SALUD MÉDICA
Health Care Policy

General Conditions

CAJA DE SEGUROS REUNIDOS

Compañía de Seguros y Reaseguros, S.A.

Registered office: Avenida de Burgos, 109 - 28050 Madrid

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In accordance with the provisions of Article 3 of Law 50/80 of 8 October 1980 on Insurance Contracts, the limitation clauses of the rights of the Insured contained in the General Conditions of the contract are highlighted in bold print.

This contract is subject to Law 50/1980 of October, of Insurance Contracts, to Law 20/2015, of 14 July, on the Regulation, Supervision and Solvency of Insurance and Reinsurance Entities, and its development regulations.

The authority responsible for controlling the activity is the Directorate-General for Insurance and Pension Funds

GENERAL CONDITIONS

PREAMBLE

This Insurance Contract is governed by the provisions of Law 50/1980 of 8 October on insurance contracts (Official Bulletin of 17 October 1980), Law 20/2015 of 14 July on the planning, supervision and solvency of insurance and reinsurance companies and its implementing regulation (Royal Decree 1060/2015 of 20 November) and by the provisions of the General, Specific and Special Conditions of this Contract. The insurance activities of the company are supervised by the Spanish Ministry for the Economy and Competition, through its Directorate-General of Insurance and Pension Funds.

By signing the application form, the Special or Particular Conditions or, where applicable, the Insurance Certificate, the Contracting Party specifically accepts the limitation clauses of the rights of the Insured person which are highlighted in bold print.

ARTICLE 1 - DEFINITIONS THAT WE WILL USE IN YOUR CONTRACT

For the purposes of this Contract, the terms below will have the following meanings:

INSURED PERSON/BENEFICIARY: is the person who receives the corresponding benefit in the cases foreseen in the contract. Generally speaking, they have a common bond of personal, family or financial interest with the contract or policy holder

ACCIDENT: bodily injury suffered during the term of the contract arising from a violent, sudden, external cause beyond the control of the Insured and occurring at an identifiable time and place.

COST-EFFECTIVENESS ANALYSIS: economic comparison of different health techniques to select the most appropriate in terms of health results, according to the available resources.

INSURER: The legal entity that assumes the contractually agreed risk in this policy is CAJA DE SEGUROS REUNIDOS, Compañía de Seguros y Reaseguros, S.A., hereinafter referred to as CASER.

EXTRA-HOSPITAL MEDICAL CARE: this is the outpatient diagnostic and/or therapeutic medical care provided in a medical centre, at the patient's home and/or in a hospital or surgery without an overnight stay and which results in a stay of less than 24 hours.

TELEMATIC MEDICAL CARE/TELEMEDICINE: medical care provided remotely using technology

HEALTH CARE ABROAD: cover providing a solution to certain situations that may arise during a trip abroad, this cover will be included and limited in accordance with what is set out in this contract. The management team requires the Insured person to contact the Assistance Centre, which operates 24 hours a day, every day of the year.

SPECIAL HOME CARE: assistance to the Insured person by a general practitioner or family doctor and a nurse at the home indicated in the contract, when the patient's illness so requires, and always after a prescription from a specialist doctor included on the Insurer's list of professionals.

CASER MEDICAL CENTRE: In-house medical centre for digital health care.

PARTICULAR CONDITIONS: This document is an integral part of the contract in which the aspects of the risk of being insured are specified.

CONTRACT HOLDER/POLICY HOLDER: The individual or legal entity that, together with CASER, signs this contract and to whom the obligations deriving from it correspond, except for those that due to their nature must be fulfilled by the Insured person.

CONTRACT: document or documents containing the clauses and agreements regulating the relationship between the Contracting Party and the Insurer. The following form an integral and inseparable part of the contract: the Application for insurance, the Health Questionnaire, the General Conditions, the Particular Conditions that individualise the risk, if any, as well as the Supplements or Appendices that include, where applicable, the modifications agreed during the term of the contract.

COPAYMENT: share of the cost assumed and invoiced to the Contract Holder or Insured person for each health service used by the Insured included in the contract, and which shall coincide with that reported by the Insurer's providers. This amount may be updated annually and may vary depending on the types of health services and/or medical specialities used, which are determined in the Specific Conditions.

MEDICAL LIST: this is the complete list of professionals and own or contracted health centres defined by the Insurer.

HEALTH QUESTIONNAIRE: A form with questions on the state of health, made available by the Insurer, in which all the necessary information that must be known by the Insurer for the assessment of the risk is declared and which each of the Insured parties must sign and declare completely and accurately.

PREVIOUS CONDITION: is a health condition, not necessarily pathological, that exists prior to the moment of taking out or registering for insurance, regardless of whether or not there is a medical diagnosis.

ILLNESS: any change in the Insured person's health that is not the result of an accident, diagnosed by a doctor during the term of the insurance policy, which makes the provision of medical care necessary.

CONGENITAL DISEASE, INJURY, DISABILITY OR DEFECT: is that which exists at the moment of birth, as a consequence of hereditary factors or conditions acquired during pregnancy up to the moment of birth. A congenital

condition may manifest itself and be recognised immediately after birth, or be discovered later, at any time during the life of the Insured person.

PREVIOUS ILLNESS: illness of the Insured prior to the start date of their contract, whether or not diagnosed at the start of the contract.

NURSE: professional legally qualified and authorised to carry out nursing activities.

FORCE MAJEURE: an event or occurrence beyond the control of the Insured person which cannot be prevented or foreseen, and which makes it impossible to comply with the obligation.

CLINICAL PRACTICE GUIDELINES: a set of recommendations based on the available scientific evidence that provide information and guidance to health personnel on the prevention and treatment of diseases.

DOCTOR: professional legally qualified and authorised to practice medicine.

SPECIALIST DOCTOR: doctor who has the necessary qualifications to practise in one of the legally recognised medical specialities.

EXTERNAL MEANS: doctors and centres not included in the Insurer's Medical List that correspond to you according to the type of insurance taken out.

OWN MEANS: doctors and centres included in the Insurer's Medical List that correspond to you according to the type of insurance taken out.

WAITING PERIOD: interval of time during which some of the cover included in the contract is not yet effective. This period shall be calculated in months from the date the contract comes into force for each of the Insured parties included in it.

DISPUTABILITY PERIOD: period of time, from the date the contract comes into force for each of the Insured parties included in it, during which the Insurer may refuse to cover benefits or contest the contract on the grounds of the existence of previous illnesses of the Insured person and which the latter has not declared in the Health Questionnaire. Once this period has elapsed, the Insurer's refusal must be based on the existence of fraudulent concealment on the part of the Insured.

SERVICE PLATFORM: Online portal **-casermasbeneficios.es-** (owned by Caser Servicios de Salud S.A.U, a Caser Group company), for the acquisition of health, prevention and wellbeing services.

BENEFIT: consists of health care derived from the illness.

PREMIUM: This is the price of the insurance. The premium receipt shall also include the legally applicable surcharges, taxes and fees. The insurance premium is annual, even if payment is paid in instalments.

CLINICAL PSYCHOLOGY: speciality of Psychology, which deals with the treatment and rehabilitation of anomalies and disorders of human behaviour.

PSYCHOTHERAPY: treatment given to a person suffering from a psychic conflict, under the indication or diagnosis of a psychiatrist.

REHABILITATION AND PHYSIOTHERAPY: all acts carried out by a rehabilitation doctor or physiotherapist in a specific rehabilitation centre, aimed at restoring the functionality of those parts of the locomotive system affected by the consequences of an illness or accident.

NEUROLOGICAL REHABILITATION: a set of specific physical therapies (also called neurological physiotherapy), prescribed by a neurologist or rehabilitation doctor, and carried out by a physiotherapist in a suitable rehabilitation centre, aimed at restoring, as far as possible, normal mobility to those patients who have suffered a sensory-motor disorder resulting from severe acquired brain damage.

INCIDENT: event whose consequences make it necessary to use health services that are totally or partially covered by the contract.

INSURANCE APPLICATION: document in which the Contracting Party describes the risk that he/she wishes to insure, with all the circumstances known to him/her that may influence the assessment of said risk, the good faith of the Contracting Party being necessary.

HEALTH CARD: A document, property of the Insurer, which is issued to each Insured person and/or Beneficiary included in the contract and whose use, personal and non-transferable, is necessary to receive the benefits covered by the contract.

EMERGENCY: assistance which, given the Insured person's clinical or medical situation, must be provided immediately in a hospital, medical centre or at the patient's home.

URGENT EMERGENCY: is a clinical situation that requires immediate medical attention, given that a delay in this may result in a risk to the life of the Insured person.

ARTICLE 2 - PURPOSE OF THE INSURANCE

Within the limits and under the conditions stipulated in the contract and on payment of the premium and co-payments that may apply in each case, the Insurer undertakes to provide the Insured person, within Spain and through the professionals arranged by the Insurer at the time the service is provided, with medical, surgical and hospital care, in accordance with standard medical practice, for all kinds of illnesses or injuries included in the description of the cover provided in the contract.

In view thereof, hospital cover and surgical operations are not covered.

In addition, diagnostic and therapeutic advances that are made in medical science after the start date of this contract may become part of the coverage of this contract provided that they are safe, effective, universal and consolidated at each renewal of this contract. The Insurer shall explicitly communicate the techniques or treatments that will be included in the cover of the contract for the following period.

The Insurer accepts no liability for expenses or services arising in public or private centres not contracted by the Insurer and which are not included in the corresponding Medical List, according to the type of treatment contracted, regardless of the prescribing or performing doctor.

In any case, the Insurer assumes the necessary urgent assistance in accordance with the provisions of the terms and conditions of the contract and in application of the provisions of Article 103 of the Insurance Contract Act.

No cash compensation may be granted under this insurance in lieu of health care benefits.

ARTICLE 3 - DESCRIPTION OF THE COVER

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

1. FAMILY MEDICINE

General medicine: includes medical assistance at the surgery, prescription of basic means of diagnosis and home care. in the latter case, provided that the patient is unable to travel for medical reasons.

Paediatrics - Puericulture: includes preventive and child development examinations.

Nursing: at the surgery and at home. in the latter case provided that the patient is unable to travel for medical reasons and subject to a prescription from a doctor of the insurer**.**

2. EMERGENCIES

Home emergency service: Emergency medical services provided in the home by Nursing. This service is offered subject to an evaluation of the Caser emergency care service and only at the registered address and under the Special Conditions of the Policy, provided that Caser has a contracted medical practitioner in the population centre where the Insured is domiciled and when their medical condition prevents them from going to the medical practitioner or the Nursing.

Outpatient emergency care: Emergency healthcare provided during the opening hours of outpatient centres (not hospitals) contracted by the Insurer. Outpatient emergency healthcare will be provided in those population centres where Caser has contracted medical practitioners to provide said service and who appear in the appropriate section of the list of medical practitioners and medical centres. 24-hour emergency care is not guaranteed.

Hospital emergency services are not covered.

3. SPECIALITIES

Health care on an outpatient or inpatient basis (at the Insurer's doctor's discretion), in the specialities listed below:

3.1. Allergology. Vaccines will be paid for by the Insured.

3.2. Anaesthesiology and resuscitation.

3.3. Angiology and vascular surgery.

3.4. Digestive system.

3.5. Cardiology. This includes a cardiovascular risk prevention programme for people over 45 years of age.

3.6. Cardiovascular surgery.

3.7. General surgery and surgery on the digestive system.

3.8. Maxilofacial surgery.

3.9. Paediatric surgery.

3.10. Plastic and reconstructive surgery.

3.11. Thoracic surgery.

3.12. Medical-surgical dermatology and venereology.

3.13. Endocrinology and nutrition.

3.14. Geriatrics.

3.15. Hematology and Hemotherapy.

3.16. Internal medicine.

3.17. Nephrology.

3.18. Neonatology.

3.19. Pneumology.

3.20. Neurosurgery.

3.21. Clinical neurophysiology.

3.22. Neurology.

3.23. Obstetrics and gynecology:

a) **Preparation for birth:** This consists of a set of techniques that are practised to prepare the expectant mother physically and psychologically for birth. Aimed at pregnant women from the second trimester of pregnancy.

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

c) **Family planning**: including tubal ligation, monitoring of hormonal contraceptive treatment and IUD implantation and monitoring. The cost of the intrauterine device (IUD) will be reimbursed provided that it is purchased by the Insured person at a pharmacy, on presentation of the corresponding medical prescription and invoice. Hysteroscopic tubal occlusion, Essure type device implantation, or any other technique will not be covered.

d) **Preventive medicine:** only includes gynaecological check-ups

e) **Diagnosis of infertility:** the coverage includes the study and diagnosis (with the usual and standardized complementary tests).

3.24. Odonto-stomatology. This includes only extractions, stomatological cures derived from extractions, plain intraoral radiography (scaling) once a year, **prescribed by an odonto-stomatologist on the list of medical practitioners of the Insurer at the doctor's surgery or odonto-stomatology practice.**

In addition, the Insured has free dental healthcare (see appendix I to this document).

3.25. Ophthalmology. Includes laser photocoagulation.

3.26. Medical oncology.

3.27. Otorhinolaryngology.

3.28. Clinical psychology. It includes, **up to a maximum of 20 sessions per Insured person and per insurance year,** individual and temporary psychological care, on an outpatient basis, the purpose of which is the treatment of processes that are susceptible to psychological intervention. In the case of **eating disorders**, this cover includes 20 additional sessions.

A prescription from a psychiatrist included in the Insurer's Medical List and authorisation from the Insurer will be required prior to the treatment being carried out.

3.29. Psychiatry.

3.30. Rehabilitation and physiotherapy. It is **included only on an outpatient basis**, for **the treatment of disorders of the locomotor system**, until the greatest possible functional recovery is achieved.

Vestibular rehabilitation is included in inner ear pathology, and pelvic floor rehabilitation for urinary incontinence, with **a maximum of 8 sessions per Insured Person and insurance annuity. In both cases, the Insurer shall arrange the centres for these treatments.**

A prescription from a specialist doctor included in the Insurer's Medical List and authorisation from the Insurer will be required before it is carried out.3.35. Rheumatology.

3.31. Rheumatology.

3.32. Pain treatment.

3.33. Traumatology and orthopaedic surgery.

3.34. Urology. This includes the diagnosis **(not treatment)** of impotence and the study and diagnosis of infertility and sterility.

4. METHODS OF DIAGNOSIS

Diagnostic tests will be only carried out **with a prior written prescription from a specialist on the list of medical practitioners of the Insurer.** This cover includes all the standard methods of diagnosis recognised in medical practice at the time the Policy is purchased. **Diagnostic studies and tests for research or scientific purposes and plastic surgery tests are not covered.** The contrast methods and radiopharmaceuticals used are included in the cover.

4.1. Clinical analyses: These include biochemical, haematological, microbiological, parasitological.

4.2. Digital dermoscopy: In early diagnosis of melanoma in people with a family and/or personal history of melanoma, in dysplastic nevus syndrome and/or presence of multiple nevi / moles.

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

4.4. Cardiological diagnostics: Electrocardiograms, stress tests, echocardiograms, conventional Holter monitor, Holter event monitor, Doppler, coronary angiography by CT.

4.5 Gynaecological Diagnosis. Includes breast tomosynthesis and breast MRI.

4.8. Obstetric Diagnosis. It includes the "triple screening" (combined first trimester test), chorion biopsy and amniocentesis, with the obtaining of the chromosomal karyotype, for the diagnosis of foetal anomalies in pregnancies at risk.

4.9 Digestive Tests. Includes virtual colonoscopy and entero-MRI. Includes liver elastography.

4.10 Radiodiagnosis.

- **Conventional radiology.** It includes the usual diagnostic techniques such as simple radiology (head, trunk, limbs, special skull and stomatological radiology) and special non-interventional radiology (digestive, urology and gynaecology).
- **Ultrasound and Doppler echocardiography**
- **Computerised axial tomography (CT/Scanner).**
- **Magnetic resonance imaging (MRI).**
- **Bone densitometry.**

4.11 Urology. Includes multiparametric magnetic resonance imaging (MRI) of the prostate.

5. TREATMENTS

In all cases, **special treatments will only be carried out after the Insured has received a written prescription from one of the specialists on the list of medical practitioners of the Insurer** at a medical centre designated by the Insurer that specialises in the illness. **The Insured will require authorisation from the Insurer in order to receive treatment.**

- **Speech therapy.** In the case of rehabilitation after major laryngeal surgery**, up to a maximum of 60 sessions per contract year.** And for organic diseases related to the vocal cords (oedemas, nodules, polyps and cancer) **up to a maximum of 20 sessions per contract year.**

- **Laser therapy:** This is included only for ophthalmological treatments and musculoskeletal rehabilitation.

6. OTHER SERVICES

- **Podiatry** includes chiropody, treatment of incarnate nail and/or papilloma at the surgery, and the biomechanical study of gait for children under 16 years of age.

7. HEALTH CARE ABROAD

The Insurer guarantees the Insured and the other Beneficiaries of the contract and during the term of the contract, the cover of this guarantee, **with a maximum of €15,000 per insured person and per insurance year.**

However, the partial reimbursement limits to be made by the Insurer shall not exceed the limits indicated in each of the covers provided.

With regard to the validity of the insurance and in order to be able to benefit from the guaranteed benefits, all of the following conditions must be met: an individual resident in Spain, holder of the contract and/or beneficiary who, from the start of the trip until its completion and within the period of validity of this cover, has suffered an illness or accident outside Spanish territory. **The trip or travel cannot exceed 90 days for this coverage to be valid.**

Travel shall be understood to be by public transport or private vehicle and must be duly justified by any means of proof (hotel reservation, airline reservation, etc.). The period of the trip that is the object of the cover includes from the moment when, within the dates contracted in the insurance policy, the client has left their usual place of residence in order to go on a trip or service contracted, until their return.

The Insured person undertakes to provide the Insurer with all the necessary documents requested in order to process the relevant formalities.

In order for the Insurer to assume its obligations, it is essential for the Insured person to contact the service provider immediately in the event of an incident to make a claim via the telephone number indicated in this document.

The exclusions specific to healthcare abroad are set out in Article 4, point 2.

7.1. GUARANTEES COVERED

1. Medical, surgical, pharmaceutical and hospitalisation expenses abroad

Under this cover the Insurer will pay, **up to a limit of €15,000,** the expenses incurred by each Insured person outside of Spain as a result of an accident or illness of an unforeseeable nature.

The reimbursement of expenses mentioned herein shall in all cases be complementary to other benefits to which both the Insured person and their successors are entitled, either through Social Security benefits or any other welfare scheme to which they may be affiliated.

In the event that any of the Insured parties should require emergency dental care, the Insurer will cover the costs arising from this **up to a maximum of €120.20.**

Under no circumstances shall expenses be covered that arise from medical or surgical treatments that are not necessary in the eyes of the Insurer's medical team or those which may be delayed until the Insured or Beneficiary returns home.

2. Hospitalisation fees

When due to an accident or illness covered by the Policy, during a trip abroad, the Insured person needs to be admitted to hospital, the Insurer will pay, up to a maximum limit of €601.01 of the amount demanded by the hospital in order to admit the Insured person.

3. Cash advance in case of serious illness abroad

If the Insured person or Beneficiary should urgently need cash as a result of a serious illness, the Insurer will provide an advance **up to a limit of €1,500.**

In order to guarantee this cash advance, the Insurer reserves the right to demand, prior to making the payment, that a person designated by the Insured in Spain takes responsibility for repayment of the amount in a reliable manner, by acknowledging the debt.

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

The Insured person undertakes to repay the amount advanced by the Insurer within 10 days of the end of the trip and, in any event, within two months of the date of the advance.

4. Medical repatriation of the wounded or sick from abroad

Depending on the urgency or seriousness of the case and the judgement of the treating doctor, the Insurer will pay for the transport of the Insured person or Beneficiary, even under medical supervision, if necessary, to a hospital in Spain close to their residence or to their own habitual residence when they do not need to be hospitalised. If the Insured person cannot be taken to a place close to their habitual residence, the Company will be responsible for the subsequent transfer to the Insured person or Beneficiary's residence.

In the event of benign illnesses or minor injuries that do not require medical repatriation, the Insurer will arrange for the transport of the Insured person by vehicle or ambulance to the place where the necessary medical care can be provided.

Under no circumstances shall the Insurer replace the emergency services of the country concerned, nor shall the Insurer be liable for the cost of such services.

In any event, the decision as to whether or not to carry out the transfer shall be taken by the doctor appointed by the Insurer in each case, in agreement with the doctor treating the Insured person and, if applicable, with their family.

The Insurer shall also pay the cost of transporting up to two people travelling with the Insured person or Beneficiary and who are also in that capacity, to their place of origin or destination, provided that the cost of this does not exceed the cost of returning home.

5. Repatriation of the deceased Insured person and accompanying persons

In the event of the death of an Insured person or Beneficiary, the Insurer organises and pays for the transport of the body from the place of death to the place of burial in Spain, as well as the return home of the other people accompanying the Insured or Beneficiary.

Also covered **up to a limit of €601.01** are the costs of a post-mortem and preparation of the body (such as embalming and the mandatory coffin for the transfer), in accordance with the legal requirements.

In any case, the cost of the actual coffin and the burial and ceremony expenses shall not be covered by the Insurer.

6. Accompaniment of mortal remains

If there is no one to travel home with the mortal remains of the deceased Insured person, the Insurer shall provide the person designated by the beneficiaries to travel with the body.

7.2. ADDITIONAL CONDITIONS TO THE HEALTH CARE COVERAGE ABROAD

1. The Insurer shall not be liable for delays or unfulfillment due to force majeure.
2. With regard to the travel expenses of the insured persons, **the Insurer will only cover the excess over the expenses normally expected by them (train tickets, plane tickets, sea crossings, fuel for the vehicle).**
3. **In order for the Insurer to carry out its obligations, the Insured person must notify the Insurer immediately of any claim via telephone which is operational** 24 hours a day, 365 days a year.

You can find the telephone number for Health Care Abroad in the digital resources provided for this purpose, or on your health card.

ARTICLE 4 - EXCLUDED RISKS

1. HEALTH CARE

a) **Health care for all kinds of illnesses, injuries, previous states or health conditions, accidents and their sequelae, congenital or previous defects or deformities diagnosed before the date on which each Insured person is registered under the contract, as well as for any signs or symptoms that could be considered to be the start of any disease or which have previously required studies, diagnostic tests or treatments of any kind, unless such illnesses, injuries, accidents, symptoms, defects or deformities have been declared by the Contracting Party or Insured person in the health questionnaire and its cover is not expressly excluded in the Particular Conditions by the Insurer. This exclusion shall not affect the Insured persons added to the contract from birth in accordance with point 1. e) of Article 10.**

b) **General medical check-ups or examinations of a preventive nature, except for what is expressly included in point 3. of Article 3. Analyses or other examinations that are necessary for the issuing of certificates, reports and any type of document that does not have a clear health care function.**

c) **Physical damage resulting from war, riots, revolutions and terrorism, those caused by officially declared epidemics, those directly or indirectly related to radiation or nuclear reaction and those resulting from natural catastrophes (earthquakes, floods and other seismic or meteorological phenomena).**

d) Health care due to the consumption of alcohol, drugs of any kind or intoxication due to the abuse of psychotropic drugs, narcotics or hallucinogens.

e) Health care for injuries caused by drunkenness, fights (except in the case of legitimate self-defence), self-harm or suicide attempts and illnesses or accidents suffered due to serious fault, imprudence or negligence on the part of the Insured person.

f) Health care required as a result of injuries sustained while taking part in bets and competitions, the practice of high-risk activities such as bullfighting and bull running, the practice of dangerous sports such as scuba diving, caving, boxing, martial arts, climbing, rugby, motor vehicle sports, quad biking, paragliding, aerial activities not authorised for public passenger transport, sailing or white water activities, bungee jumping, canyoning, skiing, snowboarding, surfing and any other manifestly dangerous activity; as well as those sustained from the professional practice of any sport.

g) Hospital healthcare (whether provided on an outpatient basis or to admitted patients), therapy and surgical operations are excluded, except for those indicated in Article 3.

h) Hospital emergencies.

i) Arthroscopies, laparoscopies, and surgical biopsies, endoscopies, fibroscopies, catheterizations, vascular hemodynamics, and interventional radiology. Prostheses of any nature, osteosynthesis material, biological or synthetic materials, anatomical and orthopedic pieces.

j) Everything concerning Psychology, ambulatory narcolepsy, sophrology, neuropsychological and psychometric tests, psychoanalytic psychotherapy, as well as psychosocial or neuropsychiatric rehabilitation, psychoanalysis, hypnosis, group psychotherapy, psychological tests and rest and sleep cures, except for what is expressly included in point 3.28. of Article 3.

k) Travel and transportation expenses, as well as ambulances.

l) Treatments for sterility or infertility, voluntary termination of pregnancy, diagnostic tests related to such termination, any surgical procedure on the unborn child and the treatment (including surgery) of impotence.

m) Surgical procedures, infiltrations and treatments, as well as any other type of procedure for the purpose of sex change or an aesthetic nature, are expressly excluded. Also expressly excluded is any disease, complication or need for special diagnostic and/or therapeutic tests that are directly related to or are the result of the Insured person having undergone a procedure, infiltration or treatment of an aesthetic nature. Only in these cases will the necessary tests for the gynaecological examination be paid for.

n) Any genetic test requested for prognostic or preventive purposes is excluded, as well as genetic predisposition studies of the Insured person or their relatives. Also excluded from coverage are genetic counselling, genetic mapping, paternity or kinship tests, as well as anything else that is not explicitly included in point 4. of Article 3.

o) Hospital care and treatment for social or family reasons, palliative care, as well as care that can be replaced by home or outpatient care.

p) Health care in private centres that are not subsidised, and also that which is provided in hospitals, centres and other publicly owned establishments that are part of the Spanish National Health System and/or those that report to the Autonomous Communities, is also excluded. In any case the Insurer reserves the right to claim from the Insured person the recovery of the costs of care that it has had to pay to the public health system for the medical, surgical and hospital care provided.

q) Regenerative medicine, biological medicine, immunotherapy, biological therapies, gene therapy and direct-acting antivirals, as well as the applications of all of them. In addition, all types of experimental treatments, compassionate use, orphan drugs, and those in clinical trials in all their phases are excluded.

r) Pharmaceuticals, medicines and auxiliary treatment aids of any kind, except for those administered to the Insured person during their stay (a minimum of 24 hours) in a hospital centre. Non-commercialised medicines in Spain are excluded. Vaccines are also excluded.

s) All diagnostic procedures or diagnostic, surgical or therapeutic techniques that arise after the signing of this policy and are not covered by the Insurer, unless the Insurer, in compliance with the provisions of Article 126.2 of Royal Decree 1060/2015 of 20 November on the supervision and solvency of insurance and reinsurance companies, has notified the Insured Person in writing of their inclusion in the insurance cover, under the terms and within the limits established in such written notification.

Also excluded are any therapeutic methods, surgical techniques or diagnostic tests carried out as part of clinical trials, or which, due to their lack of safety or efficacy, are not used in normal clinical practice. This applies to those that have not been approved by the European Medicines Agency and/or the Spanish Agency for Medicines and Medical Devices, as well as by the Health Technology Assessment Agencies dependent on the health services of the Autonomous Regions or the Ministry of Health. Also excluded from coverage will be those therapeutic methods, surgical techniques or diagnostic tests that have been clearly superseded by others available.

t) Physiotherapy and rehabilitation treatments when functional or the maximum possible recovery has been achieved, or when it becomes maintenance therapy, which in such a case would be indicated by the professional responsible for carrying out such treatments. In addition, the following are excluded: rehabilitation derived from neurological diseases, educational therapy, language education, special education for the mentally ill and early stimulation rehabilitation in cases of psychomotor developmental retardation. Cardiac rehabilitation, pelvic floor rehabilitation and lymphatic drainage are excluded except for what is expressly included in point 3.31. of Article 3. Rehabilitation in inpatients and at home is expressly excluded.

u) Alternative and complementary therapies such as acupuncture, naturopathy, homeopathy, chiromassage, mesotherapy, osteopathy, hydrotherapy and pressotherapy are excluded.

v) Any means of diagnosis for sleep disorders is expressly excluded.

w) In the speciality of Odontostomatology, obturations, endodontics, placement of prostheses and osseointegrated dental implants, orthodontics, periodontics, as well as other dental treatments other than those included in point 3.24. of Article 3 are excluded.

x) All surgical and / or therapeutic techniques that use a laser, except for those expressly included in point 5. of Article 3.

y) Chronic dialysis treatments.

z) lternative medicines, treatments in nursing homes, residences, spas and the like.

aa) Treatments involving oxygen therapy, aerosol therapy, ventilation therapy, and ozone therapy are expressly excluded.

2. HEALTH CARE ABROAD

1) **Claims that may arise directly or indirectly from previous illnesses, congenital, chronic or medical conditions under medical treatment prior to the start of the trip.**

2) **Voluntary termination of pregnancy, childbirth, except for emergencies and cases of unforeseeable complications up to the 29th week of pregnancy.**

3) **Accidents occurring in the event of war, pandemics, demonstrations and social movements, acts of terrorism and sabotage, strikes or any other case of force majeure, unless the Insured person proves that the accident is unrelated to such events.**

4) **Benefits from the practice of dangerous sports, such as mountaineering, climbing, motocross, gliding, hang-gliding, skiing, snowboarding and similar or those that require physical training.**

5) **Any expenses claimed when the insurance dates do not coincide with the actual dates of travel (both the day of departure and the return date must be taken into account).**

6) **Vaccinations and tests for previously known diseases.**

7) **Expenses relating to prostheses of any kind, physiotherapy and kinesiotherapy.**

8) **The costs of implants, experimental surgeries and treatments whose safety and cost-effectiveness are not scientifically proven or are not recognised by official medical science in Spain. Psychological and aesthetic treatments, rehabilitation or preventive medicine.**

9) **Any type of medical fee or expense less than €9.02.**

10) **Suicides, self-harm and drug or alcohol intoxication.**

11) **Under no circumstances shall the Insurer replace the emergency services of the country concerned, nor shall it cover the cost of these services.**

12) **Mental illnesses, as well as psychoanalysis and psychotherapy.**

ARTICLE 5 - METHOD OF SERVICE PROVISION

The healthcare covered by the contract shall be provided in all towns and cities where the Insurer has its own or contracted healthcare centres. When some of the services included in the contract are not available in any of these places, they shall be provided in another town where they are available, with the Insured person being able to choose where.

The incorporation of new diagnostic and therapeutic procedures and new technologies in the contract shall be carried out in accordance with the principles of medicine once their effectiveness and safety have been demonstrated and there is sufficient availability in the agreed means. Treatment, consultations, diagnostic or therapeutic means prescribed or ordered by a doctor will not be covered by this contract as long as they are not included in the benefits covered by this contract.

1. HEALTHCARE ADVICE AND GUIDANCE

The Insurer has a Healthcare Advice and Guidance Service. The aim of this service is to facilitate access to healthcare services for the Insured, explaining the procedures to be followed and facilitating said procedures as much as possible.

2. FREE CHOICE OF DOCTORS

Insured parties may go freely and directly to the primary care professionals and specialists who form part of the Insurer's current Medical List at any given time.

The Insurer recommends that each Insured person has a family doctor or paediatrician who is responsible for family care. Each Insured person may choose their family doctor or paediatrician and nurse from the doctors on the Insurer's Medical List.

3. HOME VISITS

Home visits by the family doctor or nurse will be made after prior notification by telephone to the doctor within the time frame stated by the doctor. **The home visit will only take place at the address stated in the contract.** for any modifications, the insurer must be notified at least 8 days before any service is required.

In cases of emergency, the insured person should go to the permanent emergency services set up by the insurer or contact the telephone service included for this purpose in the documentation provided to insured parties.

4. INSURED PERSON'S SHARE OF THE COST OF SERVICES (CO-PAYMENTS)

In the event of sharing the cost of the benefit, the contracting party or insured person shall pay the corresponding amount for each medical service used by the insured persons included in the contract, i.e., each of the benefits reported and invoiced by the providers to the insurer. The amount of the co-payment or participation is set out in the particular conditions to the insurer. The amount of the co-payment or participation is set out in the particular conditions.

For this purpose, the insurer shall periodically provide the contracting party with a comprehensive statement of the services used by the insured parties included in the contract, together with the amount of the co-payments corresponding to them.

The resulting total amount shall be collected by direct debit from the bank account designated by the contracting party for the payment of the premium.

The amount of the co-payments may be updated by the insurer in accordance with the provisions of article 12.

5. AUTHORISATION OF SERVICES

In general, certain special treatments, rehabilitation and physiotherapy, as well as psychological treatments and diagnostic tests, will require a written prescription from the medical practitioner of the Insurer and prior express authorisation from the Insurer.

Documentation to be submitted for services that require authorisation:

For healthcare services that require express authorisation from the Insurer, the Insured (at the request of the Insurer) provide the Insurer with a medical report. This report must include the history, date of commencement, date of diagnosis, causes, origin and evolution of the condition suffered.

The Insured must first obtain prior confirmation of the service from Insurer, which provide this confirmation unless the Insurer considers that it is a service not covered by the Policy. Once it has provided this written confirmation, the Insurer will be liable for its share of the costs of the healthcare service.

In the event of an emergency the only authorisation required will be that of the doctor of the Insurer. However, the Insured must obtain authorisation from the Insurer within 72 hours following the start of the healthcare service. The Insurer will be liable for its share of the costs of the healthcare service up to the time when

it challenges the authorisation of the doctor on the grounds that the healthcare service or hospitalisation in question is not covered by the Policy.

6. EMERGENCIES

The outpatient emergency service must be requested by phone or by going directly to one of the outpatient emergency centers established by the insurer, whose details are listed in the medical directory.

7. TEMPORARY TRIP

The Insurer undertakes to provide healthcare for the Insured person who is temporarily away from their habitual place of residence anywhere in Spain. **You will be able to choose between the Insurer's own or subsidised centres included in the Insurer's Medical List, in the town or city in Spain where you are located.**

If assistance is required outside the national territory, see Article 3 point 9 of health care abroad.

8. ASSISTANCE VIA MEANS NOT ARRANGED WITH THE INSURER

Assistance via means not arranged by the Insurer is not covered by this policy. The Insurer accepts no liability for the fees of medical centres and professionals outside its Medical List, nor for any type of cost or service provided or prescribed by them.

9. ACCREDITATION OF THE INSURED PERSON

When requesting care services, the Insured person must present their individual Salud card which the Insurer will give them for this purpose. The Insured person must sign the receipt justifying the service received.

When the doctor or the centre providing the service deems it appropriate, they may also request the National Identity Card from the persons obliged to have it.

ARTICLE 6 - PERIODS DURING WHICH CERTAIN COVERAGE CANNOT YET BE BENEFITTED FROM (WAITING PERIOD)

The benefits that will need to have fulfilled the prior waiting periods in order to be covered by the Insurer are:

- **Four (4) months:** High-tech diagnostic tests.

ARTICLE 7 - TERMS AND CONDITIONS, LOSS OF RIGHTS, TERMINATION AND INDISPUTABILITY OF THE CONTRACT

1. The declarations made by the Contracting party and the Insured person regarding their state of health in the Application Questionnaire constitute the basis for acceptance of the risk under this contract and form an integral part thereof.

2. The Insured person loses the right to the guaranteed benefit:

a) In case of withholding or providing inaccurate information when filling in the health status questionnaire (Article 10 of the Law).

The Insurer may cancel the contract by means of a declaration addressed to the Contracting party within one month of the date on which the Insurer becomes aware that the Contracting party or the Insured person withheld or provided inaccurate information. Unless the Insurer is guilty of wilful misconduct or gross negligence, the Insurer shall be liable for the premiums for the current period at the time of making this declaration.

If the incident occurs before the Insurer makes the declaration referred to in the previous paragraph, the Insured person's benefit shall be reduced in proportion to the difference between the agreed premium and the premium that would have been applied had the true nature of the risk been known. If there were fraud or gross negligence on the part of the Contracting party or the Insured person, the Insurer won't be liable for payment of the benefit.

b) If the incident whose coverage as a risk is guaranteed occurs before the premium has been paid, unless otherwise agreed (Article 15 of the Insurance Contract Law).

c) When the incident was caused by bad faith on the part of the Insured person (Article 19 of the Insurance Contract Act).

3. However, the Insurer undertakes to:

a) Not cancel the contract when the Insured person is undergoing hospital treatment until they are discharged from hospital unless they waive their right to continue such treatment.

b) Not oppose the extension of insurance contracts of Insured persons in certain situations of serious illness, provided that the first diagnosis has occurred during the period of the contract. The following are illnesses with ongoing treatment within the contract:

- Active oncological processes.
- Cardiac diseases requiring surgical or interventional treatment.
- Organ transplantation.
- Complex orthopaedic surgery in the early stage.
- Degenerative and demyelinating diseases of the nervous system.
- Acute kidney failure.
- Chronic respiratory failure.
- Chronic liver diseases (excluding those of alcoholic origin).
- Acute myocardial infarction with heart failure.
- Macular degeneration.

Not all of them are necessarily covered by the Salud Médica product. Consult the General, Special and Particular Conditions of your contract.

c) Not oppose the extension of insurance contracts with Contracting parties over 65 years of age, when they have been with the company (without failure to pay for the premium) for 5 years or more.

The above commitments shall not apply or shall be without effect in those cases in which:

a) The Insured person has failed to comply with their obligations, or they have withheld or provided inaccurate information when declaring the risk.

b) In the event of the Contracting party failing to pay for the premium or refusing to accept any updates to the policy.

c) The Contracting party does not agree to the terms of Renewal.

4. The Contracting Party may terminate the contract when the list of medical professionals corresponding to their province changes by more than 50% in the last 12 months from the start of the contract and must notify the Insurer of this decision by any credible means. This rule does not apply in the case of temporary replacements for justified reasons, or in the case of doctors of special surgical techniques, as well as dentists, analysts and radiologists.

5. If the Contracting Party, when taking out the insurance, has incorrectly stated the year of birth of one or more of the Insured persons, the Insurer may only cancel the contract if the true age of the Insured person when the contract comes into force exceeds the admission limits or underwriting policies established by the Insurer.

   In the event that, as a result of an inaccurate declaration of the year of birth, the premium paid is less than what should have been paid, the Contracting party shall be obliged to pay the Insurer the difference between the premiums actually paid to the Insurer and those which, in accordance with the tariffs, they should have paid according to their true age.

   If, on the other hand, the premium paid is higher than that which should have been paid, the Insurer shall be obliged to reimburse the Contracting Party for the excess premiums received without interest.

ARTICLE 8 - INSURANCE TERM

The insurance is renewable annually and is contracted for the period stipulated in the Particular Conditions. Upon expiry, it shall be tacitly extended for another year.

However, in addition to the provisions of Article 7.3.c. of these Conditions, either party may object to the extension of the contract by giving written notice to the other party not less than one month before the end of the current insurance period if it is the Contracting party, and two months if it is the Insurer. The Insurer must be notified by the Contracting Party.

The Insurer may not terminate the contract when the Insured person is undergoing hospital treatment until they are discharged from hospital unless they waive their right to continue with the treatment.

With regard to each Insured person, the insurance policy will be cancelled:

1. Due to death.

2. If the contract includes family members who live with the Contracting party, when they cease to live habitually in the latter's home, which must be notified to the Insurer. If these persons take out a new insurance policy with the Insurer within one month of the aforementioned notification, the Insurer will honour all the rights they have acquired, provided that they take out the same cover.

The cover taken out will not be valid until the first premium has been paid.

ARTICLE 9 - PAYMENT OF PREMIUMS

In accordance with Article 14 of the Insurance Contract Law, the Contracting party is obliged to pay the premium.

1. The first premium or part thereof shall be due in accordance with Article 15 of the Insurance Contract Law, once the contract has been signed; if it has not been paid due to the fault of the Contracting Party, the Insurer has the right to terminate the contract or to demand payment of the premium due by way of enforcement procedure according to the contract. **In any case, if the premium has not been paid before the incident occurs, the Insurer shall be released from its obligation**, unless otherwise agreed.

2. In the event of non-payment of the second or successive premiums or fractions thereof, cover shall be suspended one month after the date of termination of the contract, and if the Insurer does not demand payment within six (6) months following the said date of termination, the contract shall be deemed to be terminated. If the contract has not been rescinded or cancelled in accordance with the above conditions, the cover shall take effect 24 hours after the day on which the Contracting Party pays the premium. In any case, when the contract is suspended, the Insurer may only demand payment of the premium for the current period.

3. The Insurer is only obliged by virtue of the insurance premiums issued by its legally authorised representatives.

4. The Particular Conditions shall establish the Contracting party's designated bank account for the payment of the insurance premium, and the following rule shall apply: the premium shall be deemed to have been paid on completion, unless collection is attempted within a period of thirty (30) calendar days and there are insufficient funds in the Contracting party's account, or the latter has ordered for it to be refunded.

ARTICLE 10 - OTHER OBLIGATIONS, DUTIES AND RIGHTS OF THE INSURANCE CONTRACTING PARTY OR THE INSURED PERSON

1. The Contracting party and, where applicable, the Insured person have the following obligations:

a) To declare to the Insurer, in accordance with the questionnaire that they must submit when taking out the policy, all circumstances known to them that may affect the assessment of the risk.
They shall be exempt from this obligation if the Insurer does not request that they fill in and submit a questionnaire or when, even if they do submit the questionnaire, it concerns circumstances which, although they may affect the assessment of the risk, are not included in it.
The Insurer may terminate the contract by means of a declaration addressed to the Contracting party within one month (1) from the date on which the Insurer becomes aware that the Contracting party or Insured person has withheld or given inaccurate information. Unless the Insurer is guilty of wilful misconduct or gross negligence, the Insurer shall be liable for the premiums for the current period at the time when they make this declaration.

b) If the incident occurs before the Insurer makes the declaration referred to in the previous paragraph, the Insured person's benefit shall be reduced in proportion to the difference between the agreed premium and the premium that would have been applied had the true nature of the risk been known. If there were fraud or gross negligence on the part of the Contracting party, the Insurer shall no longer be liable for payment of the benefit. To notify the Insurer, during the course of the contract and as soon as possible, of all circumstances which, according to the questionnaire on the state of health of the Insured person previously

submitted, affect the risk and are of such a nature that, if they had been known to the Insurer at the time the contract was finalised, they would not have done so or would have finalised it under more onerous conditions.

c) Notify the Insurer as soon as possible of the change of address.
d) To notify the Insurer as soon as possible of any additions or partial cancellations of Insured parties that occur during the term of the contract, taking effect on the first day of the month following the date of the notification made by the Contracting party. The following cases of partial cancellation will be accepted: the day on which the Insured person dies, a change of residence outside Spanish territory, separation of the couple or emancipation of one of the Insured persons or in the event of the payment of insurance to one of the Insured persons as a corporate social benefit.
e) Newborn children and newly adopted children may be registered as Insured parties, without having to submit health questionnaires and without waiting periods, in the parents' contract provided that they have been insured with CASER for **at least eight (8) months**, and the registration is requested within a maximum period of 15 days from their birth, in the case of newborn children, or from their registration in the family book, in the case of newly adopted children, by means of the corresponding insurance application.

   Otherwise, the admission of the newborn or adopted child will be subject to compliance with the conditions established by the Insurer, and the ordinary waiting periods, the corresponding exclusions or the refusal of insurance may be applicable.

   In any case, the Insurer shall cover healthcare for the newborn or adopted child provided that they are registered as an Insured party.
f) Minimise the consequences of the incident, using the means at their disposal for a prompt recovery. Failure to comply with this duty, with the sole intention of harming or deceiving the Insurer, shall release the Insurer from paying out any benefit deriving from the claim.
g) To grant and facilitate the subrogation in favour of the Insurer established in Article 82 of the Insurance Contract Law.
h) Minors may only be included in the insurance policy in the event that the person or persons who have parental authority or guardianship over them is the Contracting party, unless otherwise agreed.

2. The Salud card, which is the property of the Insurer and which it will provide to each Insured person, is a document for personal and non-transferable use. In the event of loss, theft or damage, the Contracting party and the Insured person are obliged to notify the Insurer within a maximum period of seventy-two (72) hours.

   In such cases, the Insurer shall issue and send a new card to the Insured person's address stated in the contract, cancelling the lost, stolen or damaged card.

   In addition, the Contracting party and the Insured person undertake to return to the Insurer the card corresponding to the Insured person who has cancelled the contract.

   The Insurer accepts no responsibility for improper or fraudulent use of the Salud card.
3. Within one month (1) of the delivery of the contract, the Contracting party may request the Insurer to rectify any discrepancies between the contract and the insurance proposal or the agreed clauses, in accordance with Article 8 of the Insurance Contract Act.

ARTICLE 11 - OTHER OBLIGATIONS OF THE INSURER

In addition to providing the agreed assistance, the Insurer shall send the contract to the Contracting party or, where appropriate, the provisional cover document.

It will also facilitate:

1. The Salud card of the corresponding Insured person, a personal and non-transferable document, which confirms their identity and gives them the right to receive care.

2. Medical List with the list of professionals, centres and health services that will provide care. The Medical List may be updated by the Insurer and the Insurer undertakes to publish the updated information on its corporate website.

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 – COMMUNICATIONS

1. Notifications to the Insurer shall be made to the address, e-mail address or telephone number indicated in the contract.
2. Notifications and payment of premiums made to the contract broker shall have the same effect as if they had been made directly to the Insurer.

ARTICLE 14 VALIDITY

The actions deriving from this contract will expire after five (5) years as of the date on which they may be exercised.

ARTICLE 15 - JURISDICTION

This contract is subject to Spanish legal jurisdiction and, within this jurisdiction, the competent judge for hearing any actions arising from it shall be that of the Insured person's residence in Spain.

This insurance contract inseparably comprises the above General Conditions, the Particular Conditions, the Special Conditions, if any, and the appendices containing the modifications agreed by the parties.

SUPPLEMENTARY HEALTHCARE INSURANCE COVER
ANNEX I: DENTAL CARE COVERAGE

1. Purpose

In addition to the healthcare cover that is the purpose of the contract, the Insurer undertakes to provide the Insured person with outpatient dental care included in this complementary cover, either free of charge or with the maximum amounts (excesses) stipulated in the corresponding covers.

The assistance will be provided exclusively by the doctors who appear on the dental medical list for the current year in question.

No optional cash compensation may be granted under this insurance in lieu of the benefits covered by this cover.

2. Coverage Description

This cover refers to the set of stomatological procedures, both at no cost to the Insured person and the services established with maximum amounts (excesses) valid for the current financial year, to which the Insured person may have access.

The list of services established with maximum amounts (excesses) described for the present financial year may be updated annually based on the price modifications of the suppliers and/or if deemed necessary. The updated guarantees and maximum amounts can be consulted in the digital resources provided for this purpose.

3. Excluded risks

a) **Physical damage resulting from war, riots, revolutions and terrorism; those caused by officially declared epidemics; those directly or indirectly related to radiation or nuclear reaction and those resulting from natural catastrophes (earthquakes, floods and other seismic or meteorological phenomena).**
b) **Assistance derived from the consumption of alcohol, drugs of any kind, fights (except in the case of legitimate self-defence), injuries, self-harm or suicide attempts.**
c) **Any other dental services not expressly included in the Conditions of Contract describing the coverage and services provided.**

4. How services are provided

All services covered under this supplemental warranty are free of charge.

When requesting assistance, the Insured person must present the Salud Individual Card, which the Insurer will give them for this purpose. When the professional or centre providing the service deems it appropriate, they may also require the National Identity Card from the persons obliged to have it.

The Insurer accepts no liability for the fees of doctors from outside its approved Medical List, nor for the cost of any medical treatment that they may prescribe.

For the purpose of this insurance, the incident is deemed to have been reported when the Insured person requests the benefits included in this cover.

All treatments and procedures covered will be carried out exclusively on an outpatient basis, excluding hospitalisation and general anaesthesia.

If there are alternative treatments for the same process, the decision and choice of treatment shall be made by the Insured person.

5. STRUCTURE AND OPERATION OF THE SERVICE

The Insurer offers its Insured parties a wide range of stomatology professionals, equipped with the most advanced diagnostic and treatment resources, with national coverage for the provision of the service, in accordance with two modalities:

1. **Care guarantee** list of services which the insured person may use for free.
2. **Services with maximum amounts**: services to be paid for by the Insured person that can be obtained at special prices. These services are identified as **maximum amounts** (excesses) available to the Insured person so that they can be known prior to requesting quotes.

6. ACCESSING THE SERVICES

- **Choice of professional:** the selection and access to the professional is free, within those included in the dental medical list.
- **Access to the service:** in order to use the dental services and for special prices to be applied (if applicable) it is essential to present the Salud Individual Card which identifies you as an insured person.
- **Carrying out the diagnosis and quote:** once the appropriate diagnosis has been made, the healthcare professional will draw up a quote in accordance with the maximum recommended prices at the time (in the case of services with associated costs), which must be accepted by the Insured person before starting the treatment.
- **Treatment:** in order to start treatment, it will be essential for the Insured person to accept the quote for those treatments with an associated cost.
- **Payment for treatments:** in the case of treatments with an associated cost, the Insured person will pay the amount corresponding to the services provided directly to the Professional or Centre.

GLOSSARY OF TERMS - DENTAL SERVICES

ALVEOLOPLASTY: technique by means of which a tooth socket is filled with hydroxyapatite after tooth extraction.

APICECTOMY: surgical removal of the tip of a tooth root through the bone and gum.

APICOFORMATION: procedure that stimulates the formation of the root of the teeth in children.

WHITENING: a technique that lightens the colour of highly discoloured teeth.

BRACES: A dental brace or device that is attached to a tooth for the purpose of attaching an archwire. The braces can be metal, sapphire, ceramic or plastic.

VENEERS: resin or porcelain surface placed on the front of a tooth or crown to give it a natural look.

PERIODONTAL FLAP SURGERY: surgical procedure for the treatment of periodontal disease. The objectives of this procedure are: to reduce pocket depth, regenerate and prevent attachment loss.

COMPOSITE FILLINGS: tooth-coloured filling materials made of resin reinforced with silica or ceramic particles. They are used in dentistry as one of several alternatives to dental amalgams.

REPAIR: repair of damaged braces, which may be simple or require soldering of the braces.

WISDOM TOOTH: third permanent molar. Wisdom tooth.

CROWN: artificial covering of a tooth with metal, porcelain, or porcelain fused to metal. Crowns cover severely damaged teeth or those weakened by decay and are rebuilt with pins or posts.

3D SCANNER: computer program for computer tomographs that provides high resolution images of the maxilla and mandible, and that from axial plane slices, performs panoramic and transversal reconstructions.

MAXILLARY SINUS ELEVATION: surgical procedure that allows bone augmentation in the upper arch, with the aim of obtaining an adequate bone base on which to place osseointegrated implants, in those cases where the thickness of the bone does not allow it.

ENDODONTICS: removal of the nerve, dead or alive, from a tooth. The part may have one or more roots. Depending on the number of roots of the tooth, the endodontics will be single-rooted, double-rooted or multi-rooted.

EPULIS: small, benign, purplish-red tumour that develops at the level of the alveolar ridge of the gums at the expense of the bone or soft tissue.

SKELETAL: partial removable prosthesis whose structure is metallic. Skeletals have retainers, a resin base, major and minor connectors, and teeth. The number of teeth determines the size of the skeletal.

FENESTRATION OF CANINE TEETH: removal of the bone and mucosa around an impacted tooth in order to free and make the crown of the tooth visible, allowing the orthodontist to place a brace and bring this tooth into the arch.

SPLINT: dental immobilisation device, made of plastic material or acrylic resin, which is used in orthodontics as a stabiliser, to put whitening substances in the mouth, in periodontal treatments, as well as a tool that allows the rest of teeth with mobility and in treatments of temporomandibular joint pathology, to relieve the symptoms of

this joint and the consequences on the chewing surfaces of the teeth caused by excessive clenching or rubbing between the upper and lower teeth (bruxism).

FLUORIDATION: procedure by which we provide fluoride to prevent tooth decay.

FRENUM: fold of mucous membrane connecting the upper lip or tongue to the alveolar mucosa. (Can be labial or lingual).

GINGIVECTOMY: a surgical procedure in which damaged gum (gingival) tissue is removed. It is currently used for the treatment of: hyperplasia (growth) of the gum due to medication, fibrosis of the gum, supraosseous pockets in difficult places. Also used to improve access in restorative techniques that invade the subgingival space.

DENTAL IMPLANTS: small dental devices that are inserted into the upper and lower jaws to help repair an oral cavity that has few or no teeth that can be restored.

SPACE MAINTAINERS: devices, fixed or removable, aimed at preserving the space left by one or more teeth, until the eruption of the permanent successor.

CAST METAL POST: part that allows a dental crown to be repaired by placing it on an osseointegrated implant or a natural root with endodontics, making the subsequent placement of an artificial crown necessary. The cast metal posts have a part called a pin for the implant and the root and another post for the crown.

FILLING: dental filling.

PREVENTIVE DENTISTRY: subdiscipline of dentistry that deals with the prevention of disorders of the oral cavity, as well as the preservation of healthy teeth and gingival tissues.

ORTHODONTICS: a speciality within stomatology that includes all the techniques aimed at improving the positional defects of the patient's teeth, to achieve better mechanical function and satisfactory oral aesthetics.

ORTHOPANTOMOGRAPHY: Panoramic dental X-ray. X-rays of the jaws allow us to see the bone and dental structures as well as to make certain presumptive diagnoses.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD): painful or defective function of the TMJ. The TMJ is the joint that makes it possible to open and close the mouth. It is the joint where the jaw articulates with the temporal bone of the skull, in front of the ear and on each side of the head.

PERIODONTICS: branch of dentistry that deals with the diagnosis, prevention and treatment of periodontal diseases (tissue surrounding the tooth, which are the gums and bone). When these tissues become infected due to lack of care, they are destroyed and leave the tooth almost without support (periodontitis or pyorrhoea).

ODONTOGRAM: measurement of tooth mobility.

PROSTHESIS: substitution, using an artificial element, of a part of the body rehabilitating the lost function.

PULPOTOMY: partial removal of the nerve, by removing the dental pulp and subsequent filling of the tooth.

CYST: a sac without an opening or outlet, lined with epithelium and usually containing fluid. The origin may be infectious or residual. The vast majority are benign, and a pathological anatomy study should always be performed.

INTRAORAL X-RAY: exploratory technique consisting of placing radiographic plates inside the mouth, of different sizes, which are recorded from the outside by an X-ray machine.

SCALING AND ROOT PLANING: treatment aimed at removing and eliminating calculus and plaque from the roots of the teeth with selective instruments for each tooth.

RECONSTRUCTION OF POSTS OR ANGLES WITH PINS OR BOLTS: reconstruction of a badly damaged tooth, using bolts or pins to strengthen the repair.

RE-ENDODONTICS: procedure by which root canal treatment is performed again on a tooth whose initial endodontic treatment has not given the expected result.

DENTAL SEALANTS: thin plastic film that is painted on the chewing surfaces of the back teeth (molars and premolars) to prevent the formation of cavities.

TARTRECTOMY: elimination of bacterial plaque and tartar or dental calculus.

TELERADIOGRAPHY: x-ray (of the patient's craniomandibular profile) with the radiation source away from the subject and in which the beams are parallel. It is performed by placing the photographic plate outside the mouth and with the X-Ray apparatus more than two metres away from the patient's skull. The aim is to preserve the real dimensions of it as much as possible.

VESTIBULOPLASTY: surgical procedure aimed at correcting the height of the buccal vestibules (the space between the lip and the gum).

ANNEX II: SECOND MEDICAL OPINION COVERAGE

1. Purpose

The purpose of this cover is to guarantee the Insured persons a Second Medical Opinion as defined below.

The Second Medical Opinion shall consist of the assessment, by experts of recognised national and international prestige of the illness in question, of the diagnosis and treatment that the Insured person is following in the process or illness from which they are suffering, issuing the corresponding report for this matter.

2. Insured persons

The status of the Insured persons will be held by the persons, contract holders and Beneficiaries at the time of applying for cover and during the entire period of cover.

3. Description

This cover must be requested during the period of validity of this Health Care insurance contract and in accordance with the definitions detailed below:

a) Second Medical Opinion on the diseases described in this contract in the section on **illnesses subject to Second Medical Opinion**. The service consists of:
   - Second Medical Opinion with specialists of the highest national and international prestige.
   - Without the need to travel and with a response within ten working days, counting from the date on which the Insured person sends the completed Second Medical Opinion request form and the corresponding documentation.
   - Support for the patient, if he/she deems it appropriate, after the Second Medical Opinion has been processed.

b) Selection of experts and hospitals:
   - Selection and referral of national and international medical experts and hospitals.
   - Advice regarding the medical care you will receive in national and international hospitals.

c) In those cases in which the Insured person considers it appropriate to receive medical services outside the list of professionals and centres arranged by the Insurer, an Expense Management service shall be provided which shall consist of:
   - Management of appointments with national and international doctors outside the Insurer's list.
   - Obtaining budgets and estimated costs of hospitalisation.
   - Admission procedures in national and international hospitals.
   - Coordination of the patient's transfer (reservations, air and land ambulance and translation service).

Under no circumstances shall these services be provided without the prior authorisation of the Insurer.

4. Illnesses subject to Second Medical Opinion

The Second Medical Opinion may be provided in cases where the Insured person has a first diagnosis of the following serious illnesses:

- Cancer.
- Cardiovascular diseases.
- Neurological and neurosurgical diseases, including stroke.
- Chronic kidney failure.
- Idiopathic Parkinson's disease (paralysis agitans).
- Multiple sclerosis.
- Childhood diabetes.
- Tropical diseases.

5. Other conditions

The services included in this Health Care insurance contract shall only be provided when the Insured person or the Insurer's doctor attending them requests a Second Medical Opinion via the telephone number set up specifically for this purpose.

Once the request has been made by telephone, the Insurer will provide the Insured person with a questionnaire, which will be returned duly completed, together with the medical/clinical history relating to the case, the laboratory tests, medical reports, X-rays, biopsies and other medical documents available to the Insured person that

correspond to the first diagnosis established, as well as any reports and complementary tests that the Insurer may request depending on the illness.

The Second Medical Opinion service includes the fees and expenses derived directly from the provision of the medical consultation services and second diagnoses indicated above, provided that these have been requested in the aforementioned manner. **Any other expenses, costs and fees arising from medical consultations or treatment, tests and analyses, reports, X-rays and other types of explorations shall be covered by the Insured person if they are carried out by means other than the Insurer's medical teams, even if they are related to the illness or clinical condition for which the Second Medical Opinion has been requested.**

6. Use of the service

This service offers medical information to complement, from a qualified medical expert, the information that the Insured person receives from their attending doctor, and is never intended to reach a medical diagnosis or a therapeutic decision on its own.

The response obtained through the Insurer shall be conditional upon the truthfulness and accuracy of the data provided.

The answer the Insured person receives should not be used to substitute their attending doctor, as reaching any clinical decision requires a personalisation that only the actual clinical interview can provide.

7. Request for Second Medical Opinion

Requests for Second Medical Opinion services can be made by calling **91 590 96 40**. The Insured person must provide the identification details requested in order to accredit their right to the service.

INSURED PARTY'S DEFENCE SERVICE

1. CAJA DE SEGUROS REUNIDOS, Compañía de Seguros y Reaseguros, S.A. (CASER) offers its customers its Insured party's Defence Service (Complaints and Claims) at Avenida de Burgos, nº 109, 28050 Madrid, and via the email address:
   defensa-Asegurado@caser.es

2. This Service will attend to and resolve, in accordance with the current regulations, within a maximum period of two months from their submission, the complaints and claims made, directly or through accredited representation, by all natural or legal persons, insurance users and participants or beneficiaries of occupational pension plans and associates of CASER, when these refer to their legally recognised interests and rights related to their insurance and pension plan operations, whether they derive from the contracts themselves, from the regulations on transparency and customer protection or from good practice and usage, in particular the principle of equity.

   The complaint or claim may be submitted in person or by accredited representation at any of the Company's offices open to the public or at the office of the Insured party's Defence Service on Avenida de Burgos 109, 28050 - Madrid, by post or online, provided that they can be read, printed and stored, in which case it must comply with the provisions of Law 59/2003 of 19 December on Electronic Signatures.

3. If the admission of the claims or complaints is refused, or if the request is totally or partially rejected, or if a period of one month has elapsed from the date of its submission to the Insured's Defence Service without it having been resolved, the interested party may submit their claim or complaint to the Claims Service of the Directorate-General for Insurance and Pension Funds (Paseo de la Castellana, nº44, 28046 Madrid), a body that will act as an alternative dispute resolution body in consumer matters, in accordance with the First Additional Provision of Law 7/2017, of 2 November. The website address of the Directorate-General of Insurance is provided for this purpose, www.dgsfp.mineco.es/reclamaciones/ where the claimant can find information on the procedure, requirements and means to file a claim or complaint. It may also be submitted to the competent courts.

4. Both at the CASER offices, and on its website www.caser.es our customers, users or injured parties, will find at their disposal a claim form model, as well as the Entity's Regulation for the Defence of the Insured persons, which governs the activity and the operation of this Service and the features and requirements for submitting and resolving complaints and claims. Likewise, from this web page, you can file a complaint or claim.

5. The resolutions will take into account the obligations and rights set out in the General, Particular and Special Conditions of the contracts, the regulations governing insurance activity and the rules on transparency and protection of financial services customers (Insurance Contract Law, redrafted text of the Law on the Regulation and Supervision of Private Insurances, redrafted text of the Law on Pension Plans and Funds, Law on Financial System Reform Measures, Law on Alternative Dispute Resolution in Consumer Affairs, Order ECC/2502/2012, regulating the procedure for the submission of claims to the Claims Service of the Directorate-General of Insurance and Pension Funds among others, Order ECO 734/2004, of 11 March, on the customer services of financial entities, redrafted text of the General Law for the Defence of Consumers and Users and other complementary laws).