel assistance cover.

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

If minors under the age of fifteen (15) travelling with the insured party are left alone and unable to continue their journey because the insured suffers an accident or illness covered by the policy, or has to be transferred, the Insurer will arrange for them to return home. In this case the Insurer will either pay for a family member to accompany the minor/s, or arrange for someone else to accompany them, if necessary. The means of transport and travel date will be chosen by the Insurer.

9. Interpreter in the event of accident or illness

If the insured has an accident or serious illness abroad which is covered by the policy, and needs the services of an interpreter, the Insurer will send an interpreter to help him/her as soon as possible.

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

10. Advance payments for bail and legal expenses

If, as a result of judicial proceedings arising from a traffic accident which occurs outside the country of residence given in the policy, the insured party is required to post bail in a criminal case in order to be released, or has to pay a retainer fee to meet the legal defence costs, s/he may request an advance from the Insurer of **up to a maximum of €6,010.12 for the bail, and €601.01 for the legal expenses.** However, when requesting the advance the insured must give the Insurer a formal undertaking to reimburse the money advanced within sixty days**.**

In order to guarantee repayment of the advanced amount the Insurer reserves the right to require that a person in Spain, designated by the insured, gives a written undertaking before the advance is paid to reimburse the money paid through an acknowledgement of debt.

The legal defence of the insured party is specifically excluded from this cover.

11. Assistance with hospital admittance procedures

The Insurer will help arrange the insured´s admittance to hospital.

12. Deposits for hospitals

If, due to an accident or serious illness covered by the policy, the insured needs to be admitted to hospital, the Insurer will pay the costs of the deposit that the hospital may require from the insured before admitting him/her, **up to a maximum of €601.01**.

13. Cash advances in the event of accident, theft, or serious illness abroad

If the insured urgently needs cash because of an accident covered by the policy, theft of his/her possessions, or a serious illness, the Insurer will advance him/her **up to a maximum of €1,502.53.**

In order to guarantee repayment of the advanced amount the Insurer reserves the right to require that a person in Spain, designated by the insured, gives a written undertaking before the advance is paid to reimburse the money paid through an acknowledgement of debt.

Any advance payments made will be subject to the legislation of the country from which they are requested.

The insured undertakes to repay the money advanced by the Insurer within a period of 10 days, starting from the end of the journey and, in any case, within two months following the date on which the advance was paid.

14. Accompanying the body of the deceased

In the event that there is no-one to accompany the body of the deceased insured party, the Insurer will provide the person designated by his/her successors with a return train ticket (first class) or plane ticket (tourist class), so that they can accompany the body.

15. Accommodation expenses for the person accompanying the deceased

If, when the aforementioned cover has been requested, the companion has to extend their stay at the place where the insured died in order to deal with the formalities required to transfer the deceased´s body, the Insurer will pay their accommodation and meal expenses **up to a limit of €60.10/day and for a maximum of three days.**

16. Early return due to the death of a family member

If any of the insured parties have to cut short their journey while they are travelling due to the death of their spouse, an ascendant or descendant in first degree of kinship, or sibling, the Insurer will provide him/her with a return train ticket (first class) or return plane ticket (tourist class) so that s/he can travel to the place of burial of the family member in Spain and return to where s/he was before the event occurred, or with two tickets to his/her home if s/he is travelling with a companion who is also an insured party.

17. Assistance with locating and forwarding luggage

If the insured´s luggage is delayed or lost, the Insurer will help report the loss, participate in the search to find it, and make sure it is forwarded to the insured's home after it is found.

18. Shipping and/or forwarding property which has been left behind and/or stolen during the trip

The Insurer will arrange for and pay the costs of forwarding any possessions the insured has left behind in the place, or places, visited during the trip to the insured´s home.

GENERAL EXCLUSIONS TO THE TRAVEL ASSISTANCE ABROAD COVER

The following are excluded from this cover:

- **Any relapses of illnesses where the sufferer may suddenly get worse when the insured knew they suffered from the illness before starting out on the trip.**
- **Conditions for which the insured has a medical history that could be worsened by travelling.**
- **Pregnancy. Nevertheless, unforeseen complications will be covered up to the sixth month.**

- **In cases of serious dental problems, namely problems caused by infection, pain or trauma which require emergency treatment, the expenses will be limited to a maximum of €120.20 at all times.**
- **Sea, mountain, or desert rescue operations.**
- **Services required as a result of the practice of high-risk sports, such as mountaineering, climbing, motocross, gliding, hang-gliding, snowboard and similar sports.**
- **Accidents that occur while skiing.**
- **Expenses relating to a chronic illness, prostheses of any kind and thermal baths.**
- **Any medical expense below €9.02.**
- **Suicides, self-harming injuries and drug or alcohol poisoning.**
- **Under no circumstances will this service replace the emergency or assistance services of the country in question, nor will the Insurer pay the costs of such services.**
- **Illnesses caused by acquired immune deficiency syndrome (AIDS), as well as problems arising from alcoholism and drug-addition.**
- **Vaccinations and medical check-ups for previously-known illnesses.**
- **Thermal baths and UVA ray treatments.**
- **Physiotherapy and kinesiotherapy.**
- **Mental illnesses, psychoanalysis, and psychotherapy.**

ADDITIONAL CONDITIONS TO THE TRAVEL ASSISTANCE ABROAD COVER

1. This cover supplements the healthcare insurance policy, and will not be valid unless the insured has the latter.
2. The Insurer accepts no liability for delays or failures to comply with obligations when they are due to force majeure.
3. The Insurer will only pay the unforeseen travel expenses of the insured parties which they had not expected to incur (train tickets, plane tickets, tickets for sea crossings, petrol, etc.).
4. The travel assistance cover is provided by CASAVI Asistencia en Viaje, S.L., and it is responsible solely for the provision of the services.
5. **In order for the Insurer to comply with its obligations, it is essential that the insured immediately notify CASAVI Asistencia en Viaje, S.L. of the occurrence of a claimable event by calling the telephone number given in this document.**
6. **To use the services described above the insured should call the number below, and may reverse the charges if necessary:**

Assistance abroad:

34 91 595 50 49

CUSTOMER CARE SERVICES

1. CAJA DE SEGUROS REUNIDOS, Compañía de Seguros y Reaseguros, S.A. (CASER), a joint-stock insurance and reinsurance company, has a Customer Care Service department (for claims and complaints), located at Avenida de Burgos 109, 28050 Madrid, and whose email address is: *defensa-asegurado@caser.es*

2. The department will deal with and resolve claims and complaints made, either directly or through a duly accredited representative, by individuals or companies that have a CASER insurance policy or are holders or beneficiaries of a CASER employment pension plan or associated pension plan, and which concern their legally recognised interests and rights arising from contract law, transparency regulations, customer protection laws, best practice and, in particular, the principle of equity. All claims and complaints will be processed and resolved in accordance with the legislation in force, and within a maximum period of two months as from their filing.

   All claims and complaints should be sent in writing to any of the Company's offices, or the head office of CASER GESTIÓN TÉCNICA, A.I.E. (Avenida de Burgos 109, 28050, Madrid) by post, or by computer, electronic or telematic means, provided such means allow the reading, printing and saving of the documents and meet the legal requirements and specifications in the Regulations.

3. After the claimant has presented their claim or complaint and the Customer Care Services department has issued its final decision they may, if they do not agree with the decision, submit their complaint or claim to the Complaints and Claims Department of the Directorate General of Insurance and Pension Funds in Paseo de la Castellana, 44, 28046 Madrid, although it must be noted that the Directorate´s rulings are not binding. They are also entitled to take this course of action if more than two months have elapsed since they presented the claim or complaint to the department, and the department has failed to resolve it. Alternatively, they may take the appropriate legal action in the competent court.

4. Complaint forms and a copy of CASER´s Customer Care Regulations, which regulate customer care services and establish the complaints and claims procedure, are available to customers, policy and pension holders, and injured parties at all of CASER´s offices and on its website: *caser.es*

5. All decisions will take into account the obligations and rights established in the general, specific, and special conditions of the contracts, as well as the legislation that regulates the insurance sector, and the regulations on transparency and customer protection in the financial services sector (Insurance Contracts Act; Act 20 /2015 of 14 July on the Classification, Supervision, and Solvency of Insurers and Underwriters and its implementation regulations; the Financial System Reform Act; the Collective Investment Institutions Act; Royal Decree 303/2004, of 20 February; Order 734/2004, of 11 March, by the Ministry of the Economy; the Consumer Protection Act and accompanying regulations; and the General Contract Terms and Conditions Act).