CASER 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

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.

ÍNDICE

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 form, the Specific Conditions or (where applicable) the Certificate of Insurance, the Policyholder accepts specifically the clauses restricting the rights of the Insured highlighted in bold font.

ARTICLE 1 - DEFINITIONS

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

ACCIDENT: Means an event resulting in physical injury suffered while the policy is in force caused by a violent, sudden, external event beyond the control of the Insured.

INSURED: Means the natural or legal person who is a beneficiary of the insurance policy and who assumes the obligations derived from the Contract except for those for which the Policyholder is responsible. Unless otherwise expressly stated in the Specific Conditions, the Policyholder and the Insured are one and the same person.

INSURER: Means the legal person who assumes the contractually agreed risk, in this case CAJA DE SEGUROS REUNIDOS, Compañía de Seguros y Reaseguros, S.A (hereinafter referred to as the Insurer).

SPECIAL HOME MEDICAL ASSISTANCE SERVICES: Means medical assistance provided to the Insured by the general practitioner or family doctor and a Nursing Assistant or Registered Nurse at the address stated in the Policy when the ill person is suffering from a condition that requires special care but not hospital admission. This service must always be authorised in advance by a practitioner of the Insurer.

NURSING ASSISTANT/REGISTERED NURSE: Means a healthcare professional who meets the legal requirements and has the training required to practice nursing.

OUTPATIENT MEDICAL CENTRE: Means a medical establishment where healthcare is provided to patients, but without admission.

OUTPATIENT EMERGENCY MEDICAL CENTRE: Means a medical establishment where emergency healthcare is provided to patients, but without admission.

SPECIFIC CONDITIONS: Means a document that forms part of the Policy that sets out and provides details of aspects of the risk covered.

HEALTH QUESTIONNAIRE: Means the document that the Policyholder and/or the Insured must complete accurately and in full, sign and return to the Insurer so that the Insurer has all the information it needs to evaluate the risk.

ILLNESS: Means any change in the state of health of the Insured that is not the result of an accident, diagnosed by a doctor, that requires medical assistance and the first signs of which become apparent during the term of the Policy.

CONGENITAL DISORDER, DEFECT, DISABILITY OR ABNORMALITY: Means a condition that exists at birth as a result of hereditary factors or medical conditions acquired during pregnancy up to the moment of the birth itself. The condition may manifest itself and be recognised immediately after birth or may be discovered later, at any time during the life of the Insured.

PRE-EXISTING ILLNESS: Means a condition suffered by the Insured prior to the effective date the Policy.

EXCESS OR COPAYMENT: Means an amount that the Policyholder must pay the Insurer for each health service used by them or the Insured(s) parties in their policy. The amount can vary according to the type of health service and/or medical speciality provided. The amount of the Excess or Copayment, which is determined in the Specific Conditions, can be updated on an annual basis.

HOSPITAL: Means any institution legally authorised to provide medical or surgical treatment to outpatients or admitted patients for illnesses or injuries. These institutions will have a doctor permanently on duty, and will only admit persons who are ill or injured.

For the purposes of the Policy, hotels, asylums, nursing homes, hospices, spas, facilities that are primarily dedicated to the internment and/or treatment of drug addiction or alcoholism and similar institutions will not be considered hospitals.

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. In addition to healthcare professionals and institutions in the province, the list of medical practitioners for each province will include details of the information services and customer helplines that the Insured can call for the whole of Spain.

DOCTOR: Means a health professional duly authorised to practice medicine.

SPECIALIST DOCTOR OR SPECIALIST: Means a doctor who has the qualifications required to practice a legally recognised medical speciality.

WAITING PERIOD: Means the period that must pass before some of the cover included in the Policy comes into effect. This period is calculated in months, starting on the effective date of the Policy for each of the Insured parties.

POLICY: Means the document or documents that contain the clauses and pacts that regulate the Insurance Policy. 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 and the Particular Conditions (if any), as well as any supplementary documents or appendices that contain amendments agreed to during the term of the Contract.

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

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

REHABILITATION: Means all 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 musculoskeletal system of the Insured that have been affected by an illness or accident that occurs during the term of the Policy.

CLAIMABLE EVENT: Means an event suffered by the Insured as a result of which he or she requires healthcare services covered in part or in full under the Policy.

CASER SALUD CARD: Means the health card issued to each party insured under the policy by the Insurer, and which is the property of the Insurer. This card may only be used by the holder, who should produce it to receive the services covered under the Policy.

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.

EMERGENCY: Means a situation where the Insured requires immediate medical attention in order to avoid irreparable damage to their health.

- **OUTPATIENT EMERGENCY HEALTHCARE**: Means emergency healthcare services provided at medical outpatient centres.

- **HOSPITAL EMERGENCY HEALTHCARE:** Means emergency healthcare services provided in a hospital.

ARTICLE 2 - PURPOSE OF THE INSURANCE

The Insurer promises to provide the Insured with the outpatient medical care in the list of healthcare services relating to the specialities indicated in Article 3 ("DESCRIPTION OF COVER"), as well as the means of diagnosis and therapies listed in said article. The Insurer shall pay for the cost of these services directly to the medical practitioners or medical centre with whom the Insurer has entered into an agreement at the time the Service is provided.

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

At all times, the Insurer will provide the necessary emergency assistance in accordance with the provisions of the Conditions of the Policy and the provisions of Article 103 of the Insurance Contracts Act.

No cash payments in lieu of healthcare services will be made under the terms of this Policy.

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/Family doctor: Healthcare provided at the doctor's surgery or at home. Care at home will only be provided when the patient cannot travel due to medical reasons.

Paediatrics - Child care: Includes preventative and child development check-ups.

Nursing Assistant/Registered Nurse services: Healthcare provided at the doctor's surgery or at home. Care at home will only be provided when the patient cannot travel due to medical reasons and the visit has been authorised in advance by a doctor of the Insurer.

2. EMERGENCIES

Home emergency service: Emergency medical services provided in the home by Nursing Assistants/Registered Nurses. 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 Assistant/Registered Nurse.

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

The Insured will be provided with **consultations and intraconsultation diagnostic tests** for the following specialities:

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

3.2. Anaesthesiology and resuscitation.

3.3. Pathology. The 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

The Policy covers only the therapeutic targets listed in a drug's specifications and, depending on the therapeutic approach taken in each case, must be determined before the drug is administered. The drugs must be of proven clinical effectiveness and importance and sold in Spain. They must also be authorised and approved by the Spanish Agency of Medicines and Medical Devices.

3.4. Angiology and vascular surgery.

3.5. Digestive system.

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

3.7. Anal-rectal surgery. Proctology.

3.8. Cardiovascular surgery.

3.9. General surgery and surgery on the digestive system.

3.10. Maxilofacial surgery.

3.11. Paediatric surgery.

3.12. Plastic and reconstructive surgery.

3.13. Thoracic surgery.

3.14. Medical-surgical dermatology and venereology.

3.15. Endocrinology and nutrition.

3.16. Geriatrics.

3.17. Immunology.

3.18. Infectious and tropical diseases.

3.19. Internal medicine.

3.20. Nuclear medicine.

3.21. Nephrology.

3.22. Neonatology.

3.23. Pneumology.

3.24. Neurosurgery.

3.25. Clinical neurophysiology.

3.26. Neurology.

3.27. 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. It is aimed at women who are in their second or third trimester of pregnancy.

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

c) Family planning: This includes hormonal contraception monitoring and the insertion and monitoring of IUDs. **The cost of the IUD is included, provided that it has been purchased at a chemist.** The Insurer will reimburse the Insured for 100% of the cost once the Insured has presented the prescription from the doctor and the corresponding invoice. **Hysteroscopic tubal occlusion, the insertion of Essure devices and 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.

3.28. 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).

3.29. Ophthalmology.

3.30. Medical oncology. Consultation, diagnosis of and the planning of treatment for subsidiary illnesses in this area of specialisation. The application of the treatment will be paid for by the Insured.

3.31. Otorhinolaryngology.

3.32. Clinical psychology. This includes individual, short-term outpatient psychological treatment, prescribed by a psychiatrist on the list of medical practitioners of the Insurer, to treat conditions that can benefit from psychological treatment, **up to a maximum of 20 sessions per Insured per annum.**

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

3.33. Psychiatry.

3.34. Rehabilitation and physiotherapy. This includes **only outpatient treatment for problems with the musculoskeletal system.**

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

3.35. Rheumatology.

3.36. Pain treatment.

3.37. Traumatology and orthopaedic surgery.

3.38. 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, immunological, and cytopathological analyses, as well as 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 scans.

4.3. Other:

1. **Nuclear medicine:** Gammagraphy.
2. **Positron emission tomography (PET):** In cases of cancer and drug-resistant epilepsy.

4.4. Cardiological diagnostics: Electrocardiograms, stress tests, echocardiograms, conventional Holter monitor, Holter event monitor, Doppler.

4.5. Clinical neurophysiology: Electroencephalograms and electromyography.

4.6. Triple screening, amniocentesis.

4.7. Digital dermoscopy: It must be prescribed by one of the doctors of the Insurer with knowledge of the speciality to be treated, and performed at clinics that have an agreement with the Insurer. Digital dermoscopy 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.

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

5. SPECIAL 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.**

- **Phoniatrics: Covered solely as rehabilitation after major larynx surgery, for up to a maximum of 60 sessions.**

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

6. OTHER SERVICES

- **Podiatry:** Only podiatry services in a hospital (**limited to 6 sessions**) and biomechanical gait studies for children under 15.

ARTICLE 4 - EXCLUDED RISKS

a) 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.

b) Hospital emergencies, as pointed out in point 2 of Article 3.

c) Arthroscopies, surgical biopsies and laparoscopies, fibroscopies, catheterisations, vascular haemodynamics and interventional radiology. Prostheses of all types, osteosynthesis material, biological or synthetic materials and anatomical and orthopaedic components.

d) Injuries the result of wars, uprisings, revolutions and terrorism; those caused by officially declared epidemics; those directly or indirectly related to radiation or a nuclear reaction; and those the result of natural disasters (earthquakes, floods and other seismic or meteorological phenomena).

e) Pharmaceuticals, radiopharmaceuticals and medicaments of all types, as well as vaccines of all types and parapharmaceuticals.

f) Healthcare for injuries that are the result of inebriation, fighting (except in cases of legitimate self-defence) or injuries the result of self-harm of suicide attempts.

g) Healthcare arising from the consumption of alcohol or drugs of any type.

h) Healthcare required as a result of injuries suffered in the pursuit of high-risk activities such as bullfighting or running with bulls; participation in dangerous sports such as scuba diving, pot-holing, boxing, martial arts, climbing, rugby, motor sports, quad vehicle sports, 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 healthcare required for professional participation in any sport.

i) Healthcare required for all types of illnesses, injuries or accidents and 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 healthcare for symptoms that may constitute the onset 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.

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

k) General preventative check-ups or examinations, except for those expressly included in point 3 of Article 3.

l) Sterility or infertility treatments, the voluntary termination of pregnancy under any circumstances and the diagnostic tests required for the termination and treatment for impotence.

m) Filtrations, treatments and any other form of medical intervention performed purely for cosmetic reasons are excluded. Subsequent illnesses, complications and requirements which are a direct and main consequence of the Insured having undergone treatment for purely cosmetic reasons are also excluded.

n) 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 cover, except for what is expressly included in point 3.32 of Article 3.

ñ) 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.

o) Hospital healthcare and treatment for social or family reasons.

p) In odonto-stomatology, seals, endodontics, the the fitting of dental implants, orthodontics, periodontics and implants, as well as other treatments other than those included in point 3.28. of Article 3, are not covered.

q) All therapeutical techniques that use laser, other than those expressly included in point 5 of Article 3.

r) Transportation and travel expenses, as well as the cost of ambulances.

s) Dialysis and haemodialysis treatments.

t) Physiotherapy and rehabilitation when the Insured has recovered functional use of the affected part or has made the fullest possible recovery, or when it becomes occupational maintenance therapy (or does so in the opinion of the specialist in charge of the treatment). Educational therapy is excluded. Pelvic floor and lymphatic drainage rehabilitation are excluded, as is rehabilitation required as a result of a neurological disorder.

u) Genetic tests to determine whether the Insured or their present or future descendants have a genetic predisposition to diseases caused by genetic alterations are excluded, with the sole exception of those 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 are 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 requested for prognostic or diagnostic purposes.

v) Diagnostic and therapeutic procedures that have not been scientifically proven are excluded, as are those that appear after this Policy has been signed and which are not specified by the Insurer. 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 procedures 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 that are not among the leading public hospitals.

w)All sleep disorder diagnosis methods are specifically excluded, except for those specified in point 4 of Article 3.

x) Oxygen therapy, aerosol therapy, ventilation therapy and ozone therapy are excluded.

ARTICLE 5 - METHOD OF SERVICE PROVISION

The healthcare covered by the Policy will be provided in all population centres 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 population centres, it will be provided in another town where it is available. In this case, the population centre will be chosen by the Insured Party.

New diagnostic procedures, therapies and 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 with which the Insurer has entered into an agreement. This Policy will not cover treatment provided by healthcare professionals, appointments, and diagnostic or therapeutic methods prescribed by a doctor unless they are included in the healthcare services covered by this Policy.

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 can choose their primary healthcare doctors and specialist practitioners, provided that these doctors and practitioners are on the medical practitioners list of the Insurer in force at the time.

The Insurer recommends that each Insured have a general practitioner or paediatrician to provide family healthcare services. Each Insured may choose their general practitioner or paediatrician and nursing assistant from the medical practitioners on the list of the Insurer, and must inform the Insurer of their choice or any change to the same. If the Insured does not live in the catchment area of the practitioner of their choice, 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, 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 their home address at least 8 days before any request is made for healthcare service.

In the event of an emergency, the Insured should request assistance by calling 902 190 191. Assistance will be provided subject to the evaluation of the emergency Caser service and only at the address given in the Special Conditions of the Policy, provided that Caser has contracted home healthcare services in the population centre of the Insured when the Insured cannot travel to the doctor's surgery or to the surgery of the Nursing Assistant/Registered Nurse.

4. COST-SHARING

In the case of healthcare services for which copayment is required, the Insured will be required to make a copayment for each service received. Caser will calculate the total amount of copayments payable by the Insured based on invoices it receives from the doctor of the Insured. The copayments for each service 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 Insureds listed in the Policy, together with the amount of copayments for the same.

The total amount payable by the Insured will be paid to the Insurer by direct debit from the bank account designated by the Policyholder for policy premium payments.

Copayment amounts may be updated by the Insurer, in accordance with Article 12 (ANNUAL ADJUSTMENT OF THE FINANCIAL TERMS OF THE POLICY).

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

In the event of an emergency, the Insured should call the emergency services or go directly to the emergency health services centre of the Insurer. The address and telephone number of the emergency services centre are given in the list of medical practitioners of the Insurer.

7. 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, or for the costs of any hospitalisation or healthcare services they prescribe.

8. ACCREDITATION OF THE INSUREDS

When requesting healthcare services, the Insured must present the health card issued to them by the Insurer for this purpose which shows they are an Insured of Caser Salud. The Insured must sign the receipt for the service.

When the medical practitioner or centre providing the service consider it convenient to do so, they may also request to see the national identification documents of persons required to possess one.

ARTICLE 6 - WAITING PERIODS

The healthcare services for which a specific period from the effective date of the Policy must pass before they are covered by the Insurer are:

Six (6)-month waiting period:

- Family planning.
- High-tech diagnostic tests.

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