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Emisión de Pólizas y Suplementos
Gestión y Tramitación de Siniestros
Diseño e impartición de Formación en las áreas de gestión de seguros

helvetia

Insurance Policy
Helvetia "Salud" General and Specific Conditions

Edition November 2016

Table of contents

02-E71 ING/00005/G.DEHÓN/1016

Information note to the Policyholder prior to taking out the insurance

This information is provided in compliance with the provisions of Article 96 of Law 20/2015, of 14 July, on Management, Supervision and Solvency of Insurance Companies and Reinsurers and in Articles 122 and 124 of its Regulation, approved by Royal Decree 1060/2015, of 20 November.

1 Applicable Law. This insurance is governed by:

- Law 50/1980, of 8 October, on Insurance Contracts.
- Law 20/2015, of 14 July, on Management, Supervision and Solvency of Insurance Companies and Reinsurers.
- Royal Decree 1016/2015, of 20 November, on Management, Supervision and Solvency of Insurance Companies and Reinsurers.

2 Complaint bodies

In accordance with Article 97.1 of Law 20/2015, of 14 July, on Management, Supervision and Solvency of Insurance Companies and Reinsurers, conflicts that may arise between policyholders, insured parties, beneficiaries, injured third parties or rights holders of any of them with the Insurer, will be resolved by the competent Judges and Courts. In accordance with Article 97.2 and 4 of aforementioned Law 20/2015, they may voluntarily submit their differences to arbitration decision, under the terms of Articles 57 and 58 of the Consolidated Text of the General Law for the Defence of Consumers and Users and other complementary legislation, approved by Royal Legislative Decree 1/2007, of 16 November, or to private arbitration under the terms of Law 60/2003, of 23 December, on Arbitration.

In addition and in accordance with Article 97.2 of aforementioned Law 20/2015, they may submit their differences to a mediator under the terms provided for in Law 5/2012, of 6 July, on mediation in civil and commercial matters

Information clause for processing complaints and claims

In accordance with the provisions of Article 29 and subsequent of Law 44/2002, of 22 November, on Financial System Reform, Article 97.5 of Law 20/2015, of 14 July, on Management, Supervision and Solvency of Insurance Companies and Reinsurers and the development of the Regulation of the Commissioners for the defence of clients of financial services, Royal Decree 303/2004, of 20 February; and in Article 9 of Order ECO/734/2004, of 11 March, this entity has a Customer Service Department to respond to the complaints and claims filed by its customers related to their interests and legally recognised rights, with domicile at Paseo Cristóbal Colón 26, 41001, Seville (Spain) and email address: departamentoatencioncliente@helvetia.es.

In relation to the Customer Service Department, we inform you that:

1. The Insurer has the legal obligation to attend and resolve the complaints and claims of its clients within a maximum period of two months as of receipt of the same. However, the Insurer undertakes to complete the file in the maximum period of one month from the date on which the query, complaint or claim was filed in the Customer Service Department.

   When the Insurer is unable to respond within this time limit, the claimant will be informed regarding the causes of said delay with an indication of the time frame within which it is likely the investigation will be completed and the claim will be resolved. Nevertheless and in any case, the claim must be resolved within two months as of the date the query, complaint or claim is submitted.

2. Any query, complaint or claim shall be made in writing and addressed to the Customer Service Department, in person or through duly accredited representation, at any of the Company's branches, or via computerised, electronic or telematic means, provided these allow reading, printing and saving the documents.

3. The Insurer has in its offices, available to its customers, the model for the presentation of claims and complaints adapted to the legal requirements, and the operating rules of the Customer Service Department.

4. The decision of the Customer Service Department will be reasoned and will contain clear conclusions regarding the request posed in the query, complaint or claim, on the basis of the contractual clauses, on insurance law and on good practices and uses of the insurance sector.

5. After this period, the claimant may transfer his/her complaint or claim to the Claims Department of the Directorate General of Insurances, in which case the claimant must certify that the two-month period has elapsed since the claim was presented before the Customer Service Department, without said claim having been resolved, or that the claimant's request has partially or totally been dismissed or not accepted.

This clause is not applicable to the operations classified as "high risk" (Article 107 of Law 50/1980, on Insurance Contract). However, customers may address, prior to the filing of the corresponding arbitration or judicial, the Customer Service Department, which will attend and make a decision regarding the complaint or claim within a maximum period of two months from the receipt of any such complaint or claim.

3 Insurer

The Insurer is Helvetia Compañía Suiza, Sociedad Anónima de Seguros y Reaseguros, with registered office at Paseo de Cristóbal Colón, 26, Postal Code 41001, Seville (Spain). The Ministry of Economy and Finance, through the Directorate General of Insurances and Pension Funds, is responsible for controlling and monitoring its insurance activity.

4 Jurisdiction

The domicile of the insured shall be applicable for the knowledge of the actions arising from the Insurance Contract.

Express consent clause on assignment and computerised handling of data

In accordance with the provisions of Statutory Law 15/1999, of 13 December, on Protection of Data of a Personal Nature and any additional regulations, Helvetia Compañía Suiza, Sociedad Anónima de Seguros y Reaseguros informs you that the personal data provided in this document (including health related information, if any) will be incorporated into a file of the Insurer's responsibility for the purpose of managing the insurance relationship.

The policy holder consents that the data derived from an accident reported by the same or by any other interested party and which refers to his/her own data for the duration of the insurance cover will be handled for the purpose of managing said accident, hence this data may be assigned or communicated to third parties responsible for dealing with the accident (experts, workshops, doctors, lawyers, etc.). In this sense, they may also be communicated to all third parties that provide a service to Helvetia Seguros which necessarily involves accessing the personal data when this is necessary for the maintenance, development and control of the legal relationship.

Likewise your data may be communicated to the Co-insurance and Reinsurance Entities in cases involving co-insurances and reinsurances when this is necessary for the development, maintenance and control of the legal relationship.

The policy hodler's data could be included into common files in the legally foreseen cases with the aim of preventing fraud, facilitating redress in the event of an accident, assess risks and/or locate stolen vehicles or in other events for which express consent is granted.

As the holder of the data (including health-related data if any), you are informed and expressly accept the data be included into other common files that may exist for the settlement of claims and the actuarial statistical cooperation for the purpose of allowing the pricing and selection of risks and the preparation of studies into insurance techniques, which will be the responsibility of TIREA, SERSANET and ASITUR.

Helvetia Seguros may request business and solvency reports to supplement the information you have provided to us.

We inform you of the possibility of making use, for its handling or assignment to third parties, of the personal data of which you are a holder for the purpose of carrying out satisfaction surveys, send you commercial communications, publicity and promotional information, either by mail or by electronic means, of products and services provided by Helvetia Seguros, both during the validity of the policy or policies that you may have taken out with Helvetia Seguros and after these have ended, as well as for the purpose of adapting our communications to your personal profile.

For the same purpose as mentioned above, the data assignment may be carried out with other companies within the Group belonging to the insurance sector located in countries that provide a level of protection comparable to that of the Spanish legislation.

To this end we request your conformity and consent to said handling, to which you may express your refusal within thirty days, warning that in the event of not acting we shall deem that you consent to the handling of your personal data in the sense indicated in the preceding paragraph.

In the event of not wanting to grant your consent, you may proceed to mark with an X in the box(es) below and deliver this to any of our branches.

The policyholder is informed that a previously granted consent may be revoked at any time, and to do so he/she may address any of our branches.

☐ I do not authorise the handling of my personal data for the purpose of conducting surveys, sending commercial communications, publicity and promotional information.

☐ I do not wish to receive commercial communications by email or any other similar means of communication (SMS, MMS, etc.).

You may also exercise your right to access, modify, oppose and cancel the data handling by addressing any of our branches.

In the event of including data relating to any individuals other than the Policyholder, the latter undertakes to inform such persons regarding the points set forth above.

Article 1 - Definitions

For the purposes of this Policy, the following should be understood:

1.1 Insured
The person who is the holder of the interest exposed to the risk, to whom the rights deriving from the contract may correspond, where applicable. The Insured may assume the obligations and duties of the Policyholder.

When an Insured was not initially included in the Contract, the Policyholder may include this party by means of the corresponding statement. The Insurer may grant the status of Insured and, in the event of accepting this, may exclude the services derived from pathological conditions or illnesses prior to the declaration of inclusion in the Policy or expressed in the course of the medical examination, with the exception of those relating to newborn children whose inclusion will be effective immediately if this is requested within the first month of life of the newborn and the mother is also covered.

1.2 Insurer
Helvetia Compañía Suiza, Sociedad Anónima de Seguros y Reaseguros (hereinafter the Insurer), company issuing this Policy, which in its condition of Insurer and through the collection of the Premium, assumes the cover of the risk object of this Contract in accordance with the conditions of the insurance policy.

Helvetia Compañía Suiza, Sociedad Anónima de Seguros y Reaseguros is domiciled at Paseo de Cristóbal Colón 26, 41001 Seville (Spain) and is subject to the control of the Directorate General of Insurances of the Ministry of Economy and Finance.

1.3 Accident
A body injury that derives from a violent, sudden and external cause not intended by the Insured.

1.4 Work accident and occupational illness
Any alteration of the state of health, caused by an accident or not, that is derived or is the result of carrying out a working activity, and is considered as such according to legal regulations.

1.5 Medically necessary act
All care procedure, consultation, means of diagnosis or treatment, commonly accepted as decisive by doctors in Spain and that lacks a more efficient alternative. The fact that a care procedure, consultation, means of diagnosis or treatment is prescribed or ordered by a physician does not necessarily imply this is medically necessary.

1.6 Extreme or high-risk sports
All sports or leisure activities with some sports component which, due to their real or apparent danger or due to the difficult or extreme conditions in which they are carried out, are included under this term.

1.7 Disease
Alteration of the state of health, confirmed by a legally recognised medical practitioner and that requires medical care.

1.8 Congenital Disease
A disease which exists at the moment of birth as a result of hereditary factors or conditions acquired during pregnancy. A congenital condition may occur and be recognised immediately after birth, or be discovered later at any moment of the person's life.

1.9 Excess
Amount or economic percentage that at the time of the accident is payable by the Insured and that has been expressly agreed to for certain coverages of the policy.

1.10 Reasonable and usual expenses
The amount to be paid by the Insurer for the health benefits covered by this insurance must be within the usual and reasonable range for the place and the means with which they are provided.

1.11 Hospital
All public or private establishment that is legally authorised for the treatment of diseases or bodily injuries, provided with the means to carry out diagnosis or surgical interventions. For the purposes of the Policy, hotels, old people's homes, rest houses, spas, facilities mainly devoted to the treatment of chronic diseases and conditions and similar institutions shall not be considered hospitals.

1.12 Hospitalisation
Period of time, measured in stays, during which a patient remains in a closed regime, i.e. admitted to hospital, staying overnight and eats his/her main meals at the hospital, provided that said admission is prescribed by a physician of the Insurer and medically necessary.

1.13 Home hospitalisation
Series of treatments and healthcare provided in the home of a complexity, intensity and duration comparable to those that the same patient would receive in a conventional hospital.

1.14 Surgical intervention
This is an operation with diagnostic or therapeutic purposes, conducted by incision or another internal approach system, carried out by a surgeon in an authorised centre (hospital or outpatient basis) and that typically requires the use of an operating theatre.

1.15 Injury
All pathological change that occurs in a healthy tissue or organ and that involves anatomical or physiological damage, i.e. a disturbance in the physical integrity or functional balance.

1.16 Osteosynthesis material
Parts or elements which are metal or of any other nature used for joining the ends of a fractured bone, or for the fixation of a joint.

1.17 Orthopaedic material
Anatomical parts or elements of any nature used to prevent or correct deformities of the body.

1.18 Doctor
Doctor or graduate in medicine legally trained and authorised to medically or surgically treat the disease or injury guaranteed by any of the coverages included in the Policy.

1.19 Consultant physician/surgeon
Doctor belonging to the Insurer's medical pool specifically designated by the same to attend to special cases upon reasoned request of a medical specialist of the Insurer.

1.20 Newborn or newly born
A baby that is just born or was born no more than 3 days prior.

1.21 Waiting period
Period of time, calculated from the date the Insured is registered under the Policy, during which some of the policy coverages do not yet come into effect.

1.22 Challenging period
Period of time during which the Insurer may refuse to provide its benefits or contest the Contract alleging the existence of pre-existing illnesses affecting the Insured and not declared by the latter. After this period, the Insurer will only have this power in the event of the Holder and/or the Insured having acted deceitfully.

1.23 Policy
The document or documents that contain the terms and covenants regulating the insurance policy. These General and Specific conditions, the Restrictive clauses, the individual conditions that identify the risk and the Special conditions if any, as well as the appendices that gather, in their case, the amendments agreed during the validity of the insurance policy are considered an integral and inseparable part of the Policy.

1.24 Pre-existence
Any alteration of the state of health that was known prior to the date of inclusion of the Insured under the Policy, as well as any disease, defect, deformity or medical-surgical situation that may arise from said alteration and provided it was not declared at the time of completing the Health Questionnaire. Also considering a pre-existence to be any other circumstance or circumstances, relating to the state of health, that increase the risk and are of such a nature that if they had been known by the Insurer at the time of the perfection of the Contract, this would not have been signed or would have concluded in more burdensome conditions .

For the purpose of this Contract, a pre-existence is also considered to be an illness known prior to taking out the policy or during the initial 180 days counted as of the date of entry into force of the Policy.

1.25 Provision
The healthcare derived from the treatment of an accident. Care is understood to be the act of attending or caring for the health of a person.

1.26 Premium
The price of the insurance. The premium is unique, annual and payable in advance. However, its payment by instalments may be agreed. The receipt shall also contain the legally chargeable surcharges and taxes.

1.27 Prosthesis
Any element that is intended to temporarily or permanently replace the lack of an organ or body part, and is of an artificial nature (total or partial).

1.28 Incident
All event the consequences of which are covered by any of the coverages of the Policy.

1.29 Policyholder
The individual or legal entity that together with the Insurer agrees to this Contract, and accepts the obligations provided for herein in exchange for which the Insurer cover their cost, although some of them due to their nature, should be payable by the Policyholder.

1.30 Transplant
Application of a part of tissue taken from another part of the same body or from another body.

1.31 Family household unit
Group of persons living in the home designated as usual place of residence in the Specific Conditions of the Contract and who are linked by any blood relationship or affinity ties.

1.32 Vital emergency
This is a clinical situation that requires immediate medical attention, given that a delay in the same could lead to a vital commitment or irreparable damage to the physical integrity of the patient.

A serious illness does not necessarily involve a vital emergency.

Specific Conditions of the Insurance Contract

Article 2 - Object of the insurance

2.1 The Insurer guarantees healthcare and other services agreed in the Particular Conditions of the Policy, and according to the Insurer's Medical pool, when the Insured suffers an illness or accident, both covered by the same and provided the required waiting periods contemplated in those coverages have ended.

2.2 In any case, according to Article 103 of the Insurance Contract Law, the Insurer assumes the necessary care of an urgent nature, in accordance with the conditions of the Policy.

2.3 The Insurer shall not grant optional compensation in cash in replacement of rendering the medical care.

2.4 The coverages that the Insured may take out, by common agreement with the Insurer are the following:

2.4.1 Basic Coverages

2.4.1.1 Primary healthcare.

2.4.1.2 Emergency healthcare.

2.4.1.3 Medical specialities.

2.4.1.4 Diagnostic tools.

2.4.1.5 Hospitalisation.

2.4.1.6 Special treatments.

2.4.1.7 Preventive medicine.

2.4.1.8 Second opinion.

2.4.1.9 Other services.

2.4.1.10 Obstetric care and care for the newborn.

2.4.1.11 Travel assistance.

2.4.2 Optional Coverages

2.4.2.1 Dental care.

Article 3 - Territorial extension

The coverages of this Policy are valid exclusively in Spain, and the healthcare shall be provided according to the provisions set forth in Article 7 "Way of providing the healthcare".

The exception to the territorial extension established in general in the previous paragraph shall apply to the travel assistance, for which the provisions set forth in the Appendix "Travel Assistance" shall prevail.

Article 4 - Delimitation and scope of the coverages of the insurance

4.1 Basic coverages
The Insurer takes charge of guaranteeing the coverages that are indicated below, in the conditions established in each case and in so far as their inclusion is expressly stated in the Particular Conditions for each of the Insured parties included in the Policy.

4.1.1 **Primary healthcare**
Through the explicit inclusion of this coverage in the Particular Conditions of the Policy, the Insurer guarantees to provide the Insured with Primary healthcare under the following terms:

4.1.1.1 **General healthcare**
General healthcare comprises medical healthcare provided at the medical practice, indication and prescription and performing tests and basic diagnostic tools (analytical and general radiology), and at home **when due to reasons that depend only on the illness suffered by the Insured, the latter is unable to attend the medical practice.**

4.1.1.2 **Paediatrics and childcare**
Paediatrics and childcare comprise medical healthcare provided to children below the age of 14 at the medical practice, indication and prescription of tests and basic diagnostic tools (analytical and general radiology), and at home when due to reasons that depend only on the illness suffered by the Insured, the latter is unable to attend the medical practice.

4.1.2 **Emergency healthcare**
Through the explicit inclusion of this coverage in the Particular Conditions of the Policy, the Insurer guarantees to the Insured a permanent emergency healthcare service that will be provided at the emergency centres indicated in the medical pool. If the case so requires and at the discretion of the Insurer's doctor, the emergency healthcare will be provided at home by the permanent on-call doctor.

4.1.3 **Medical specialities**
Through the explicit inclusion of this coverage in the Particular Conditions of the Policy, the Insurer guarantees to the Insured the provision of medical healthcare under an outpatient regime or through hospital admission, as appropriate, according to the medical criterion of the Insurer's doctor, for each of the **medical specialities** that are listed below and under the terms provided for in the same.

4.1.3.1 **Allergology and immunology**
The medication and self-administered vaccines shall be payable by the Insured.

4.1.3.2 **Anaesthesiology and resuscitation**
Includes all types of anaesthesia prescribed by the Insurer's doctors, including epidural anaesthesia in deliveries.

4.1.3.3 **Angiology and vascular surgery**

4.1.3.4 **Circulatory system. Cardiology**

4.1.3.5 **Digestive system**

4.1.3.6 **Respiratory system. Pneumology**

4.1.3.7 **Anorectal surgery. Proctology**

4.1.3.8 **Heart surgery**

4.1.3.9 **General and digestive surgery**

4.1.3.10 **Breast surgery**

4.1.3.11 **Maxillofacial surgery**

4.1.3.12 **Paediatric surgery**

4.1.3.13 **Plastic and reconstructive surgery**
This does not include plastic surgery, except for breast reconstructions as a result of a partial or total removal of the same, **provided that this is caused by an organic pathology.**

4.1.3.14 **Thoracic surgery**

4.1.3.15 **Medical-surgical dermatology and venereology**

4.1.3.16 **Endocrinology and nutrition:** Treatments are not guaranteed when there is no underlying organic pathology.

4.1.3.17 **Geriatrics**

4.1.3.18 **Gynaecology**
Medical healthcare provided on outpatient basis or by means of hospital admission in relation to typically female pathologies. **This cover excludes healthcare derived from pregnancy, childbirth or normal and/or pathological postpartum period, the coverage of which is specified in the section 4.1.10 "OBSTETRIC CARE AND CARE FOR THE NEWBORN", hence the provisions set forth therein shall prevail.**

4.1.3.19 **Haematology and haemotherapy**

4.1.3.20 **Internal medicine**

4.1.3.21 **Nuclear medicine**

4.1.3.22 **Nephrology**

4.1.3.23 **Neurosurgery**

4.1.3.24 **Neurology**

4.1.3.25 **Odonto-stomatology**
The Insurer makes available to the Insured, throughout the national territory, an Odonto-stomatology Service by which the Insured can access a Medical Pool of private Dentists and Stomatologists.

From this Medical pool of Dentists and Stomatologists, the following types of services may be requested:

- Services without cost, for the dental services specified below, and which must be prescribed by dentists included in the Authorised Medical Pool.
- Services at prices established in the dental healthcare supplement in the event of having taken out the coverage **4.2.1 Dental healthcare with significant discounts on the retail sale price**.
- Services included in your Policy and that you can access without cost:

Initial consultations

- Patient examination for diagnosis, treatment plan and quote with or without X-rays.
- Initial oral examination and diagnosis.
- Emergency consultation.
- Check-up consultation (annual dental check-up).

Diagnostic Tests

- Orthopantomographs (prescribed by a specialist listed in the medical pool and carried out by an authorised specialist listed in the medical pool).
- Intraoral radiology.

Extractions

- Extractions (**excluded parts included, wisdom teeth or those requiring maxillofacial surgery**).
- Removing stitches.

Fillings

- Temporary fillings.
- Prefabricated post or radicular retention (unit).
- Pins or spikes in dentin (unit).

Periodontics

- Occlusal analysis.
- Selective drilling.

Preventive Dentistry

- Fluoridations.
- Occlusal sealants.
- Mouth cleaning (prophylaxis on periodontium healthy).
- Oral health education.

Prosthesis

- Repairing removable dental prosthetics.
- Rebasing removable dental prosthetics.

- Resin or similar provisional conditioners from removable dental prosthesis.
- Occlusal adjustments without mounting cast on articulator for prosthesis.
- Occlusal adjustments with mounting cast on articulator with occlusal study impression taking.

Orthodontics

- First consultation for patient check-up (diagnosis, quote, treatment plan).

Implantology

- Implantological study.
- False titanium post.
- Healing collar.
- Cementing collar.
- Surgical orthotic.
- Radiological orthotic.

Oral Surgery

- Frenectomy.
- Cystectomy.

4.1.3.26 **Opthalmology**
Including conventional ophthalmic surgery, corrective myopia surgery, **exclusively via surgical procedure,** cataract surgery including phacoemulsification, photocoagulation with laser and corneal transplant. **The procedure for obtaining the cornea to be transplanted will be the responsibility of the Insured.**

In the case of cataract surgery, the intraocular lens or lenses will be payable by the Insurer and the remaining external prostheses, such as glasses and contact lenses will be payable by the Insured.

4.1.3.27 **Oncology**
Includes the diagnosis, planning and the treatment by medical specialists in oncology of the diseases and of the subsidiary diseases involved in this speciality.

4.1.3.28 **ENT**
Includes turbinoplasty by radiofrequency.

4.1.3.29 **Psychiatry**
Includes the treatment of mental and nervous diseases under prescription from a physician of the Insurer, excluding in all cases the treatments or techniques involving psychoanalysis, hypnosis, sophrology, psychotherapy in individual or group sessions, ambulatory narcolepsy, psychological tests.

4.1.3.30 **Clinical Psychology**
Includes psychological care of an individual and of a temporary nature, on an outpatient basis, prescribed by a psychiatrist included in the Insurer's medical pool and the purpose of which is the treatment of processes susceptible to psychological intervention, up to a maximum of 15 sessions per Insured and year.

Prior authorisation must be obtained from the Insurer prior to being carried out.

4.1.3.31 **Rheumatology**

4.1.3.32 **Orthopaedic Surgery and Traumatology**
Including arthroscopic surgery, hand surgery and spine surgery.

4.1.3.33 **Urology**
Includes the use of laser for surgical treatment of benign prostatic hyperplasia.

4.1.4 Diagnostic procedures

Through the explicit inclusion of this coverage in the Particular Conditions of the Policy, the Insurer guarantees to provide the Insured with diagnostic procedures listed below: These diagnostic procedures **include known examinations used frequently by most doctors in Spain, the efficiency and effectiveness of which has been scientifically proven to the effective date** of the Policy by the medical technique with the appropriate instrumentation and technology, whether or not they include invasive techniques. Technical advances that take place in the future will be included, where applicable, implementing the appropriate supplement and payment of a surcharge, if applicable.

Diagnostic procedures must be in all cases be previously prescribed in writing by a doctor authorised by the Insurer, and will always be carried out at the centres designated by the Insurer.

Contrast media used for the performing diagnostic procedures are covered.

4.1.4.1 **Clinical analyses**
Microbiological, biochemical, haematological, immunological and allergic, karyotypes and genotypes.

4.1.4.2 **Diagnostic Imaging**
Conventional radiology, ultrasounds, mammograms, CT scans, orthopantomographs, arthrographies, vascular radiology, CT (Computerised Axial Tomography or Scan) and MNR (Nuclear Magnetic Resonance).

Includes PET (Positron Emission Tomography) and PET (Positron Emission Tomography) plus CT (Computerised Axial Tomography or Scan) exclusively for the following conditions:

1 Thyroid and oesophagus cancer

1 Microlithic lung cancer and solitary pulmonary nodule

2 Primary or recurrent colorectal carcinoma

3 Lymphomas

4 Malignant melanomas

5 Brain tumours

6 Unknown and primary tumours with presence of metastases and negative functional diagnostic tests

Limited to a maximum of two studies per year, excluding their use for the diagnosis or study of any other pathology not explicitly included in this section.

4.1.4.3 **Special techniques**
Scans and Endoscopies. **Specifically excluding digestive studies by means of endoscopic capsule.**

4.1.4.4 **Pathological anatomy**
Biopsies and cytology.

4.1.4.5 **Cardiovascular diagnosis**
Electrocardiogram, echocardiograms, catheterisation, Doppler, Holter and Ergometrics.

4.1.4.6 **Neurological Diagnosis**
Electroencephalograms, echoencefalograms, electronistagmometries, electromyographies, measurements of the speed and nerve conduction.

4.1.4.7 **Gynaecological Diagnosis**
Cytologies, laparoscopies and ultrasounds.

4.1.4.8 **Ophthalmologic diagnosis**
Retinographies, fluorescein angiographies, campimetries and ultrasounds, monitoring.

4.1.5 **Hospitalisation**

Through the explicit inclusion of this coverage in the Particular Conditions of the Policy, the Insurer guarantees healthcare assistance on a hospital admission basis for surgical medical treatments or for performing diagnostic explorations which cannot not be performed on an outpatient basis.

The hospitalisation will be prescribed by one of the Insurer's physicians, **whenever deemed medically necessary, and will always be in hospitals designated by the Insurer.**

The hospitalisation will be carried out in a single room with a bed for a companion and a private toilet, except for in the event of manifest impossibility, for all cases with the exception of a hospitalisation in ICU, psychiatric department and that which is carried out in an incubator, in which case a companion bed will not be provided.

In addition to the room and food services provided to the patient, the insurance covers the costs relating to the operating theatre, anaesthesia, complementary examinations, medication, transfusions and special treatments.

The hospitalisation will not have a duration limit for cases in which said hospitalisation is due to surgical causes and while this remains the cause of the hospital admission. **All other hospitalisation events will have a limit of 60 days per year, exception of psychiatric hospitalisation for which the limit shall be 30 days per year. These limits shall be independent for each type of hospitalisation.**

Hospitalisation includes:

4.1.5.1 **Medical hospitalisation**

The duration of the hospital stay will be determined by the Insurer's physician responsible for the healthcare assistance, and will be extended until said physician deems the patient is ready for being discharged home.

4.1.5.2 **Surgical hospitalisation**

The duration of the hospital stay will be determined by the Insurer's physician responsible for the healthcare assistance, and will be extended until said physician deems the patient is ready for being discharged home.

4.1.5.3 **Hospitalisation in ICU**

This stay will last for as long as deemed necessary by the person responsible for the ICU unit.

4.1.5.4 **Paediatric hospitalisation**

Paediatric hospitalisation due to surgical intervention or medical illness **expressly excluding hospitalisation of a newborn which is contemplated under the terms specified in the OBSTETRIC CARE AND CARE FOR THE NEWBORN coverage.**

The duration of the hospital stay will be determined by the Insurer's physician responsible for the healthcare assistance, and will be extended until said physician deems the patient is ready for being discharged home.

4.1.5.5 **Psychiatric hospitalisation**

Only for patients previously diagnosed by a specialist doctor authorised by the Insurer in acute or chronic processes in a period of turmoil.

4.1.5.6 **Home hospitalisation**

If the Insurer's doctor responsible for a patient admitted in a hospital considers it appropriate to continue providing this healthcare through home hospitalisation, the Insurer will provide the home nursing and technical care services for the period of time prescribed by said physician, until the patient is definitively discharge. Said care shall be, at least, the necessary nursing visits prescribed by the Insurer's physician and the medical assistance provided by the services required as a continuation of the previous hospital assistance.

In order for the Insurer to provide these services, the following criteria must be met:

- Willingness of the patient.
- Temporary nature of the processes dealt with.
- Need for a primary caregiver.

Expressly excluding social assistance and hospitality, accompanying the patient, mobilisation and body hygiene, clothing care, pharmaceuticals, vaccines, syringes, compresses or incontinence nappies, orthopaedic devices, monitoring, passive rehabilitation equipment and any method or device used with a social purpose.

4.1.6 **Special treatments**
Through the explicit inclusion of this coverage in the Particular Conditions of the Policy, the Insurer guarantees the healthcare assistance indicated below, always provided by written prescription issued by one of the Insurer's physicians and will always be provided **at the centres designated by the Insurer and in a manner consistent with the coverage contracted.**

4.1.6.1 **Aerosol therapy, oxygen therapy and ventilation therapy**
This service will be provided for subsidiary diseases of said treatments on an outpatient basis or at home and **when faced with acute processes or flare-ups of chronic processes,** provided they are prescribed by an Insurer's physician and are medically necessary.

4.1.6.2 **Blood or plasma transfusion**
The medical act of the transfusion will be paid for by the Insurer, as will the blood and/or plasma to be transfused within the hospital centre.

For exchange transfusions, the management of the process involving the collection of the blood to be used will not be the responsibility of the Insurer, as this will be carried out by professionals and centres responsible for the patient care, and will be subject to the availability of blood products in the blood banks based on their fields of action. The act of the transfusion will be the responsibility of the Insurer.

4.1.6.3 **Haemodialysis and artificial kidney**
This service will be provided exclusively, both on an outpatient basis and during hospitalisation, for processes involving acute renal failure. **The transportation of the patient to and from the centre will be payable by the Insured.**

4.1.6.4 **Radioactive isotopes**
For the treatment of ailments that require this, and the product used will be payable by the Insurer.

4.1.6.5 **Renal lithotripsy**

4.1.6.6 **Speech therapy**
Exclusively as a form of rehabilitation in major larynx interventions.

4.1.6.7 **Laser**
Exclusively for skeletal and muscle rehabilitation, and the ophthalmic version with the exception of correcting myopia and ocular refraction defects and surgical treatment of benign prostatic hyperplasia. The technical advances that take place in the future will be included, where applicable, implementing the appropriate supplement and payment of a surcharge, if applicable.

Excluding any other diagnostic or therapeutic technique that uses laser, except the ones indicated above.

4.1.6.8 **Percutaneous nucleotomy.**

4.1.6.9 **Chemotherapy and oncology radiation, which includes cobalt therapy, brachytherapy, linear accelerator**
On an outpatient basis or during hospitalisation, the Insurer will pay for the drugs corresponding to the specific cytostatic drugs as well as the adjuvant antiemetic medication used exclusively for the chemotherapy session, which are available on the domestic market and are authorised by the Ministry of Health, in the indications listed in the product's technical sheet. Including implantable reservoirs for intravenous perfusion used in chemotherapy.

4.1.6.10 **Rehabilitation and physiotherapy**
Exclusively for affections of the locomotive system, on an outpatient basis, subject to prescription by one of the Insurer's physicians, and until having obtained, in the opinion of the Insurer's physician, the total functional recovery or the maximum possible recovery due to this process having entered into an insurmountable state of stabilisation or having become a maintenance or occupational therapy.

4.1.6.11 **Pain management**
Exclusively for the terminally ill, both on an outpatient basis and during hospitalisation, although for the latter the hospital stay is limited to the period of time deemed convenient by the Insurer's physician attending the unit, or while it is medically necessary.

4.1.6.12 **Transplants**
Including autologous transplantation of bone marrow from malignant tumours of haematological strain and cornea tumours, yet under no circumstance will be Insurer be obliged to handle the process for obtaining the organ to be transplanted.

4.1.6.13 **Contraceptive methods**
Exclusively including tubal ligation, vasectomy and the techniques for applying IUD, **While the device itself will be paid for by the Insured.**

4.1.6.14 **Diagnosis of sterility**
Only including the diagnosis of sterility.

Excluding, in any case, techniques for treatment of infertility, artificial insemination and in vitro fertilisation (IVF).

4.1.7 **Preventive medicine**
Through the explicit inclusion of this coverage in the Particular Conditions of the Policy, the Insurer guarantees the preventive medicine programmes for the early detection of diseases, which will always be carried out at the centres designated by the Insurer, and include the following:

4.1.7.1 **Child prevention**
Includes preventive medicine actions carried out on children below the age of 14, with a twice-yearly frequency between 0 to 6 years, and annual between 7 to 14 years, if so advised by the Insurer's physician, and according to the following specifications:

- Medical visit that will exclusively include: Eye check-up. ENT check-up. Cardio-respiratory system check-up. Muscle tone and strength. Reflexes and cranial nerves. Blood pressure and pulse. Height and weight. General exploration.
- Blood analysis (with haemogram, glucose and cholesterol) and urine test.
- Child's vaccines, **excluding the cost of the medication.**

4.1.7.2 **Adult prevention**
Includes acts of preventive medicine that are listed below, within the specific programmes for each age and gender, and with an annual frequency, unless the Insurer's physician considers greater frequency depending on the existing pathology. Adult prevention will consist of:

Gynaecological health. Including:

- Anamnesis and gynaecological exploration.
- Colposcopy.
- Cytology.
- Specific analysis.
- Ultrasound of the uterus and ovaries **as of the age of 40.**

Early detection of breast pathologies. Including:

- Clinical history and exploration.
- Breast ultrasound.
- Specific analysis.
- In light of situations of risk that could be detected, if the professional in charge of the patient considers the need, this would include a breast mammogram.

Cardiovascular risk prevention. Including:

- Clinical history and exploration.

- Analysis: cholesterol, HDL, glycaemia and triglycerides.
- Electrocardiogram.
- Ergometry, if after the calculation of the cardiovascular risk, the values obtained were high with regards to the theoretical values that would additionally correspond, if the assessment carried out by the physicians indicates its appropriateness, then an echocardiogram would be performed.

Early detection of prostate pathologies. Including:

- Clinical history and exploration.
- Specific analysis.
- Urology ultrasound.

Early detection of colon cancer. Including:

- Genetics
- Colposcopy.

4.1.8 **Second opinion**

Through the explicit inclusion of this coverage in the Particular Conditions of the Policy, the Insurer guarantees to provide the Insured with a second opinion regarding the diagnosis or treatment of the serious illness listed in this section:

4.1.8.1 **By specialists from any country in the world**

The Insurer makes available to the Insured an international second diagnostic service, by which the Insured can request through the Insurer a second medical opinion report of the disease suffered, as well as diagnostic and/or therapeutic recommendations, specialists, international health or academic centres that to this purpose are facilitated by the Insurer.

This service will cover the following serious diseases:

- **Cancer.**
- **Cardiovascular Diseases.**
- **Organ transplants.**
- **Neurosurgical and neurological diseases, including cerebrovascular accidents.**
- **Chronic renal failure.**
- **Idiopathic Parkinson's disease (Paralysis Agitans).**
- **Alzheimer's Disease.**
- **Multiple Sclerosis.**

In the event that the centre requires tests, studies or additional assessments, it shall inform the Insured, who must decide whether or not to proceed with their implementation. If so, the costs of such tests, studies or assessment shall be borne by the Insured.

If the Insured decides that the healthcare is to be provided at the specialised centre of choice, the Insured will be charged for all expenses arising from the assistance provided.

4.1.8.2 **By renowned specialists in Spain**

As a result of a malignant neoplastic disease, **and exclusively for this pathology,** the Insured may seek a second opinion on the diagnosis and/or treatment to follow, the Insurer will provide a specialised and renowned centre from those with which it has established agreements in Spain. In such a case, the Insurer will transfer to this centre the clinical history and the complementary tests performed on the Insured, and will pay for any additional tests that are requested.

If the Insured decides that healthcare assistance is to be provided at the specialised centre of choice, due to it not being possible to provide it at the centres indicated in the Insurer's Medical Pool, the Insurer will pay for the costs arising, provided that they are of the same nature as those covered by the guarantees contracted in the policy. The Insured shall pay for the travel expenses.

When the Insured has requested the second opinion in Spain, in the terms described in this section, the latter will not be able to request the second opinion described in point 4.1.8.1.

4.1.9 **Other services**

4.1.9.1 **Ambulances**
For the transfer by land of the patient from his/her home to a hospital centre within the same province and vice versa, provided this has been prescribed by one of the Insurer's physicians due to being medically necessary, the situation of the patient precludes the use of the regular transport services (public services, taxi or own vehicle) and is caused by reason of a healthcare assistance covered by this contract.

Excluding transfers for receiving rehabilitation treatment or for diagnostic tests carried out under an out-patient basis.

The authorisation of medical transport shall not entail, under any circumstance, that the Insurer will assume the responsibility of the healthcare assistance provided by the centre of origin or destination, whose authorisation will be managed in accordance with the procedure set forth in Article 7 "WAY OF PROVIDING THE ASSISTANCE".

4.1.9.2 **Technical Healthcare Assistant/University Diploma in Nursing (A.T.S./D.U.E.)Service .**
The A.T.S./D.U.E. Services includes assistance in the consultation room and at home when for reasons that depend solely on the disease suffered by the Insured, the latter is unable to attend the consultation room, always prior prescription issued by one of the Insurer's physicians and when the Insurer has access to services taken out to this effect.

4.1.9.3 **Podiatry**
Up to a maximum of 3 podiatry sessions per year.

4.1.9.4 **Prosthesis**
The cost and placement of the prosthesis itself, will be payable by the Insurer in the event of: Heart valves (mechanical or biological), pacemaker, prosthetic vascular by-pass, stent, hip prostheses (cemented or not), prosthetic knee, shoulder prosthesis, bone prostheses, osteosynthesis material and hydrocephalus valves, breast prosthesis and tissue expanders for the reconstruction of the breast which has undergone a mastectomy and synthetic mesh for the reconstruction of the abdominal or chest wall.

In all cases, the Insurer reserves the necessary process for obtaining the required elements. The cost of any other type of prosthesis, orthotics, anatomical and orthopaedic pieces as well as their placement will be payable by the Insured.

4.1.9.5 **Grafts**
Only autografts are included.

4.1.9.6 **Consultant physicians/surgeons**
These will be appointed by the Insurer for special cases and upon reasoned request of a specialist doctor included in the Medical Pool.

4.1.9.7 **Medical Telephone Service**
The Insurer makes available to the Insured a permanent medical telephone service, attended by family doctors who can advise the Insured regarding any medical questions or consultation.

Likewise, also providing a telematic medical service.

4.1.9.8 **Telephone Psychological Advice Service**
The Insurer makes available to the Insured, a service through which the latter will receive the psycho-emotional support required, by means of a telephone-based psychological assessment, either immediately or scheduled, a clinical psychologist, who will provide customised and free advice and guidance which shall in no case represent a clinical diagnosis.

4.1.10 Obstetric care and care for the newborn
Through the explicit inclusion of this coverage in the Particular Conditions of the policy, the Insurer guarantees to the Insured the provision of medical care related to pregnancy, childbirth and the postpartum period as well as care for the newborn, on an out-patient basis or via hospital admission as appropriate, according to the medical criteria of the Insurer's physician and according to the conditions of contract.

Excluding, in any case, techniques for treatment of infertility, artificial insemination and in vitro fertilisation (IVF).

4.1.10.1 **Obstetrics**
Healthcare assistance during pregnancy, delivery and normal or pathological postpartum period, including diagnostic tests and other services to be provided or prescribed by the obstetrics specialist.

4.1.10.2 **Obstetric diagnosis**
Amnioscopies, ultrasounds and monitoring.

4.1.10.3 **Obstetric hospitalisation**
Hospitalisation due to obstetric cause (maternity or admission due to pregnancy and/or its complications), being attended by an obstetrician, assisted by a midwife in the event of maternity, and including the costs of the operating theatre or labour room and anaesthesia, with the limit of stays prescribed by the obstetrician for normal deliveries and no limit on complicated or premature births.

The hospitalisation will be carried out in a single room with a bed for a companion and toilet service, except for in the event of manifest impossibility.

In addition to the room and food services of the patient, complementary explorations, drugs, transfusions and special treatments are covered.

4.1.10.4 **Childbirth preparation**
Includes the psychoprophylactic preparation for childbirth with theoretical and practical classes.

4.1.10.5 **Care for the newborn**
Includes check-up and care for the newborn, hospitalisation of the healthy, premature or pathological newborn, at a specialised neonatal centre.

For the newborn to be covered by this policy the following requirements will necessarily have to concur: that the mother is registered at the time of birth, that the mother has exceeded the waiting periods established for obstetric and newborn care coverage and, lastly, that the Insured is up to date with the payment of the premium. Otherwise, the newborn will not be covered by the policy.

4.1.11 Travel assistance
Through the explicit inclusion of this coverage in the Particular Conditions of the Policy, the Insurer guarantees to provide travel assistance in accordance with the services and conditions that are presented in the travel assistance guarantee appendix.

4.2 Optional Coverages

4.2.1 Dental Health
Through expressly taking out this coverage in the Particular Conditions of the Policy, the Insurer guarantees the Insured will be provided with dental health programmes that will be provided at the dental practices organised by the same, according to a supplement that will be delivered to the Insured, detailing the services that are included, the conditions under which they will be provided and the participation of the Insured in the cost of the services.

The additional cost for dental care will be included in the reference Policy, and will have no validity by itself, as it will always be linked to the vicissitudes of this Policy.

The amounts of the premium for this coverage, as well as the participation of the Insured in the cost of the services will be updated following the criteria established in article 16 "Premium Updates".

Article 5 - Risks excluded

5.1 The healthcare assistance derived from diseases, defects or pre-existing deformations, as a result of accidents or illnesses, occurring prior to the date of inclusion of each Insured party under the policy, and/or the healthcare assistance due to congenital diseases, whether or not expressed, as well as those that may be derived from the latter, except where they have been declared by the Insured or by the Policyholder in the health questionnaire and have been accepted by the Insurer.

5.2 The healthcare assistance derived from being infected by the Human Immunodeficiency Virus (HIV), AIDS and the diseases and manifestations associated with this disease.

5.3 The necessary healthcare assistance for the treatment of detoxification caused by chronic alcoholism, drug addiction and/or drug dependency.

5.4 The healthcare assistance due to wars, riots, revolutions, terrorism, sabotage, strikes, demonstrations and popular movements, quarrels and detentions by any authority; those caused by officially declared epidemics; directly or indirectly related to radiation or nuclear reaction and arising from cataclysms (earthquakes, floods and other seismic or meteorological phenomena).

5.5 The healthcare assistance derived from accidents at work and/or occupational diseases.

5.6 The healthcare assistance covered by any compulsory insurance, including compulsory car insurance.

5.7 The healthcare assistance provided in hospitals or by physicians other than those that are listed in the Medical Pool made available to the Insured and according to the coverage contracted, unless it is considered of vital emergency. Likewise, excluding healthcare assistance provided at centres integrated into the National Health System that are not associated to the Insurer.

5.8 Pharmaceutical products and other medicinal products administered outside the hospitalisation regime, as well as vaccines, contrasts and other health products, except those expressly accepted in these General Conditions. Similarly, excluding the costs arising from travel and displacement, except for ambulances under the terms referred to in 4.1.9.1 "Ambulance" and those expressly accepted in these General Conditions.

5.9 All those diagnostic and therapeutic procedures derived from naturopathy, acupuncture, massages, lymphatic drainage, quiropraxis, mesotherapy, magnetotherapy, pressotherapy, and other alternative medicines, as well as those that consist of mere leisure activities, rest, comfort or sport. Similarly, spas treatments and cures for rest or sleep.

5.10 Everything related to psychoanalysis, hypnosis, individual or group psychotherapy, psychological tests and narcolepsy as well as therapies expressly excluded in the Clinical Psychology paragraph. Likewise, excluding educational therapy such as language education in congenital processes or special education in patients with a mental condition.

5.11 Necessary healthcare assistance for the treatment of injuries arising from professional practice of any sport or participation as a federated amateur in official competitions. In the same manner, excluding necessary healthcare assistance for the treatment of accidents and their consequences resulting from the practice of extreme or high-risk sports as well as bullfighting activity involving wild bulls.

5.12 The assistance derived from diseases or injuries caused by suicide attempts or caused intentionally by the Insured to him/herself (including the ingestion of toxic products, narcotics, intoxications due to alcohol abuse, narcotic drugs or psychotropic substances, etc.), and those derived from direct or indirect involvement of the Insured in fraudulent actions.

5.13 The healthcare assistance caused by or related to issues merely of an aesthetic nature, hair treatments, cosmetic treatments, related to or for gender transformation, weight loss cures and surgery for treating obesity, except for the medical treatment of obesity when there is an underlying organic pathology. Equally excluding any healthcare assistance or complication that could manifest itself later and is directly caused by the Insured having undergone an intervention, infiltration or aesthetic/cosmetic treatment.

5.14 Organ transplants, except for autologous bone marrow transplant due to malignant tumours of a haematological strain and cornea transplant. In the latter case, the Insurer shall not be responsible for the cost of the cornea to be transplanted.

5.15 General medical examinations of a preventive nature, studies for screening or non-specific detection of pathologies, including genetic determinations aimed at detecting a predisposition to diseases or their present or future appearance, except for those expressly referred to in section 4.1.7 "PREVENTIVE MEDICINE" of these General Conditions.

5.16 Healthcare assistance or hospitalisation due to social problems.

5.17 The cost of any other type of prosthesis and its placement (including intersomatic and interspinal vertebral prosthesis), bone grafts, anatomical pieces, orthopaedic and osteosynthesis except those expressly mentioned in Section 4.1.9.4 Prosthesis of these General Conditions, as well as in Section 4.2.1. DENTAL HEALTH if this coverage has been taken out.

5.18 Congenital diseases of the newborn if, at least, nine months have not elapsed since the mother has had the effective right to the benefits of the coverage included in "Obstetric care and care for the newborn". In the event of being covered by the coverage, this will only cover the first year of life of the newborn.

5.19 Assistance related to legal and forensic medicine.

5.20 Outpatient and in hospital healthcare assistance provided to the Insured by people linked to the Policyholder or the Insured, by family ties of up to forth degree of consanguinity.

5.21 The consultations, diagnostic or treatment procedures as well as surgical techniques considered experimental or in the process of research or not commonly accepted by doctors in Spain.

5.22 Healthcare provide as outpatient, at home or in hospital that is merely of a palliative nature, provided that there are alternative medical or surgical procedures and the clinical situation of the Insured would allow for the implementation of the latter.

Article 6 - Coming into force of the contracted services and waiting periods

All the benefits which are assumed by the Insurer under the Policy, shall be provided as of 24 hours after the day on which the Contract has been formalised, through the signing the Policy by the parties to the contract and that the first receipt of the premium has been paid. However, the previous general principle does not include cases and assumptions that are subsequently cited, to which the following waiting periods shall apply:

6.1 For diagnostic procedures
Six months in all diagnostic procedures referred to in paragraph 4.1.4."Diagnostic procedures", except for conventional radiology and haematological and biochemical analysis that will have no waiting period.

6.2 For hospitalisation and surgical interventions
Six months for hospitalisation and surgical interventions, including outpatient procedures, for any reason and nature, except in cases of surgical interventions of vital emergency. For the specific cases mentioned in paragraph 6.3 "Special treatments" and 6.7 "Obstetric care and care for the newborn", there provisions included therein shall prevail.

6.3 For special treatments
Twelve months for haemodialysis treatments and artificial kidney, renal lithotripsy, laser therapy, chemotherapy, cobalt therapy and linear accelerator.

Twelve months for contraceptive treatments.

Six months for rehabilitation treatments.

Twenty four months for the diagnosis of sterility.

6.4 For preventive medicine
Twelve months in order for the Insured to make use of the preventive medicine services, except for prevention for children, in which case no waiting period shall apply.

6.5 For second opinion
Twelve months in all cases.

6.6 For other services
Twelve months in order for the Insurer to pay for the coverage of the placement and cost of the prosthesis.

6.7 For Obstetric care and care for the newborn

All benefits related to or caused by pregnancy, childbirth or postpartum period shall be subject to a **waiting period of eight months** as of the date of registration of the Insured person.

This consideration excludes assistance in complicated childbirth of vital emergency and premature childbirth (which is understood as that which occurs prior to the 28th week of gestation), for which not waiting period shall apply.

For the event in which the obstetric care and the care for the newborn is the result of treatments aimed at overcoming infertility, the waiting period for any benefit, for any cause, will be extended up to thirty six months, calculated in the same manner.

6.8 For clinical psychology

Six months for all services related to Clinical Psychology.

Article 7 - Form of provision of the healthcare assistance

The healthcare assistance will be provided in accordance with the Policy, in all municipalities where the Insurer has an agreed Medical Pool, and according to them. However, for correct use of the assistance services, the following should be taken into account:

7.1 Assistance orientation

The Insurer has an assistance orientation service whose purpose is to provide the Insured with access to the different healthcare services, informing of the procedures to be followed. The Insured may access this service by phone or in person at the offices established by the Insurer to this effect.

7.2 Choice of physician or hospital centre

The Insured may choose any of the doctors or hospitals that are included in each of the Medical Pools of the different provinces, regardless of whether or not these coincide with the place of residence.

However **when this choice involves a physician whose territorial scope of action does not include the address of the Insured, the Insurer shall not be obliged to provide the home care or the costs associated with the transfer.**

When in any of the municipalities where agreed Medical Pools are located, there is a lack of availability of any of the services covered by the Contract, these shall be provided in the province where they can be performed, at the choice of the Insured.

7.3 General medicine, paediatrics, childcare and A.T.S./D.U.E.

The Insured is free to choose for his/her assistance any of the doctors which the Insurer has included in its medical pool, during the days and hours established for this purpose by the doctor in question.

Irrespective of the foregoing, the Insurer may propose to the Insured the general or family doctor and, where applicable, the paediatrician that it deems most appropriate, in order to register them as responsible for the family care. In the event of carrying out this registration, the Insured may modify it whenever desired by simply informing the Insurer, without there being any need to reason the decision.

7.4 Home visit

Homes visits relating to general medicine, paediatrics and child care, and A.T.S./D.U.E., will be requested, for patients who are unable to travel to the doctor's consultation, before 9 am, to be carried out that morning, and before 4 pm, to be carried out that afternoon.

In urgent cases, the Insured must go to the permanent services that have been established by the Insurer, or contact the assistance guidance service.

The Insurer is obliged to provide assistance only in accordance to its Medical Pool and at the home of Insured which is listed in the Policy. Any change of the latter shall be notified to the Insurer by reliable means with a minimum advance notice of eight days prior to requiring any service be provided at the new address.

7.5 Authorisation of services

The hospitalisation or provision of the services which the medical pool so determines, shall be ordered in writing by one of the Insurer's doctors and the Insured must obtain authorisation over the phone or in person at the offices established for this purpose by the Insurer. After having granted the authorisation, this will entail an economic obligation affecting the Insurer.

In the event of a vital emergency, the Insured must obtain authorisation from the Insurer, either over the telephone or in person, for him/herself or in somebody else's name, at the offices established for this purpose, within 72 hours following the admission or the provision of the assistance service. The Insurer shall be economically bound until the moment when it objects to the physician's order, in the event of considering that the Policy does not cover the service or hospitalisation.

7.6 Emergency service

To receive an emergency service, this must be applied for over the telephone or by going directly to a permanent emergency centre of those established by the Insurer, the address and telephone number of which are listed in the Medical Pool that is provided to the Insured.

In the event of a vital emergency, the Insured may consult with the closest doctor or centre, and the Insurer will deal with the reimbursement of the medical fees and hospital expenses incurred, subject to prior justification by means of the pertinent invoices and medical report. This will require that the Insured inform the Insurer within 72 hours following the provision of said assistance, in order to be able to proceed to the transfer, provided that the clinical situation of the patient permits this, to one of the Insurer's authorised centres. Likewise, the Insured should also provide a written description of the incident within a maximum period of 7 days, according to article 16 of the Insurance Contract Law.

When the vital emergency is treated at a centre belonging to the National Health System not working in collaboration with the Insurer, unless there is express commitment from the same, the Insured shall be required to pay to all effects and for the reimbursement of the pertinent expenses the latter will follow the procedure described in the preceding paragraph.

7.7 Service for relocated persons within the national territory

A temporarily relocated Insured person will use the services provided by the Insurer and that are listed in the Medical Pool of the province to which the Insured has relocated. In the event of the Insurer not having a medical pool in that province, the Insured will use the resources available for assistance to relocated persons which are listed in the Medical Pool of his/her province of residence that will be provided by the Insurer.

In any case the Insurer guarantees assistance of an urgent nature, when by reason of the urgency the Insured is unable to go to the services contracted by the Insurer, in accordance with the second paragraph of point 7.6 "Emergency service".

When assistance needs of an exceptional nature so require, the Insurer may forward or transfer the Insured to any hospital centre for his/her medical treatment or hospitalisation.

7.8 "Emergency service".

When assistance needs of an exceptional nature so require, the Insurer may forward or transfer the Insured to any hospital centre for his/her medical treatment or hospitalisation.

7.9 Fees for physicians and hospitals not included in the Medical Pool

The Insurer is not responsible for the fees charged by doctors not included in the Medical Pool, or the expenses arising from hospital stays or services prescribed by the latter. Similarly, neither will the Insured be responsible for hospital expenses generated in hospitals other than those included in the Medical Pool.

In any case the Insurer guarantees assistance of an urgent nature, when by reason of urgency the Insured is unable to go to the services contracted by the Insurer, in accordance with the second paragraph of point 7.6. "Emergency service".

7.10 Identification documents

To receive the necessary services, the Insured must be up to date with the premium payments and must show his/her healthcare card, which is a personal and non-transferable document. Likewise, the Insured will also be obliged to show his/her National Identity Document, if so required.

In the event of loss or theft of the healthcare card, the Policyholder and/or the Insured is obliged to inform the Insurer within the period of 48 hours, and the latter will proceed to cancel the lost or stolen card and issue a new one.

The participation of the Insured in the cost of the healthcare services used shall be agreed, and these will be accredited by means of the healthcare card or another document certifying the assistance received. The Insurer may establish the that said participation shall be cost-free and may resume its charge when deemed necessary.

The amounts of the Insured's participation in the cost of the services is established in the Particular Conditions, and alike the premium, it may be updated, always established within the limit that, in its case, is indicated by the applicable provisions.

General Conditions of the Insurance Contract

Article 8 - Payment of Premiums

8.1 The Policyholder is obliged to pay the Premium.

8.2 The first premium shall be payable once the contract has been signed. If it had not been paid by causes attributable to the Policyholder, the Insurer has the right to terminate the contract or to demand payment of the premium due through legal channels on the basis of the Policy. In any case, if the premium has not been paid prior to the incident occurring, the Insurer shall be released from its obligation, unless otherwise agreed.

8.3 In the event of lack of payment of the second and successive premiums, the coverage shall be suspended one month after the due date of the receipt, and if the Insurer does not claim payment within six months following said due date, it shall be understood that the contract has been terminated. If the contract has not been resolved or terminated in accordance with the above conditions, the coverage will resume its effect 24 hours after the day on which the Policyholder pays the premium. In any case, when the contract is put on hold, the Insurer may only demand payment of the premium for the current period.

8.4 The Insurer is only obliged by virtue of the receipts delivered by its legally authorised representatives. The premium receipts for this insurance shall be issued by the Insurer itself.

8.5 The collection of the premium receipts by means of bank accounts opened at banks and savings banks may be agreed in the Particular Conditions.

Article 9 - Other obligations, powers and duties of the Policyholder or Insured

9.1 The Policyholder and, where applicable, the Insured, have the following obligations:

9.1.1 The Policyholder has the duty, before the conclusion of the contract, to declare to the Insurer, in accordance with the questionnaire that the latter will provide, all the circumstances known by him/her that may influence the risk assessment. The Insured will be released for said duty if the insurer does not provide the questionnaire or when, even after having provided it, these are circumstances that may influence the risk assessment but are not included in the questionnaire.

9.1.2 Inform the Insurer, during the course of the contract and as soon as possible, of all circumstances which, in accordance with the Insurer's health questionnaire previously presented, may increase the risk and are of such a nature that if they had been known by the Insurer at the time of the perfection of the contract, this would not have entered into or it would have concluded under more burdensome conditions.

9.1.3 Inform the Insurer, as soon as possible, regarding a change of address.

9.1.4 Inform the Insurer, as soon as possible, regarding the registrations and cancellations relating to Insured persons that take place during the term of this contract, adapting the premium to the new situation. The newborn children of the Insured will be included immediately into the Policy, with all of their rights and obligations, unless during the pregnancy they are specifically excluded by the Policyholder, and not applying a waiting period exceeding that which at the time of birth the mother was still pending.

9.1.5 Lessen the impact of the incident, using the means at its disposal for an early recovery. A failure to comply with this duty, with the clear intention of causing harm or misleading the Insurer, will release the latter from providing any benefits derived from the incident.

9.1.6 The Insured or otherwise the Policyholder will be the only party obliged to pay for any healthcare assistance received at the centres integrated in the National Health System, unless express commitment is provided by the Insurer and is required to inform the aforementioned centre regarding this, if necessary.

9.2 The Policyholder may claim, within the period of one month as of delivery of the Policy, that the Insurer rectifies any differences between the Policy and the insurance proposal or the agreed clauses.

Article 10 - Other obligations of the Insurer

10.1 In addition to providing the contracted assistance, the Insurer shall deliver to the Policyholder the Policy or, where applicable, the provisional coverage document or the corresponding document, as well as a copy of the health questionnaire and other documents that have been signed by the Policyholder.

10.2 The Insurer will also provide the Policyholder with the identification document of the Insured person or persons and, as basic information of the healthcare means made available to the Insured, a copy of the Medical Pool corresponding to his/her province of residence, specifying the permanent centre or centres for medical and surgical emergencies, the permanent outpatient care service, hospitals and clinics, the addresses and consultation times of the physicians.

Article 11 - Duration to the insurance

The insurance is provided yearly and is renewable, with its first annual expiry date on 31 December of the year it is first taken out, regardless of the effective date. Therefore, the payment for the first year will be the proportional part of the annual premium corresponding to the period of time mentioned above. Subsequent renewals will take place automatically on 1 January of each year, except in the event of either of the parties opposing said renewal, by means of written notification to the other party concerned and with notice of no less than two months for the Insurer and one month for the Policyholder, prior to the conclusion of insurance year in course.

Notwithstanding the foregoing, the Insurer will not oppose the renewal of the contract in the following cases and provided that the following conditions are met:

1. Not opposing the renewal of insurance contracts that are insured with certain situations of serious illness, provided the first diagnosis occurred during the valid period of the policy. Illnesses with ongoing treatment during the valid period of the contract will be those listed below:

    - Active cancer processes.
    - Heart diseases attributed to surgical or interventionist treatments.
    - Organ transplant.
    - Complex orthopaedic surgery in evolutionary phase.
    - Degenerative and demyelinating diseases of the nervous system.
    - Chronic renal failure.
    - Torpid chronic respiratory failure.
    - Chronic liver disease (excluding those of alcoholic origin).
    - Acute myocardial infarction with heart failure.
    - Macular degeneration.

2. Not opposing the renewal in relation to Insurance Contracts that cover people over the age of 65, when their accredited loyalty to the company, free from non-payments, exceeds 5 or more continuous years.

3. The previous commitments shall not apply or shall cease to have effect in cases in which:

    - The Insured has failed to comply with his/her obligations or there has been a reserve or inaccuracy on their part when declaring a risk.
    - A non-payment of a premium occurs or the Insured refuses to accept a premium update.

4. The waiver by the company of its right to oppose the continuity of the policy inexcusably requires that the Policyholder accepts the premium and participates in the corresponding cost of the services provided, and that the Insurer may periodically

update these in order to adapt them to the evolution of the insurance costs, always in accordance with the actuarial criteria and within the limits of the law and of the contract.

If the Policy includes the relatives normally living with the Policyholder, when any of them ceases to habitually reside at the domicile of the Policyholder, this must be communicated to the Insurer and the insurance will not longer cover these people. If these people take out a new insurance, before the one month as of the previous communication, the Insurer will maintain the seniority rights they have acquired, provided these are entered into the contract.

Guarantees. If the new Policy signed includes services not contained in the previous Policy and there are waiting periods applying to their use, these periods would be respected as if this were a new insurance.

The insurance cover shall automatically cease as of the termination date of the Policy, or as of the cancellation date of any of the Insured persons. However, if the Insured is undergoing treatment for any disease, the Insurer undertakes to provide the assistance included in said treatment for the duration of the same.

Article 12 - Bases, loss of rights, cancellation and indisputable rights of the Contract

12.1 This Contract has been concluded on the basis of the statements made by the Policyholder and the Insured in the Insurance Health Questionnaire, regarding their state of health and normal profession. Such statements constitute the basis for the acceptance of the risk of this Contract and shall form an integral part thereof.

12.2 The Insured loses the right to the guaranteed benefits:

12.2.1 If upon completing the questionnaire, the Policyholder or Insured has been inaccurate or have deliberately omitted any circumstance known by the same which may influence the risk assessment. The Insurer may terminate the Contract during the thirty days following the date on which it has become aware of said omission.

12.2.2 In the event of aggravation of the risk, if the Policyholder or the Insured fail to inform the Insurer and have acted in bad faith.

12.2.3 When the incident has been caused in bad faith of the Insured.

12.3 The Policyholder may terminate the contract when the Medical Pool is modified, provided this change affects the local family doctor, obstetrician or paediatrician, or 50% of the specialists comprising the Insurer's Medical Pool, which will always have at its offices a complete and updated list of said specialists for the Insured to consult.

12.4 The Policy will be indisputable in so far as the health status of the Insured and the Insurer will not be able to refuse to provide its benefits alleging the existence of pre-existing diseases, after ONE year from the effective date of this Contract to coverages not affected by waiting periods and calculated as of the end of the waiting periods for those coverages which do have them, except for in the event of the Policyholder or the Insured having acted deceitfully.

12.5 In the event of an inaccurate indication of the date of birth of the Insured, the Insurer may only contest the contract if the true age of the Insured, at the time of the entry into force of the Contract, exceeds the acceptance limits established by the Insurer.

In another case, if as a result of an inaccurate age declaration the premium paid is lower than that which should be paid, the Insured shall be obliged to pay to the Insurer the difference between the amounts actually paid to the latter in concept of premiums and the amounts which should have been paid based on the Insured person's true age.

If on the contrary the premium paid is greater than the one that should have been paid, the Insurer shall be obliged to return the excess of the premiums received without interest.

Article 13 - Communicating an incident

For the purposes of this insurance, an incident is understood to have been communicated when the Insured requests the provision of assistance, except in the cases specified in article 7 "Forms of provision of healthcare assistance" in which case the parties shall proceed as established therein.

Article 14 - Communications

14.1 Communications made by the Policyholder to the insurance agent which has mediated in the Contract shall have the same effects as if they had been carried out directly to the Insurer. The communications made by the insurance agent to the Insurer on behalf of the Policyholder shall have the same effect as if they had been made by the Policyholder him/herself, unless indicated otherwise by the same.

Article 15 - Jurisdiction and complaint bodies

15.1 Supervisory Body and Member State
The supervision of the Insurer's activity is carried out by the Directorate General of Insurances, which is dependent on the Ministry of Economy.

15.2 Jurisdiction
A judge at the domicile of the Insured shall be competent for passing judgement regarding the actions arising from this Insurance Contract.

15.3 Complaint bodies
Any disputes that may arise in relation to this Insurance Contract shall be resolved by the competent Judges and Courts, in accordance with the law in force and especially with the provisions of articles 38, 39 and 104 of the Law of Insurance Contract and article 61 of the Law on Private Insurances.

In accordance with article 62.2 of Law 30/1995, of 8 November, on Private Insurances, the Policyholders, Insured persons, and injured third parties or rights holders of any of the preceding, are deemed interested parties for the purpose of presenting claims before the Directorate General of Insurances, Consultations and Claims Department, in relation to this Contract.

They may also voluntarily submit their differences to arbitration decision under the terms of article 31 of Law 26/1984, of 19 July, General Law for the Defence of Consumers and Users and its development standards, as established in article 61 of Law 30/1995, of 8 November, of Law on Private Insurances or private arbitration regulated by Law 36/1988, of 5 December, on Arbitration.

Article 16 - Premium updates

16.1 The Insurer may update the premiums annually in accordance with article 25.3 of the Law on Private Insurances, and its developing regulations.

This update will be based on the technical and actuarial calculations required to determine the incidence on the premium of the changes experienced by the cost or the frequency of healthcare benefits covered by the insurance, the incorporation into the guaranteed coverages of technological innovations that have appeared or come into use after the perfection of the contract, or other acts of similar consequences.

Likewise, the modification of the tariff structure parameters, their annual costs and the number of claims made against of the policy will also be taken into account.

The premium amount will be modified for each renewal period, if this takes place (expressly or tacitly), in the same proportion in which the values of the factors on which it is based are modified, according to each of their influences.

16.2 The Insurer shall inform the Policyholder two months prior to the renewal of the policy, regarding both the modification of the premium and any changes in the structure of the age groups existing at the time of taking out the policy.

Article 17 - Tariff structure according to age and province

The premium to be paid by the Policyholder and, where applicable, by the Insured will vary depending on the age and province.

When the Insured moves on to a higher age table or changes the province of the domicile of the provision, the premium that corresponds to the new situation will automatically be applied.

Article 18 - Prescription

The actions deriving from the Contract shall prescribe after five years from the day on which they took place.

Article 19 - Additional covenant

This insurance contract includes in an inseparable manner, integrating a unitary whole, the General Conditions, the Particular Conditions, the Special Conditions if any, the questionnaire and/or application and the Appendices that reflect the modifications of any of the above agreed by the parties.

The Policyholder/Insured declares to have read and understood all the limitations and exclusions contained in this Policy, expressly accepting them.

The Policyholder/Insured

Signed

Travel Assistance Guarantee Appendix

Article 1 - Definitions

For the purpose of this Policy, the following should be understood:

1.1 Insured persons
The individual, resident in Spain, beneficiary of the healthcare assistance.

1.2 Scope of the insurance and duration
The insurance is valid all over the world and in Spain outside the province of the normal residence of the Insured. Its duration is linked to that of the healthcare assistance insurance.

1.3 Validity
In order to benefit from the guaranteed benefits, the Insured must reside in Spain, reside normally in this country and the time spent away from said normal domicile shall not exceed 90 days per trip.

Article 2 - Guarantees covered

2.1 Transport or repatriation of sick and wounded persons
In the event of the Insured suffering an illness or accident, the Insurer will cover:

a) The ambulance costs for transporting the Insured to the nearest clinic or hospital.

b) The monitoring carried out by the medical team, in contact with the physician that is seeing to the sick or injured Insured to determine the suitable measures for providing the best treatment and the most appropriate means, for eventually transferring the Insured to another more appropriate hospital centre or to his/her home.

c) The transport costs arising from the most appropriate means of transport of the injured or sick, to the prescribed hospital or to his/her usual place of residence. If the insured were admitted to a hospital which is not close-by his/her home, the Insurer will cover when need, the subsequent transfer to his/her home.

The means of transport used in Europe and countries bordering the Mediterranean, when the urgency and the seriousness of the case so requires, will be a special medical aircraft.

In any other case, or in the rest of the world, this will be carried out by means of a regular flight or by the fastest and most appropriate means, depending on the circumstances.

2.2 Sending a doctor
If the severity of the Insured does not allow for being transferred and the assistance that could be provided is insufficiently suited, the Insurer will send a doctor to the place where he/she is located.

2.3 Transport or repatriation of the companions of the Insured
When one of the Insured has been transferred or repatriated due to sickness or accident in application of Guarantee 2.1 (Transport or repatriation of sick and injured persons) above and this circumstance prevents the rest of the family members who are also insured from returning to their home using the means they had initially planned, the Insurer will bear the costs related to:

a) The transport of the remaining insured persons to their normal place of residence or to the place where the transferred or repatriated Insured has been hospitalised.

b) The provision of a person to travel and accompany the remaining Insured referred to in point (a) above, when these are children of the repatriated Insured under the age of 15 and they do not have a family member or trusted person to accompany them on the return journey.

2.4 Early return of the Insured due to death of a family member
If in the course of a trip the spouse, ascendant or descendant of first degree, brother or sister of the Insured person dies and in the event of the means used for travelling or the ticket he/she has bought does not allow to return early, the Insured would bear

the cost of this person's transport to the burial place in Spain of the family member and, where applicable, the return flight to the place where the Insured was at the time the event took place, if the Insured must continue with his/her travel plans due to professional or personal reasons, or two tickets to his/her normal place of residence provided the companion is also an Insured person.

2.5 Round-trip ticket for a family member and hotel expenses abroad

When the Insured is hospitalised and said hospital stay is expected to extend beyond 5 days, the Insurer shall make available to a family member of the Insured a round-trip ticket to be by his/her side. If said hospitalisation is abroad, the Insurer will cover the expenses of the family member's stay in a hotel, subject to being presented with the corresponding receipts, **up to 90 euros per day with a limit of 10 days and 900 euros**.

2.6 Home-based care for the family

If in the course of a trip and as a result of an accident or illness, the Insured should be hospitalised, and his/her spouse were to travel to the place where this event has taken place, by application of the coverages of the Policy, provided that this event leads to persons over the age of 70 years and/or under the age of 15 living normally with the Insured were to be left alone in their home, the Insurer will pay **up to 50 euros per day for a maximum of seven days, for a person to take care of them.**

The Insurer will cover this payment or will reimburse these expenses subject to being presented with the corresponding receipts and prior authorisation.

2.7 Medical, surgical, pharmaceutical and hospitalisation expenses abroad

If as a result of a disease or an accident abroad the Insured requires medical, pharmaceutical or surgical care or is admitted to hospital, the Insurer will cover:

a) The expenses and fees for medical and surgical care.

b) Pharmaceutical expenses prescribed by a doctor.

c) Hospitalisation expenses.

The maximum amount covered by the Insurer, for all of the above costs that are incurred abroad, is 12,000 euros.

2.8 Costs for extending a stay in a hotel abroad

Where the above guarantee of payment for medical expenses applies, the Insurer will cover the costs for the Insured extending a stay in a hotel abroad, after his/her hospitalisation and under medical prescription, **up to 90 euros per day and with a maximum of 900 euros.**

2.9 Expenses for emergency dental treatment abroad

If as a result of acute dental problems such as infections, pain or trauma arising while abroad which require emergency treatment, the Insurer will cover the expenses inherent to the aforementioned treatment **up to a maximum of 120 euros.**

2.10 Shipment of medicines abroad

If the Insured while abroad has made use of Guarantee 2.7 (Medical, surgical, pharmaceutical and hospitalisation expenses abroad), the Insurer will cover the expenses arising from sending the necessary medicines for curing the Insured, prescribed by a physician, and that cannot be found in the place where the Insured is located.

2.11 Remote assistance orientation

If the Insured during his/her travels were to require medical-related information which cannot be obtained locally, the latter may request that the Insurer provides this information over the telephone by means of the Permanent Assistance Centre. The Insurer will facilitate advice related to health issues included in the Policy under the supervision of its healthcare team, without the Insurer being considered responsible for the actions undertaken by the holder.

2.12 Transport or repatriation of deceased and accompanying Insured persons

The Insurer will deal with all the formalities to be carried out in the place where the Insured has died, as well as their repatriation to the place of burial or incineration in Spain.

In the event of the family members who are also insured and accompanying the Insured at the time of death could not return by the means originally envisaged or could not afford their return ticket, the Insurer will cover their transport to the place of burial or their place of residence in Spain.

If the relatives were children under the age of 15 years of the Insured who has died and do not have a relative or trusted person to accompany them on the journey, the Insurer will provide a person to travel with them to the place of the burial or their place of residence in Spain.

2.13 Search and transport of baggage and personal effects

In the event of theft, loss or misplacement of luggage and personal effects, the Insurer will provide the Insured with advice on filing a complaint relating to the facts. Also and if these were recovered, the Insurer shall be responsible for sending these to the Insurer's travel location or to his/her home.

2.14 Communicating messages

The Insurer will communicate urgent messages if so requested by the Insured, provided these derive from events covered by these Guarantees.

2.15 Travel information

The Insurer shall, at the request of the Insured, provide information concerning:

a) Vaccination and request for visas to foreign countries as well as any requirements that are specified in the most recent TIM publication (Travel Information Manual), a joint publication of fourteen airlines members of the IATA (International Air Transport Association).

The Insurer will not be held responsible for the accuracy of the information contained in the TIM or for the modifications that may affect the aforementioned publication.

b) Addresses and telephone numbers of Spanish embassies and consulates throughout the world, where they exist, as listed in the "Guide to Spanish Representations abroad" published by the Ministry of Foreign Affairs.

2.16 Shipment and/or forwarding objects forgotten and/or stolen in the course of the trip

The Insurer will organise and bear the cost of forwarding to the address of the Insured any objects that have been forgotten in the place or places where the latter has have been during the course of his/her travels.

This Guarantee extends to the objects that have been recovered after a robbery during said trip. Likewise, the Insurer will send to the Insured wherever the latter is at the time, those objects (in accordance with the legislation of the country) that may be considered basic necessities and that the Insured has forgotten at his/her home when departing on the trip, provided they are difficult or costly to replace in the place where the Insured is located.

In all the cases identified in this Guarantee, the Insurer will only assume the organisation of the shipment as well as its cost, **up to the amount of 120 euros.**

2.17 Advancement of funds abroad

If as a result of a theft of the Insured's means of payment (cash, credit cards, traveller's cheques, etc.), the Insured were to be left without funds to continue his/her journey, the Insurer will provide an advance of funds **up to a maximum of 600 euros.**

The Insurer reserves the right to request the Insured provide some sort of guarantee, warranty or a deposit to ensure the recovery of the advanced monies.

For the provision of this guarantee, the Insured will necessarily have to provide the report filed before the competent authorities.

Article 3 - Limits of the coverage for travel assistance, exclusions

a) The guarantees and benefits that have not been requested from the Insurer and which have not been agreed to, except in cases of force majeure or proven material impossibility.

b) All illnesses or injuries that occur as a consequence of illnesses which are chronic or suffered prior to the start of the journey, as well as their complications and relapses.

c) When the trip is carried out for the purpose of receiving medical treatment, unless the Insured or his/her successors duly certify that the illness or accident, or death where applicable, bears no relation to the medical treatment originating the travel.

d) Any disasters occurred in the event of war, manifestations and popular movements, acts of terrorism and sabotage, strikes, arrests made by any authority for an offence not derived from a motor vehicle accident, restrictions on free movement or any other case of force majeure, unless the Insured proves that the incident has no relation with such events.

e) Death caused by suicide or diseases and injuries resulting from an attempted suicide or caused intentionally by the holder, also including those arising from criminal actions directly or indirectly perpetrated by the holder.

f) The treatment of diseases or pathological conditions caused by intentional ingestion or administration of toxic products (drugs), narcotics, or by the use of drugs without medical prescription.

g) The costs of prostheses, glasses and contact lenses, childbirths and pregnancies except for unpredictable complications during their first six months, and any type of mental illness.

h) Injuries occurring in the exercise of a profession of a manual nature.

i) The events caused in the practice of competitive sports, in sports or high risk activities (rafting, paragliding, climbing, etc.), as well as the rescue of persons at sea, mountain or desert.

j) Any kind of medical or pharmaceutical expense not exceeding 9 euros.

k) In the transfer or repatriation of deceased persons: the costs of the burial or incineration and the ceremony.

Article 4 - Additional provisions of the travel assistance coverage

In telephone communications requesting the assistance of the aforementioned Guarantees, the Insured must indicate: name of the Insured, healthcare assistance policy number, the place where the person is located, telephone number and type of assistance required.

The Insurer is not responsible for any delays or failures due to causes of force majeure or to those of a special administrative nature or policies of any given country. In any case, if a direct intervention is not possible, the Insured shall be reimbursed upon his/her return to Spain, or in the event of need, as soon as he/she is in a country which meets the above mentioned circumstances, for the expenses which have been incurred and are guaranteed, subject to presenting the corresponding receipts.

If the Insured is entitled to reimbursement for the proportion of the ticket that is not consumed, upon making use of the repatriation guarantee, said reimbursement will revert to the Insurer.

The compensations established in the Guarantees shall in any case complement the contracts that may cover these same risks, the social security benefits or any other collective provision regime.

The Insurer is subrogated in the rights and actions that might correspond to the Insured due to facts which have led to the intervention of the latter and up to the total amount of the services rendered or paid.

For the provision, by the Insurer, of the services inherent to the foregoing Guarantees it is essential that the Insured requests said intervention, as of the time of the event, by telephoning the number included in the Particular Conditions of the Policy.

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