CASER SALUD INICIA

Health insurance policy

General Conditions

CAJA DE SEGUROS REUNIDOS

Compañía de Seguros y Reaseguros, S.A.

Registered address: Avenida de Burgos, 109 - 28050 Madrid

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Registered in the Madrid Register of Companies
General Volume 2245 – Page 179 – 8th Section – Sheet M-39662, Registration A 435
Business tax number: A 28013050

Mod.: K0001225-B

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 50/80 of 8 October, to Royal Legislative Decree 6/2004, of 29 October, which approved the revised text of the Private Insurance Classification and Supervision Act, and to its implementation regulations.

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

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INSURED DEFENSE SERVICE

GENERAL CONDITIONS

PREAMBLE

This insurance contract is regulated by the provisions of the Insurance Contracts Act of 8 October, (published in the Official Gazette of 17 October, 1980), by Royal Legislative Decree 6/2004, of 29 October, which approved the revised text of the Private Insurance Classification and Supervision Act, by its implementation regulations (Royal Decree No. 2486/98, of 20 November), and by the general, specific and special conditions of this contract. The company´s insurance activities in Spain are supervised by the Spanish Ministry for the Economy and Competition, through its Directorate-General of Insurance and Pension Funds.

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

ARTICLE 1 - DEFINITIONS

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

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

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

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

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

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

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

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

- **OUTPATIENT EMERGENCES**: means emergencies where treatment is provided in medical and outpatient clinics.

- **HOSPITAL EMERGENCIES**: means emergencies where treatment is provided in a hospital.

EMERGENCY OUTPATIENT CLINIC: means an establishment which provides emergency medical assistance to patients but does not provide hospitalisation care.

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

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

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

HOSPITALISATION:

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

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

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

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

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

LIST OF MEDICAL PRACTITIONERS: means the list of healthcare professionals and institutions belonging to or contracted by the Insurer in each province, with their addresses, telephone numbers and opening hours. The list of medical practitioners for each province will include, in addition to the healthcare professionals and institutions in the province, the

information services and customer helplines that insured parties can call for the whole of Spain.

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

OUTPATIENT CLINIC: means an establishment which provides medical assistance to patients but does not provide hospitalisation care.

POLICY: means the document or documents that contain the clauses and agreements that regulate the insurance contract. The following form an integral and inseparable part of the policy: the insurance application; the health questionnaire; the general conditions; the specific conditions that specify the risks; the special conditions, if any; and the supplementary documents or appendixes that contain any modifications agreed upon during the term of the contract.

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

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

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

PROSTHESES, IMPLANTS AND GRAFTS: means any element of any kind that replaces, either temporarily or permanently, all or part of an organ, tissue, body fluid, or limb.

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

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

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

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

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

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

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

ARTICLE 2 – PURPOSE OF THE INSURANCE

The Insurer undertakes to provide the insured, in Spain, with the outpatient and specialist medical services (diagnosis and treatment) listed in the insurance policy, subject to the limits and conditions stipulated in the policy, and payment of the premium and applicable deductibles. All healthcare services will be provided by the medical practitioners and institutions with whom the Insurer has entered into an agreement at the time when the service is provided.

Consequently, hospital healthcare services and surgical operations are not covered by this policy.

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

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

ARTICLE 3 – DESCRIPTION OF THE HEALTH INSURANCE COVERAGE

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

1. FAMILY MEDICINE

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

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

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

2. EMERGENCY HOME VISITS

Emergency medical visits, and nursing assistant/registered nurse services at home. These services will be provided after Caser's emergency service has assessed the situation to the insured´s home that appears in the specific conditions of the policy, provided that Caser has contracted home visit services in the place where the insured lives, and when the insured´s illness prevents him/her from going to the surgery of the doctor, or nursing assistant/ registered nurse.

EMERGENCY OUTPATIENT TREATMENT

Emergency outpatient healthcare will be provided at the emergency outpatient clinics (not hospitals) in the towns where Caser has an agreement to provide such services. These clinics are listed in the appropriate section of the Services Guide.

Emergency hospitalisations are excluded.

3. MEDICAL SPECIALITIES

The healthcare services provided for the following medical specialities comprise **specialist consultations and diagnostic tests**:

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

3.2. Anaesthesiology and resuscitation.

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

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

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

3.4. Angiology and vascular surgery.

3.5. Digestive system.

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

3.7. Anal-rectal surgery. Proctology.

3.8. Cardiovascular surgery.

3.9. General surgery and digestive system surgery.

3.10. Maxillofacial surgery.

3.11. Paediatric surgery.

3.12. Plastic and reconstructive surgery.

3.13. Thoracic surgery.

3.14. Medical-surgical dermatology and venereology.

3.15. Endocrinology and nutrition.

3.16. Geriatrics.

3.17. Immunology.

3.18. Tropical and infectious 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. Only sleep studies at home are included.

3.26. Neurology.

3.27. Obstetrics and gynaecology.

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

b) **Pregnancy healthcare/monitoring:** the pregnancy is monitored by an obstetrician. **High-risk pregnancies which require hospitalisation are not covered.**

c) **Family planning:** monitoring treatment with contraceptive pills, insertion and monitoring of intrauterine IUD coils. The cost of the device is included.

d) **Preventive medicine:** annual gynaecological check-ups (this includes the visit to the gynaecologist, medical report, smear test, ultrasound scan, and breast thermography or mammography), for the early diagnosis of breast and cervical neoplasms. This cover also includes the study and diagnosis of infertility and sterility.

e) **Monitoring and treatment of menopause.**

3.28. Dentistry-oral medicine. This only includes tooth extraction and follow-up care, plain intraoral X-rays, and annual dental cleaning, and must be prescribed by a dentist–oral surgeon in the Insurer´s list of medical practitioners.

3.29. Ophthalmology.

3.30. Medical oncology. Consultations, diagnoses, and treatment planning for secondary illnesses arising from cancer. The costs of the treatments will be paid by the insured.

3.31. Otorhinolaryngology.

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

This cover includes **child psychology**.

Authorisation from the Insurer will be required prior to treatment.

3.33. Psychiatric treatment.

3.34. Rehabilitation and physiotherapy. Cover only includes outpatient treatment for disorders of the musculoskeletal system.

A prescription from one of the Insurer´s specialists and authorisation from the Insurer will be required prior to treatment.

3.35. Rheumatology.

3.36. Pain treatment.

3.37. Traumatology and orthopaedic surgery. Ozone therapy for herniated (slipped) disks is excluded.

3.38. Urology. Includes diagnosis of impotency (not treatment) as well as a study and diagnosis of infertility and sterility.

4. DIAGNOSTIC METHODS

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

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

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

4.3. Others:

a) **Nuclear medicine.** Gammagraphy.
b) **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 and Doppler.

4.5. Clinical neurophysiology: electroencephalograms and electromyography.

4.6. Polysomnography: only for the study of obstructive sleep apnea syndrome at home.

4.7. Triple screening, amniocentesis.

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

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

5. SPECIAL TREATMENTS

A prescription from one of the Insurer's doctors related to the speciality and authorisation from the Insurer will be required prior to treatment.

- Phoniatrics. **Exclusively as rehabilitation following major larynx surgery,** for up to a maximum of 60 sessions.
- Laser therapy. This is **only** included for **ophthalmological treatments, and musculoskeletal rehabilitation.**

6. OTHER SERVICES

- Podiatry: chiropody, **only in the doctor´s surgery, up to a maximum of 6 sessions.**

ARTICLE 4 – EXCLUDED RISKS

a) Any hospital healthcare, whether as an outpatient, inpatient, or at a day hospital, as well as any therapeutic and surgical treatment that is not specifically listed in Article 3.

b) Emergency hospitalisation, as indicated in Point 2 of Article 3.

c) Arthroscopic surgery, laparoscopic surgery, surgical biopsies, endoscopies, fiberscopes, catheterisations, vascular hemodynamics and interventional radiology. Prostheses of any type, osteosynthesis, biological or synthetic materials, anatomical and orthopaedic devices.

d) 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).

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

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

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

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

i) The healthcare required for all kinds of illnesses, injuries, or accidents, together with their long-term impacts or consequences, congenital defects or abnormalities, and pre-existing conditions which were diagnosed prior to the effective date of the policy for each insured party, and for which the insured has required analyses, diagnostic tests or treatments of any kind, as well as the healthcare for symptoms that may be the start of a medical condition, 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 unless they are specifically included in Point 3 of Article 3.

l) Sterility or infertility treatments, voluntary termination of pregnancy in any circumstances as well as the diagnostic tests required for the termination, and treatment (including surgery) for impotence.

m) The following are expressly excluded from cover: any healthcare services, filtrations, treatments, and any other type of medical intervention that is performed for purely aesthetic reasons, as are any illnesses or complications that appear subsequent to cosmetic treatment the insured has undergone.

n) Everything related to psychology, narcolepsy, sophrology, neuropsychological and psychometric tests, psychoanalytic psychotherapy, psychosocial rehabilitation or neuropsychiatry, psychoanalysis, hypnosis, individual or group psychotherapy, psychological tests, rest cures and sleep therapy, are

specifically excluded from the coverage, except when expressly included in Point 3.32 of Article 3.

o) Healthcare for AIDS, and the illnesses caused by the human immunodeficiency virus (HIV).

p) Any healthcare or treatment for social or family reasons.

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

r) Surgical correction of myopia, hypermetropy or astigmatism and presbyopia and any other refractive eye condition.

s) All the surgical and/or therapeutic techniques that use laser, except for those expressly included in Point 5 of Article 3.

t) Transportation and travelling expenses, as well as ambulance expenses.

u) Dialysis and haemodialysis treatments.

v) Physiotherapy and rehabilitation treatments when the insured has recovered functional use of the affected part or has made the fullest possible recovery, in the opinion of the specialist on the Insurer´s list of medical practitioners in charge of the treatment, or when it becomes occupational maintenance therapy. Educational therapy is excluded. Pelvic floor and lymphatic drainage rehabilitation are excluded, as is the rehabilitation required as a result of a neurological disorder.

w) All genetic tests are excluded, except for those that are expressly included in the coverage, such as amniocenteses (except for the in situ hybridisation technique) and karyotype (except for karyotype of aborted foetus) and the therapeutic targets described in Article 3.

x) Diagnostic and/or therapeutic techniques that are not usually used or accepted by the Spanish National Health Service.

New diagnostic and therapeutic procedures, and new technologies, will be added to the insurance policy coverage in accordance with the principles of evidence-based medicine, after they have been shown to be effective and safe, and when the Insurer´s contracted medical institutions and clinics are able to provide them.

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

z) Assistance with birth, caesareans, high-risk pregnancies that require hospitalisation and 3D ultrasound scanning are excluded.

aa) Oxygen therapy, aerosol therapy, and ventilation therapy are expressly excluded.

ARTICLE 5 – HOW THE SERVICES ARE PROVIDED

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

1. HEALTHCARE ADVICE AND GUIDANCE

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

2. FREE CHOICE OF DOCTORS

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

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

3. HOME VISITS

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

If the insured wants to request an emergency home visit, s/he should phone 902 190 191, and Caser´s emergency services will arrange the visit after evaluating the situation. Emergency home visits will be made only to the address given in the policy, **and provided that Caser has contracted home visit services in the town where the insured lives, and the patient is unable to go to the doctor´s surgery or the nursing assistant/registered nurse´s office because of their illness.**

4. COST-SHARING

The insured will pay the deductibles that are established in the specific conditions for all the healthcare services provided, as co-payment.

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

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

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

5. AUTHORISATION OF SERVICES

In general, some special treatments, rehabilitation treatments, physiotherapy, psychology, and diagnostic tests will require a written prescription from the Insurer's medical practitioner and prior express authorisation from the Insurer.

Documentation to be submitted for services that require authorisation:

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

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

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

6. EMERGENCIES

The insured should request emergency services by telephone or by going directly to the outpatient emergency clinic that appears in the appropriate section of the Insurer´s list of medical practitioners.

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, nor for the costs of any hospitalisation or healthcare services they prescribe.

8. ACCREDITATION OF INSURED PARTIES

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

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

ARTICLE 6 – WAITING PERIODS

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

Three-month waiting period:

- Advanced-technology diagnostic methods.

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).

b) 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.

c) 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.

d) In the case of aggravation of the risk, when the policyholder or insured fails to notify the Insurer and have acted in bad faith (Article 12 of the Act).

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

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

3. The policyholder may 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.

4. If the insured has had a medical examination or all his/her rights have been recognised, the Insurer may not deny him/her any services on the grounds of his/her state of health or allege the existence of pre-existing illnesses, unless the insured has a medical condition

which was discovered in the aforementioned examination, and the appropriate reservation was included in the policy's specific conditions.

If the insured does not have a medical examination or not all of his/her rights are recognised, this policy will become incontestable one year after it has been signed by the parties, unless there was wilful intent on the part of the policyholder.

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 and, unless otherwise agreed, will expire on the date of expiry that appears therein. 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 above, 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 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 Insurance Contracts 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 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 rules 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 appropriate, 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.

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.

b) 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, of any additions to or removals from the policy of insured parties during the term of such policy. The coverage for additional insureds will come into effect on the first day of the month following that of the date of notification made by the policyholder, while the removal of insureds from the policy will come into effect at the end of the insurance period. In both cases the amount of the premium will be adjusted to reflect the new situation.

e) Newborns and adopted children may be included as additional insureds in the policy of their parents, and do not need to have a health questionnaire or waiting periods, provided the parents have been CASER insured parties for a minimum of eight 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 for all applicants. In this case the ordinary waiting periods and the exclusions for illnesses 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 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 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 the 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 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 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.

The Insurer may update the medical practitioners list annually, adding or removing medical practitioners, healthcare professionals, hospitals and any other institutions on the list. The policyholder and/or insured parties must use the services of the healthcare providers who are on the list when they request the healthcare service. To this end they may request an updated list of medical practitioners by calling the phone line set up for this purpose, or view the list at the Insurer´s website: www.caser.es

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

The Insurer may update the premiums and the deductibles, or co-payments, for the healthcare services annually, as stipulated in Point 4 of Article 5 of the general conditions.

These premium and deductible 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 and sex 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 deductibles 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 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.

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. The conditions or illnesses for which this service is available are listed in part 4 of this section.

2. Insured parties

The policyholder, and the beneficiaries included in the policy when the service is requested and who have insurance cover for the insurance period underway, 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

This service 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.

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 Mondial Assistance Service España S.A.

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 be 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: The Insurer, through Mondial Assistance Service España S.A., whose registered office is at Avda. Manoteras, 46-bis, edif. Delta Norte 3, 28050-Madrid.

In order for the Insurer to comply with its obligations, it is essential that the insured immediately notify Mondial Assistance Service España S.A., of the occurrence of a claimable event by calling the telephone number given in this document.

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, 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 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 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 Mondial Assistance Service España, S.A., and it is solely responsible 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 Mondial Assistance Service España S.A., 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:

34 915 955 049