General Conditions

Asisa Salud

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ASISA SALUD GENERAL CONDITIONS

PRELIMINARY CLAUSE

This insurance contract is governed by the provisions of the following regulations: Law 50/1980, October 8, Insurance Contracts; Law 20/2015, July 14, Regulation, Supervision and Solvency of Insurance and Reinsurance Companies; Royal Decree 1060/2015, November 20, Regulation, Supervision and Solvency of Insurance and Reinsurance Companies and Law 22/2007, July 11, Distance marketing of financial services for consumers, as well as other applicable Spanish legislation.

The following documentation is an integral part of the contract: Insurance Application, Health Questionnaire, General Conditions, Particular Conditions, Special Conditions (if applicable), plus their Annexes, Appendices and Supplements. **The limiting clauses on the rights of the insured that have been expressly accepted by the Policyholder will apply.** Simple transcripts or references to mandatory legal precepts will not require this acceptance.

The Spanish State, through the General Directorate of Insurance and Pension Funds, is responsible for the control and supervision of the insurance business of ASISA, ASISTENCIA SANITARIA INTERPROVINCIAL DE SEGUROS, S.A.U.

DEFINITIONS

The following definitions will be understood for the purposes of this contract:

Accident: A bodily injury due to a violent, sudden, external cause beyond the intention of the Insured.

Insured: The natural person for whom the insurance applies.

Insurer: ASISA, ASISTENCIA SANITARIA INTERPROVINCIAL DE SEGUROS, S.A.U, which assumes the contractually agreed risk. The Insurer is also be referred to as the Company in this document.

Insurance Contract (Policy): The document that contains the conditions governing the Insurance. The following form an integral part of it: Insurance Application; Health Questionnaire; General conditions; Particular Conditions, which individualise or specify the risk that is insured; Special Conditions (if applicable); Supplements, Annexes or Appendices that are issued to complement or modify it.

Co-payment: The Insured's participation in the Cost of the Services or Amount the Policyholder has to pay to the Insurer towards the cost of each health service used by the Insured. This amount varies according to the different kinds of healthcare services or acts and medical specialities; this may change at each annual contract renewal, following communication by the Company beforehand.

Medical Panel/List of Doctors and Services: Approved list of professionals and health establishments available for the contracted insurance product, organised by province, which the Company makes available to the insured through its offices, at www.asisa.es and the Asisa app .

The information regarding the health providers listed in the Medical Panel may vary so, before requesting and providing services, it should be checked that the health

professional or centre is approved by ASISA; in the event of any problem, the Company can be consulted through the different information channels available.

The policyholder and insured are informed, and should assume, that the professionals and health centres that are part of the Medical Panel will act with full independence of criteria, autonomy and have exclusive responsibility in the field of healthcare that is their own.

Health Questionnaire: A complete and truthful statement that must be given by the Policyholder or Insured before entering into the insurance contract, so that ASISA can properly assess the risk to be insured. If any information in this document is inaccurate or withheld from it, the Company is empowered to terminate the contract, at whatever time of validity it has remaining, and will be released from the payment of any benefit, even if authorisation for its provision had already been provided.

Previous or pre-existing illness/disease: Circumstance related to the state or health condition, not necessarily pathological, suffered by the insured before taking out (effective incorporation to) the contract.

Fraud: Action or omission committed as fraud or deception with the intention of causing damage or obtaining a benefit for the interests of a third party.

Address of the Policyholder and Insured: The person specified in the Particular Conditions.

Illness: Any alteration to the insured's health not caused by an accident, diagnosed by a doctor, which requires the provision of healthcare.

Hospital: Establishment dedicated to the continuous, 24 hours a day care of the sick and injured by medical and nursing staff with the appropriate resources for this.

Day hospital: Hospital centre for medical and surgical procedures, with or without anaesthesia, with a registered stay for the patient of less than 24 hours.

Hospitalisation The insured being kept in a Hospital for a minimum of 24 hours.

Waiting Period: Time during which some of the benefits established in the contract coverage are not covered. The established Waiting Periods are calculated from the contract start date or the registration date for a new insured person.

Insurance period: The time from the insurance contract/new insured registration start date to its termination (expiry), or the time between each extension.

Benefit: Assistance coverage due to the occurrence of a claim in the manner established in these General Conditions.

Premium: The cost of the Insurance. The Premium will also include legally applicable surcharges and taxes.

Claim: Occurrence of a circumstance provided for in the contract which gives rise to the Insurer's obligation to provide the Insured with assistance within the scope established.

Health Card: A document issued by ASISA, ASISTENCIA SANITARIA INTERPROVINCIAL DE SEGUROS, S.A.U., which is delivered to each insured to demonstrate personal and non-transferable entitlement to receive the services covered by the insurance contract.

Policyholder (contracting party): The physical or legal person who signs this contract with the Insurer, and to whom the obligations derived from it correspond, except for those that must be fulfilled by the Insured due to their nature.

Emergency: A situation requiring healthcare without delay, due to the pathology or symptoms.

Sudden emergency: Occurrence of a sudden, abrupt pathology whose nature and symptoms involve an imminent or very close risk to the life of the insured, or irreparable damage to his physical integrity if immediate therapeutic action is not carried out.

CONDITIONS

FIRST: INSURANCE PURPOSE AND LIMIT

This is a health insurance contract for healthcare to be given by the Company's Medical Panel/List of Doctors.

Thus, after signing and paying the Premium for it, the insurer will provide the Insured, within the limits and conditions stipulated in the contract and nationally, with a wide range of duly authorised professionals, centres and health services, from which the Insured may request healthcare in the specialities and modalities included in the insurance coverage, **provided that they are resources or techniques recognised by the usual medical practice at the time of signing this contract.**

The Company reserves the right to include treatment techniques and diagnostic resources already in use at the time of contracting and/or covered in it, as well as new ones that may arise in medical practice, after informing the policyholder or contractor at each contract renewal; this may impact on the insurance premium to be paid. **Consequently, those benefits whose incorporation has not been expressly communicated by the Company may not be considered included in the coverage of this insurance contract.**

Provided the provisions of this contract are met, the Company will be directly responsible for the cost of the care the aforementioned approved professionals, centres and health services provide for the insured, who must use the means of identification/payment that the Company indicates. **In no case may optional compensation be granted in substitution of the provision of health care services included in the contract.**

The Insurance Company assumes the necessary urgent assistance during the contract, in accordance with the provisions of its conditions, as provided for in article 103 of the Insurance Contract Law: to be provided by the resources authorised by the Company at all times, according to the Medical Panel applicable for this insurance product.

SECOND: INSURED BENEFITS DESCRIPTION

To make use of for the benefits insured under this health care insurance contract, the Company has a Medical Panel available for the Insured, which provides the Emergency Services, list of doctors of different specialities, nurses, other health professionals and authorised health centres within the respective province.

1. Emergency Service

ASISA has an Emergency Coordination Centre for the whole of Spain, operating 24 hours a day, every day of the year, via the free telephone number 900 900 118, offering a comprehensive emergency care service. This provides emergency care and

information about emergencies throughout the national territory (telephone medical consultations; medical, paediatric and nursing visits at home in provincial capitals and large municipalities; emergency ambulances and information on emergencies and authorised hospitals).

Additionally, in each provincial capital and in other large municipalities, the Company provides the insured with a home emergency service twenty-four hours a day, as well as a permanent hospital emergency service in authorised centres.

The Medical Panel provided for the Insured via different means (Provincial Offices, ASISA website (www.asisa.es), mobile app and other available information channels) contains the telephone numbers to request any service and the centres where you must go in an emergency.

2. Primary care: General and Family Medicine, Paediatrics and Nursing. 2.1 2.1 General and Family Medicine

This includes medical care in consultation, on request and scheduled, as well as for the indication or prescription of basic diagnostic and therapeutic procedures (analytical and general radiology).

Care may be provided either in consultation or at the insured's home (whenever possible), when circumstances require, in the opinion of the doctor, and for **those patients who cannot move due to their pathology.**

2.2 Paediatrics

This includes medical care in consultation, on request and scheduled, as well as for the indication or prescription of basic diagnostic and therapeutic procedures (analytical and general radiology) for children up to and including 14 years of age.

Care may be provided either in consultation or at the insured's home (whenever possible), when circumstances require, in the opinion of the doctor, and for **those patients who cannot move due to their pathology.**

Newborns will be entitled to this medical care, in consultation or at home, charged to the insurance contract of the insured mother, **for up to the first 30 days of life.** To be applicable for the care, they must be insured by the Company within the stated period.

2.3 Nursing

This will be provided either in consultation or at the insured's home (whenever possible), when circumstances require for **those patients who cannot move due to their pathology.** In all cases, a prescription is required beforehand from a doctor on the ASISA Physicians List who is treating the patient, with an indication of the treatment and its duration.

3. Specialist Medicine

Medical speciality consultation: The Insured can freely choose the Specialist Doctor for the following specialities from among those listed in the Medical Panel:

- Allergology
- Anaesthesiology and Resuscitation
- Angiology and Vascular surgery
- Digestive system
- Cardiology

- Cardiovascular surgery
- General and Digestive system surgery. Proctology
- Oral and Maxillofacial Surgery
- Orthopaedic surgery and Traumatology
- Paediatric surgery
- Plastic and Reconstructive Surgery
- Thoracic surgery
- Medical-Surgical Dermatology and Venereology
- Endocrinology and Nutrition
- Stomatology and Dentistry
- Geriatrics
- Haematology and Hemotherapy
- Physical medicine and Rehabilitation
- Internal medicine
- Nuclear medicine
- Nephrology
- Pneumology
- Neurosurgery
- Clinical Neurophysiology
- Neurology
- Obstetrics and Gynaecology
- Ophthalmology
- Medical Oncology
- Radiotherapy Oncology
- Otorhinolaryngology
- Psychiatry
- Rheumatology
- Urology

If the Company has no professionals of a speciality in a particular province, the Insured may make use of this service through the Company's Medical Panel in any other province where such a speciality exists, **but will have to pay for all travel expenses.**

4. Diagnostic resources

The use of diagnostic resources always require a written prescription from a medical specialist in the field from the Company's Medical Panel/Doctor's List. In addition, they must be used only by a doctor or centre arranged by ASISA for the specific case.

For those services marked with an asterisk (*) in this section, prior, express authorisation from the Company is also required and a 6-month waiting period is established.

The following are considered examples of diagnostic resources:

Clinical analysis: Haematology, biochemistry, bacteriology and immunology, cytology and karyotypes.*

Genetic studies*: Only when their purpose is to diagnose a certain disease, in accordance with the corresponding protocols and clinical guidelines for affected patients who have signs or symptoms of it.

Also included are genetic studies to identify therapeutic targets in neoplastic processes*, **whose determination is required in the anti-tumour drug technical file prepared by the corresponding health authority.**

The Oncotype® and MammaPrint® genomic platforms for breast cancer are also covered*, **as long as they respond to the recommendations established for each. A prescription and report by a specialist in Medical Oncology from the ASISA Medical Panel is required, with the requested platform being stated (only Oncotype® or MammaPrint®), as well as prior, express authorisation from the Company.**

Also included is the prenatal study of foetal DNA in maternal blood***, exclusively for the detection of foetal aneuploidies of chromosomes , 13, 18 and 21 and abnormalities of the sex chromosomes, when indicated according to the risk indices established at any time by the Spanish Society of Gynaecology and Obstetrics. In addition to the prescription a report from the prescriber is also required.**

Genetic studies for identification of carriers, pre-symptomatic studies or those for genetic counselling; family, genealogical, parentage or identification studies; prenatal genetic diagnosis studies (except foetal DNA in maternal blood in the conditions indicated above) or those for pre-implantation genetic diagnosis are not covered.

The genetic studies that are covered by this contract always require a prescription and report by an ASISA Medical Panel specialist, as well as prior, express authorisation from the Company, with a 6-month waiting period being established in all cases.

Pathological anatomy. This includes General anatomopathological studies (biopsies, cytology and immunohistochemical studies) and the genetic (molecular) studies* essential for the diagnosis of certain diseases in affected, symptomatic patients and for the identification of therapeutic targets, **under the conditions and within the limits and exclusions detailed in the Genetic Studies section.**

Necropsies or autopsies are not covered.

Diagnosing by Imaging and Nuclear Medicine: Conventional radiology, diagnostic interventional or vascular Radiology**(*)**, ultrasound, Doppler ultrasound, hepatic elastography, mammography, CT or CAT **(*)** (Computerised Axial Tomography scan) **(excludes CAT spectroscopy**), M.R.I. Nuclear Magnetic Resonance (NMR)**(*)**, bone densitometry, scintigraphic studies**(*)**, SPECT**(*)** and SPECT-CT**(*)**, P.E.T. (Positron Emission Tomography)=PET, =PET-CT **(*) (exclusively for oncological, cardiac and neurological pathologies in which the FDG marker is approved by the Spanish Agency of Medicines and Health Devices, according to its technical sheet), included in Annex I of these General Conditions(*)**. **PET-MRI is not covered.**

Circulatory system: Electro and Phonocardiogram, Echocardiogram, Doppler ultrasound, Catheterisation*, Holter monitor (ECG and BP; **implantable Holters are not covered**), ergometry and Cardiac Electrophysiological studies*.

Digestive system: Endoscopy, capsule endoscopy scans **(*) (only for diagnosis of gastrointestinal or intestinal bleeding of unknown or hidden origin).**

Clinical Neurophysiology: Electroencephalography, Echoencephalography, Electronystagmography, Electromyography, Electroretinography, Electroneurography. Polysomnographic studies **for sleep apnoea/hypopnoea syndrome (OSAHS), respiratory pathology and neuromuscular diseases, narcolepsy and other hypersomnias and seizures or epilepsy*.**

Obstetrics and Gynaecology: Diagnostic Laparoscopy*, Diagnostic Hysteroscopy*, Ultrasound, Foetal Monitoring, Amniocentesis*, Karyotype tests*. Pregnancy control, including triple screening, as well as non-invasive prenatal screening by prenatal study of foetal DNA in maternal blood **(*)**, **exclusively for the detection of foetal aneuploidies of chromosomes, 13, 18 and 21 and abnormalities of the sex chromosomes, when indicated according to the risk indices established by the Spanish Society of Gynaecology and Obstetrics.**

Ophthalmology: Retinography, Angiofluoresceingraphy, Optical Coherence Tomography (OCT), Campimetry, Ultrasound.

Otorhinolaryngology: Direct and indirect laryngoscopy, diagnostic tests for vestibular pathology (electronystagmography, videonystagmography) **(*)**, auditory evoked potentials and otoacoustic emissions.

Urology: Urethrocystoscopy, Cystoscopy, Ureteroscopy, Uroflowmetry, Urodynamic Studies.

Prostate biopsy by image fusion is included, **provided there is a high clinical suspicion of prostate cancer, accredited by a medical report with PSA values and their rate of increase, after having had an earlier conventional or ultrasound-guided biopsy performed in the previous year with a negative result.**

5. - Special Treatment Techniques.

All special treatment techniques require a written prescription from a medical specialist in the field on the ASISA Medical Panel/Doctor's List. **In addition, they must be performed only by a doctor or centre authorised by ASISA for the specific case.**

In addition, in all cases, express prior authorisation is required by the Company and a waiting period of 6 months is established.

These services include:

Aerosols, Ventilation Therapy and Oxygen Therapy at home using a single source of oxygen (the medication will be at the Insured's expense). Home treatments using CPAP or BiPAP (mechanical devices that provide positive pressure in the upper airways) are included **for Obstructive Sleep Apnoea-Hypopnoea Syndrome, as well as for Respiratory insufficiency and COPD.** Titration polysomnography is also included to adjust the device.

Circulatory system.- Cardiac catheterisation with or without angioplasty; therapeutic cardiac electrophysiological study (ablation of AV conduction, accessory pathways and ventricular tachycardias). **Ablation or isolation of pulmonary veins is not covered.**

Oncological surgery of the breast.- Breast Reconstruction will be covered (**exclusively after mastectomy due to neoplasia**), including expanders and breast prostheses, if necessary, as well as DIEP or TRAM flap techniques. In these cases, contralateral breast symmetrisation is also covered, **provided it is carried out at the same time as**

the reconstruction of the breast affected by the neoplasm, or within 6 months of this, at most.

Laser Surgery.- For Otorhinolaryngology, Gynaecology, Proctology (for Haemorrhoids, anal and perianal fistulas and fissures, condylomas and rectal polyps) and Ophthalmology (photocoagulation in retinal pathologies) and laser treatment of Glaucoma), therapeutic laser bronchoscopy and laser lithofragmentation by ureteroscopy. Greenlight (KTP and HPS), diode, holmium and thulium lasers are included for the treatment of benign prostatic hyperplasia. Endoluminal treatment of varicose veins by laser, radiofrequency and microfoam is also covered, **exclusively in processes with symptomatic clinical venous insufficiency (CEAP grade C3 or higher), with treatment for aesthetic reasons not being covered.**

Extracorporeal lithotripsy.- For the treatment of renal lithiasis. **The treatment of gallstones is not covered.**

Nuclear medicine.- **The medication will be charged to the insured**, except when treatment is performed during hospitalisation.

Neurophysiological monitoring: This will be covered **only in surgeries when a risk to nerve structures is clearly identified during surgery.**

Neuronavigation: This will be covered **only for brain and major spine deformity surgery**.

Oncology.- Chemotherapy (includes antineoplastic cancer chemotherapy and immunotherapy drugs used in intravenous or intravesical chemotherapy administered in Oncology Units on a day hospital basis; **special forms of chemotherapy are not covered (such as Intraoperative or Intraperitoneal Chemotherapy)**, Radiotherapy, including Intensity Modulated Radiotherapy, as well as Brachytherapy **for the treatment of prostate, gynaecological, genital and breast cancer.** Stereotactic Radiosurgery is included **exclusively for tumours located in the central nervous system (not covered are Stereotactic Radiosurgery for other pathologies, Radiosurgery with Gamma Knife or CyberKnife, Tomotherapy, Intraoperative Radiotherapy and Proton Therapy, as well as other special forms of radiotherapy).**

Therapeutic Interventional Radiology.-

Rehabilitation: Outpatient physiotherapy treatments are covered **for pathologies of the locomotor system with recoverable functional deficit until the injuries are stabilised.** It includes Physiotherapy, Electrotherapy, Kinesitherapy, Magnetotherapy, Laser therapy, as well as shock wave treatments for the following osteotendinous injuries: degenerative tendinopathies, tendinosis, osteonecrosis, pseudoarthrosis, osteochondritis and calcifications.

The following are also covered:

- Pelvic floor rehabilitation.
- Vestibular rehabilitation.
- Cardiac rehabilitation.
- Lymphatic drainage, **only in the event of alterations caused by oncological processes and treatment.**
- In Speech Therapy/Phoniatrics, **exclusively covered are the treatment of recoverable speech pathologies, derived from organic processes, until the stabilisation**

of the process. Treatments for learning disorders, dyslexia, dysgraphia and dyscalculia are not covered.

- Orthoptic and Pleoptic treatments are included.

Dialysis. - Haemodialysis and peritoneal dialysis, **for acute or chronic kidney failure**.

Pain treatment.- Implantable pumps for drug infusion and electrodes and devices for brain or spinal cord stimulation are not covered.

6. Other services

6.1 Podiatry:

The Podiatry service, which includes consultation and/or podiatric treatment (chiropody), is provided only under consultation, **with a limit of 12 sessions per year.** The biomechanical study of gait is also covered.

6.2 Psychotherapy:

For the treatment of mental health diseases of a temporary nature and psychological origin (pathologies related to adaptation, stress, temporary depressive conditions, behaviour, anorexia and bulimias). **They require a prior prescription and report by a specialist in psychiatry from the Company's Medical Panel, as well as express prior authorisation from him for a professional or authorised centre.**

The maximum number of sessions covered by the Company is 20 per insurance year for all pathologies covered by this benefit, except for eating disorders, anorexia and bulimia, which have a limit of 40 sessions per insurance year. Coverage is also included for the treatment of psychological disorders caused by bullying, cyberbullying and gender violence, **with a limit of 40 sessions per insurance year.**

Psychological and neuropsychological tests, psychopedagogy, group or couple psychotherapy, psychoanalysis and psychoanalytic therapies, outpatient treatment of narcolepsy or hypnosis are not covered by the Company.

A Waiting Period of 6 months is established.

6.3 Family Planning:

Includes consultation, vasectomy, tubal ligation and IUD implantation, including the cost of the device (**hormonal IUDs are not covered**). Diagnostic study of the causes of sterility or infertility (serological and hormonal studies, karyotype, as well as hysterosalpingography in women and spermiogram tests in men).

A Waiting Period of 6 months is established.

6.4 Preparation for childbirth:

Through courses that include theoretical and practical training, with physical exercises, relaxation techniques, expulsion and simulation of the period of dilation and childbirth.

A prescription is required from a specialist in Obstetrics and Gynaecology from the Company's Medical Panel.

6.5 Stomatology and Dentistry:

In addition to consultations and check-ups, dental extractions, mouth cleaning (tartrectomy) and descaling are included, as well as dental radiology for these treatments and fluoridations for children under 6 years of age.

6.6 Second Opinion

The Insured will have the right to the provision of a Second Medical Opinion for certain pathologies and clinical conditions that appear in Annex II of these General Conditions, which also includes the form of access to it.

6.7 Preventive medicine

Includes programmes in Paediatrics, Gynaecology, Cardiology, Urology and the Digestive System in accordance with the generally accepted recommendations, which appear in Annex III of these General Conditions.

6.8 Virtual Doctor

This service is available to the insured in the private area of the asisa website (www.asisa.es) or app for mobile devices, and consists of a medical Panel that attends, reports on and informs the insured about possible queries regarding any pathology or health problem.

7.- Hospitalisation (including by Day)

This will occur only in hospitals arranged by the Company. It will include a single room with a bed for a companion, **unless this is clearly impossible or for psychiatric or neonatal hospitalisation cases or for the Intensive Care Unit.** In addition to room and board services for the patient, additional diagnostic examinations, required therapy, medication, transfusions and possible surgical treatment will be covered, including operating room expenses, medication and anaesthesia; **this is all in accordance with the General and Particular Conditions of the insurance.**

An appropriate prescription prepared by the physician responsible for treating the insured is essential; this person must be a medical specialist in the field, listed on the Medical Panel and expressly authorised by the Company beforehand. The prescription must include the reason for hospitalisation and the operation or care to be performed, with a forecast of the time required. The doctor's order must be referred to a Centre approved by the Company and the reason for hospitalisation must be included in the services covered by the contract.

If hospitalisation is required urgently, a written prescription from the Medical Panel doctor or the Centre's admission report will suffice. **However, the Insured, or his relatives, where appropriate, must inform the Company of this situation within 7 days, and obtain the corresponding authorisation to bind the Insurer financially.**

If these requirements are not met, the Company will not authorise any hospitalisation, take charge of any health benefit or assume any other financial obligation, directly or indirectly related to the cause of admission.

There is no limit to hospitalisation time **(except as provided for in each case), which will depend on the technical need to prolong the stay, according to the criteria of the responsible doctor from the ASISA Medical Panel of Doctors. However, hospitalisation authorisations will have the time limit recorded on the written forecast by the doctor ordering admission, or according to statistical procedural averages as estimated by the Company. To prolong the hospital stay, the appropriate request must be processed, and a new report from the doctor in charge provided, to include the reasons for the prolongation and an estimate of the extra time required.**

Under no circumstances will non-medical reasons, such as social problems (e.g. difficulties with family care at home or absence of relatives) be accepted as reasons for staying.

Expenses derived from hospitalisation in a non-subsidised centre (private or public) are not covered, even if prescribed by professionals on the ASISA Medical Panel, unless they are due to a sudden emergency. In these cases, the insured or his relatives, as appropriate, must inform the Company and provide proof of this situation within 7 days. The Hospitalisation must be in the centre closest to the place where the Emergency situation occurs. The insured must be transferred to an authorised Centre, after prior coordination with ASISA, once the medical situation allows.

Hospitalisation coverage includes:

- **Hospitalisation for maternity:** attendance at childbirth or caesarean section and puerperium, with an Obstetrician and Midwife belonging to the ASISA Medical Panel. This also includes anaesthesia in normal deliveries.
- **Paediatric hospitalisation: For children only up to 14 years old, inclusive.**
  * Attention for the newborn from the moment of delivery, at the indication of the Paediatrician.
  * Hospitalisation for medical or surgical reasons in the Company's authorised centre is also included, including admission of the newborn (e.g. to neonatology or incubation) if necessary. When the child's age and the Centre allow it, the patient may be accompanied.

As long as the delivery/caesarean section has been covered by ASISA, the hospitalisation of the newborn will be covered by the mother's insurance contract, **up to a maximum of 30 days from the date of birth; for continuity of care by the Company, the newborn must be discharged from ASISA within the aforementioned period, as provided for in section (b) of the Eighth General Condition.**

Hospitalisation for surgical reasons. In addition to surgical operation expenses, it also includes the preoperative study, visits and cures in the immediate postoperative period, as well as the prostheses or implants expressly included in point 10 of this Second condition.

- **Hospitalisation for medical reasons** (not requiring surgery):

For treatment and procedures that cannot be supplied at home or on an outpatient basis with the proper techniques, and thus require hospitalisation, in the opinion of the Medical Panel specialist.

- **Psychiatric Hospitalisation: For the treatment of patients with acute or chronic psychiatric problems that have become acute and are recoverable.**

A companion bed is not included in these cases. A limit of 50 days of Hospitalisation per insurance annuity is established.

- **Hospitalisation in specialist units**, such as for Surveillance in an Intensive Care Unit (ICU) or for a Coronary Unit. **A companion bed is not included in these cases.**
- **Day hospital:** Hospital assistance for medical and surgical procedures, with or without anaesthesia, with a registered stay for the patient of less than 24 hours.

The Day Hospital regime for medical or psychiatric treatment **does not cover medication, except for antineoplastic cancer chemotherapy medication, with cytostatics or other medications, and intravenous or intravesical treatment in Oncology units.**

An appropriate prescription prepared by the physician responsible for treating the insured is essential; this person must be a medical specialist in the field, listed on the

Medical Panel and expressly authorised by the Company beforehand. The prescription must include the reason for the care to be carried out. The doctor's order must be referred to a Centre approved by the Company and the reason must be included in the services covered by the contract.

A Waiting Period of 8 months is established for this coverage (Hospitalisation, including by Day).

8.- Day surgery

This includes any diagnostic or therapeutic intervention prescribed and carried out by a specialist doctor in the field belonging to the Company's Medical Panel in an authorised centre, which normally requires a same day surgery unit.

For this type of surgery, a Waiting Period of 6 months is established. It requires a prior prescription and express authorisation by the Company.

9. Patient transfer (Ambulance)

Transfers by authorised ambulance covered by the insurance will be those conducted within the national territory, from the home or place where the insured is located to the authorised centre where the care services they need and which are covered will be provided and from the centre to the insured's home after completion of the care, **provided that an Company staff doctor prescribes this in writing and there are special circumstances that make it physically impossible for the insured to use ordinary transport services (public services, taxi or private vehicle)**.

Transfers using transport other than ambulances (e.g. medical planes, trains, ships or helicopter) or those made by non-contracted means, including public services, are not covered under any circumstances.

10.- Prosthetics and Implants

The Company, with prior express authorisation, covers prescription, implantation and material expenses exclusively for the internal surgical prostheses and surgical implants detailed below:

- Internal skeletal prostheses and material for osteosynthesis **(excluding implants made up of natural bone or substitutes for it, except for bone grafts, biological ligaments and osteotendinous grafts, provided that they are necessary for a surgical intervention previously authorised by the Company and are requested from authorised national storage banks of bone and tissue).**
- Heart valve prostheses **(except transcatheter, transapical or percutaneous valve prostheses of any type: TAVI and others);** by pass type vascular prostheses, endoprostheses of the aorta and its branches, aortic valve conduits in cases of aortic valve pathology and coronary stents.
- Single-chamber and dual-chamber pacemakers **(devices for cardiac resynchronisation and atrial stimulation are not covered, nor, in general, are any type of implantable Holter, implantable automatic defibrillator or ICD).**
- Breast prostheses including expanders **(exclusively after mastectomy for neoplasms).**
- Monofocal intraocular lenses for the treatment of cataracts. **Bifocal, multifocal, toric or refractive error correcting lenses of any kind are not covered).**
- Synthetic abdominal or thoracic wall meshes **(biological meshes are not covered).**

- Biliary prostheses.
- Coils for embolisations.
- CSF diversion systems for hydrocephalus.
- Testicular prostheses.
- Reservoirs for the administration of oncological drugs or pain treatment (Port-a-Cath® type).

Any other expense related to the prescription, implantation or prosthetic product or material for internal surgical implantation or for external use, or any non-autologous active, synthetic or biological implantable product, material or substance, not included in the aforementioned covered items, will be borne by the insured. Platelet growth factors or any kind of stem cell treatment are not covered.

Prostheses included in the previous sections that incorporate technical modifications, in terms of the design and/or type of device, components, the material used, or the implantation methods or energy sources are not covered. Also not covered are active implants for general use until the time of contracting, unless they are incorporated into this insurance contract coverage, following express communication by the Insurance Company.

11.- Transplants

Expenses derived from performing bone marrow (both autologous and heterologous) and cornea transplants (**the cost of the cornea being paid for by the Insured**) are covered by the Company.

Obtaining and transplanting organs can be carried out only in accordance with the provisions of current health legislation. The Company will in no case assume the management of obtaining the organ or tissue to be transplanted, the management of obtaining the cornea or donor bone marrow which will be paid for by the insured.

No other type of organ, tissue or cell transplant are covered.

A prescription is required from a specialist in the field from the ASISA Medical Panel, as well as express, prior authorisation from the Company.

A Waiting Period of 8 months is established.

12. Occupational Accidents and Obligatory Motor Vehicle Insurance

This includes healthcare following occupational and professional accidents and those covered by the Mandatory Motor Vehicle Insurance, unless expressly excluded in the Particular Conditions.

13. Travel Assistance

The Insured with residence in Spain will have Travel Assistance coverage **in accordance with the conditions appearing in Annex IV of these General Conditions.**

THIRD: EXCLUDED BENEFITS

In addition to those specifically established in each case, the following benefits are excluded from this insurance coverage:

1. **Those produced by events derived from armed conflicts or terrorism, whether**

or not preceded by an official declaration of war, as well as officially declared epidemics or pandemics.

2. **Those directly or indirectly related to explosions or chemical, biological, nuclear or radioactive contamination, which must be covered by civil liability insurance for nuclear damage.**
3. **Those produced by extraordinary or catastrophic events, such as floods, tornadoes, hurricanes, typhoons, earthquakes or landslides.**
4. **Care derived from the attention for pathologies, situations or processes prior to contracting the insurance or those present at the time it was taken out, which were known and not declared in the questionnaire the Insured has to complete; as well as their sequelae, evolutionary outbreaks and complications.**
5. **Care derived from the attention for pathologies caused by participation of the Insured in professional activities or sports that involve high danger, either as a professional or an amateur, such as: underground, underwater or aerial activities; those with motor vehicles or boats; boxing, martial arts, bullfighting, climbing, mountaineering, canyoning, bungee jumping or any other of a similar nature.**
6. **Care derived from chronic alcoholism, drug addiction, intoxications due to alcohol abuse, psychotropic drugs (unless prescribed by a doctor), narcotic drugs or hallucinogens.**
7. **Plastic surgery for aesthetic reasons, as well as any diagnostic or therapeutic technique performed for aesthetic or cosmetic purposes. Sex change surgery. Bariatric Surgery (surgical treatment of obesity or metabolism control). Robotic Surgery (with a Da Vinci robot or any other device).**
8. **Preventive Medicine (except that included in Annex III of these Conditions), health checks or examinations and genetic studies; except for the cases expressly included in point 4 (Diagnostic Resources) of the Second Condition of these General conditions.**
9. **Homeopathy, organometry and acupuncture; as well as experimental diagnostic or treatment techniques or those not recognised by medical science or carried out for clinical trials of any kind.**
10. **Fillings, dental prostheses, dental implants, periodontal treatments, orthodontics and endodontics; as well as previous diagnostic tests or studies related to these treatments and any diagnostic technique or treatment for aesthetic or cosmetic purposes.**
11. **In Psychiatry and Neuropsychiatry, psychological tests and psychoanalysis treatments or techniques, psychotherapy (except for that established in the provision of psychotherapy in point 6.2 of the Second General Condition), hypnosis, sophrology, neuropsychological or neurorehabilitation treatments and outpatient treatment of narcolepsy.**
12. **In obstetrics and gynaecology: infertility treatment techniques, artificial insemination and in vitro fertilisation, hormonal IUDs and obstetric ultrasound scans of 4 or more "D" (4D, 5D, 6D, etc.). Voluntary termination of pregnancy is also excluded.**
13. **Rehabilitation and functional recovery processes that require educational therapy, such as language education in congenital processes or special education**

for patients with psychiatric disorders. Maintenance and occupational therapies, early stimulation, neurorehabilitation, cognitive stimulation and, in general, treatments of neurological or neurodegenerative disorders not related to the locomotor system.

All cases of rehabilitation in chronic pathologies are excluded and/or when the process has entered an insurmountable state of stabilisation, according to the rehabilitation doctor's report, except in cases of exacerbation of the process.

14. **Implants made of natural bone (unless they are necessary for interventions authorised by the Company and provided they are requested from national bone and tissue storage banks) or substitutes for it and platelet growth factors. Orthotics, as well as orthopaedic and anatomical products. Penile and scrotal prostheses, breast prostheses and skin expanders (except as indicated in the Breast Cancer Surgery section in point 5 of the Second Clause); dental, cochlear, middle ear implants and any type of implant or prosthesis that is not in general Public Health surgical practice. Any expense related to the prescription, implantation or prosthetic product or material for internal surgical implantation or for external use of any implantable, active, synthetic or biological, non-autologous product, material or substance, not expressly included in point 10 of the Second Clause of these Conditions (related to Prostheses and Implants) is not covered. Prostheses included in the previous point 10 of the Second Clause, when they include technical modifications, in terms of the design and/or type of device, components, the material used or the implantation methods or energy sources are not covered. Also not covered are active implants for general use until the time of contracting, unless they are incorporated into this insurance contract coverage, following express communication by the Insurance Company.**

15. **Medication, except in the cases of hospitalisations and antineoplastic oncological chemotherapy medication with cytostatics or other drugs, intravenous or intravesical, used in outpatient oncological chemotherapy treatments administered in Oncology Units on a day hospital basis (excluding any other medication administered on a day hospital basis). Special forms of chemotherapy, such as Intraoperative or Intraperitoneal Chemotherapy, are excluded. Experimental treatments, those for compassionate use and those for indications other than those authorised in the technical data sheet of the medication in question will be considered excluded in all cases.**

16. **Regenerative and cellular therapies of any type are excluded, as well as treatments based on tissue engineering or gene or genetic therapies; as well as any treatment based on genetic modifications of the patient's cells through any procedure (including CAR T-cell therapies).**

17. **Positron Emission Tomography (PET) scans (except for those oncological, cardiac and neurological pathologies included in Annex I of these General Conditions). Spectral CAT Obstetric ultrasound of 4 or more "D" (e.g. 4D, 5D and 6D).**

18. **Neurophysiological monitoring and Neuronavigation, except in the cases provided for in the Second General Condition.**

19. **Laser treatments for myopia, hyperopia, astigmatism and other refractive pathologies, as well as laser surgery, regardless of the organ to be treated, except in the cases expressly included in point 5 (Special Treatment Techniques) of the Second Clause of these General conditions.**

20. **Stereotactic radiosurgery, except for the treatment of localised tumour lesions of the central nervous system, radiosurgery with Gamma Knife or CyberKnife, intraoperative radiotherapy, tomotherapy, proton therapy or other special radiotherapy techniques, except in the cases expressly included in point 8 (Special Treatment Techniques) in the Second Condition of these General Conditions. No form of radiotherapy for benign non-oncological pathology is covered.**
21. **All types of transplants are excluded, except bone marrow (autologous and heterologous) and cornea (the cost of which is borne by the insured).**
22. **All diagnosis or treatment resources, procedures and techniques not recognised or not universalised in normal medical practice, or those of an experimental or investigational nature, are all excluded from the insurance coverage.**
23. **Any diagnostic or therapeutic technique not expressly included in the coverage of the contract, or recently incorporated into normal medical practice after contracting the insurance, unless the Company expressly communicates otherwise. Any diagnostic or therapeutic act that involves a modification of the general medical practice prior to taking out the insurance, in terms of the approach route or devices, materials or energy sources used, unless expressly included in the coverage following prior communication by the Company.**
24. **Any care prescribed and/or carried out by professionals or centres not authorised by the Company, except as established for the case of Hospitalisation due to sudden emergency.**
25. **Any care (e.g. consultation, diagnostic resources, prostheses or implant, service treatment technique) related to benefits not covered by this insurance contract.**

FOURTH: USE OF THE SERVICES

1. General

The Insured, to whom the exercise of the rights included in this contract corresponds, must identify himself when requesting the insured health services included in the Second General Condition using his ASISA health card and any other document identifying him, e.g. ID card (DNI), passport or driving licence. This health card is personal and non-transferable; improper or fraudulent use of it will give rise to the exercise by ASISA of the corresponding legal action.

The care costs covered by this contract will be paid directly by ASISA to the professionals and authorised centres that have provided the service, so the insured will not have to make any payment.

ASISA will not be responsible for the cost of any service that has not been prescribed or performed by professionals from the Medical Panel or in centres or services authorised by it.

For diagnostic resources, special treatment techniques, hospitalisation, outpatient surgery or other services requiring a prescription, **this will be provided by an appropriate medical specialist on the Company's List of Doctors. When indicated, this prescription must be expressly authorised by ASISA beforehand through any of the different channels established for this purpose, in accordance with the instructions provided by the Company in this regard at all times. For services carried out on an**

urgent basis that require authorisation from the Company, this will be obtained within 7 days of them taking place. The updated list of services that require authorisation can be consulted at any time on the Company's website (www.asisa.es) and on other available information platforms (e.g. app, telephone, branch office).

If express authorisation is required from the Company to be entitled to the corresponding provision (e.g. diagnostic resources, special treatment techniques, hospitalisation, outpatient surgery or other detailed services), in accordance with the provisions of the Second General Condition, the document issued for this purpose will be invalid if, at the time the insured receives the assistance or authorised service, not all the requirements have been met to be entitled to the coverage for the care specified in that authorisation document, as established in these General Conditions, (e.g. if the premium or co-payment has not been paid, or the Health Questionnaire contains inaccurate or incomplete declarations).

Given the changes that may occur in the Company's Medical Panel/List of Doctors, the insured should take the necessary action before the request and provision of services covered by the insurance to ensure that the professional or centre is authorised by ASISA to provide the health services covered. The Medical Panel listed on the Company's website (www.asisa.es), app or via the different information channels the Company makes available to the insured can be consulted for these purposes.

When the insured has to travel to another national province, he should contact an ASISA centre or office, or that of a collaborating Company in a province where the Company has no Provincial Centre, to find out the authorised Medical Panel that can provide the treatment in accordance with this contract. This information is also available on the ASISA website(www.asisa.es) and other information channels the Company makes available.

If the insured travels to another province to receive care, whether by personal preference or because the care is not available in the province of his registration, he will always have to pay for the expenses involved; **in no case will they be assumed by ASISA**.

2. Participation of the Insured in the cost of services (Co-payment)

Unless otherwise specified in the Particular Conditions, the insured's participation in the cost of the services, or Co-payment, is agreed for each consultation, session, treatment or health service covered by the Company that is used, as established in the Particular and/or special Conditions. The amount of the co-payment may be updated at each contract renewal, as communicated by the Company.

3. Free choice of doctor

For the provision of the contracted care, the general principle of freedom to choose a doctor from among those listed in the Company's Medical Panel applies, except for certain specialities that may have a single service provider. The Insured will contact the chosen doctor directly, except for cases with additional requirements, in accordance with the clauses of this contract.

4. Waiting Periods

Some of the benefits covered by this insurance have a certain waiting period established, during which time they are not covered; this is calculated from the start date of the contract or from when a new insured is included.

FIFTH: INSURANCE CONTRACT DURATION

The insurance is stipulated for the period of time provided in the Particular Conditions of this insurance contract. Upon expiry or termination, it will be extended for periods not exceeding one year, in accordance with article 22 of the Insurance Contract Law. **However, either party may refuse the extension by advance written notification to the other. This notification period is at least one month before the end of the current insurance period for the policyholder, and at least two months for the insurer.** The insurer must notify the Policyholder at least two months before the end of the current contractual period of any modification to the insurance contract.

If Asisa decides not to extend the insurance contract for the following contractual period, as provided for in the preceding paragraph, if the insured is hospitalised at the time the contractual relationship ends, the Company will be obliged to assume coverage for this admission until discharged from hospital, unless the Insured refuses to continue the treatment.

If the insurance contract is terminated by the Policyholder or insured, the coverage will cease on the expiry or termination date established in the Particular Conditions, without the provisions of the previous paragraph being applicable. Thus, if the Insured is receiving any type of insured benefit at the time of expiry or termination of the contract, Asisa's insured coverage will cease on that date without it being obliged to assume any cost from that date, including even if it is derived from a claim that occurred during the term of the insurance, unless the termination of the policy is motivated by gross negligence or fraud by the insured.

SIXTH: PREMIUMS (INSURANCE COST)

The Policyholder is obliged to pay the Premium or insurance cost as provided in the Particular Conditions, in accordance with article 14 of the Insurance Contract Law. The premium the Policyholder is obliged to pay is annual, but can be paid in instalments by agreement. Unless otherwise specified in the Particular Conditions, the premium will be paid by direct debit by the Policyholder.

All existing taxes, surcharges and fees and others that may be established for insurance contracts in the future, are to be paid by the Policyholder when legally attributable.

The first Premium or fraction thereof will be payable at the signing of the contract, in accordance with the provisions of article 14 of the Insurance Contract Law. If it is not paid due to the fault of the Policyholder, the Insurer has the right to terminate the contract or demand payment by enforcement based on the contract. If it is not paid before any claim is made, the Insurer will be released from its obligation (Article 15 of the Insurance Contract Law).

If a second or any successive Premium or fractions thereof is not paid, the Insurer's coverage will be suspended for one month after the due date, with ASISA reserving the right to terminate the contract. If the insurer has not terminated the contract or claimed the premium or fraction thereof within six months following non-payment, the contract will be understood to be terminated. If the contract has not been terminated in accordance with the above conditions, the coverage will be effective again, non-retroactively, 24 hours from the day the Policyholder pays the premium. When the contract is suspended, the Insurer can demand payment of the Premium for the current Insurance Period only.

Splitting the premium payment does not release the Policyholder from the obligation to pay the entire annual premium. He will lose the right to split the Premium as agreed if any fraction is not paid, with the total Premium agreed for the remaining Insurance period being due from that moment on.

The Insurer and Policyholder are bound only by the receipts issued by the management or their legally authorised representatives.

If the Contract is terminated early by the Policyholder, the part of the annual premium not paid will be owed to the Insurer, as the premium is a single payment for the contractual period, regardless of whether its payment is allowed to be split.

The premium for each insured is calculated on the risk factors detailed below: age of the insured on December 31 of the expiring insurance period and geographic area of the insured's address in the contract. Through this document, the policyholder expresses his agreement with any modifications to the premium amount for this reason. The Insurance Company may take into consideration changes in healthcare costs, morbidity, the incorporation of new benefits or technological innovations when updating the premium. The premiums to be paid may also vary depending on other personal circumstances of the insured.

The premium is reviewed in accordance with the provisions of article 94.1 of the Law of Regulation, Supervision and Solvency of Insurance and Reinsurance Entities, which provides that premium rates must be substantiated on technical bases and statistical information prepared in accordance with the provisions of this Law and its implementing regulations. They must be sufficient to allow the insurance company to satisfy all obligations derived from the insurance contracts and, in particular, to establish the appropriate technical provisions, according to reasonable actuarial assumptions.

ASISA will provide a written communication of the change in the premium and co-payment amounts for the following annuity two months before the renewal of the insurance contract.

Once the aforementioned communication has been received, the policyholder may make use of the right established in the FIFTH Clause.

The Policyholder will be understood to have accepted the new contract conditions with the payment of the first Premium for the new extension period.

CO-PAYMENTS: Unless otherwise agreed in the Particular Conditions of the insurance, the contracting parties agree to the insured's participation in the cost of the services he uses. This participation will be a single co-payment for each consultation, session, treatment or service used by the insured, **whose amount may be changed annually by the Company at each contract renewal after informing the Policyholder of it.**

Co-payments will be made by the Company in the account designated by the Policyholder for the payment of the premium, although, exceptionally, payment may be made by the insured at the direct debit facility provided by the latter for such purposes.

The Company will provide a periodic summary of the amount of the co-payments corresponding to the services used.

The provisions of this SIXTH Clause for non-payment of the second and successive premiums or fractions thereof will be applicable also if co-payments are not made, with the policyholder being responsible for these at all times; even if it has been agreed that these will be paid by the insured. Therefore, if the co-payment has not

been paid by the insured, the policyholder assumes the commitment to pay these. As such, it authorises ASISA to request their payment by the direct debit designated at any time for the payment of the premium, as well as exercise any legal actions corresponding to it due to the obligations to pay the premium and co-payments.

SEVENTH: OBLIGATIONS AND DUTIES OF THE POLICYHOLDER AND/OR INSURED

The Policyholder and, where appropriate, the Insured have the following obligations:

a) Declare all known circumstances that may influence the assessment of the risk to be insured by ASISA, by following the Questionnaire submitted, before the signing of the contract. He will be exonerated from this if ASISA does not submit the Questionnaire or when, even if it is submitted, there are circumstances that may influence the risk assessment that are not included in it. The information provided by the Policyholder/Insured must be truthful and complete, as it constitutes the basis for the acceptance of the risk of this contract, of which the Questionnaire is part.

b) Inform the Insurer of a change in the address or email address specified in the contract, both for the policyholder and the insured, as well as other information provided to the Company for communication purposes, within eight days of it occurring. To maintain the right to care, the new address must be within the healthcare scope of the insurance company.

c) Minimise the consequences of a claim, by using the available resources for a prompt recovery. Failure to comply with this duty with the manifest intention of harming or deceiving the Insurer, will release the latter from all benefits derived from the claim.

d) Provide the Insurer with all the information it requires to exercise the right of subrogation, provided for in articles 43 and 82 of the Insurance Contract Law, in the rights and actions that, due to the care provided and up to the limit of its amount, may correspond to the Insured vis-à-vis persons responsible for the illness or injury, or regarding the persons or entities that legally or by regulation must satisfy these healthcare expenses.

e) The Insured has the obligation to provide Asisa with the medical reports and/or estimates to determine whether the required care provision is covered by this contract, in those cases where it is expressly required. Asisa will not have to guarantee the requested benefit if the aforementioned reports and estimates are not provided in cases where this has been expressly required of the Insured. The insurer may reclaim the cost of coverage of any benefit from the Insured which it should not have assumed, once the information provided by the Insured is known.

f) Inform the Insurer of the loss, theft or deterioration of the card as soon as possible, so it can issue and send a new card to the address of the insured in the contract and cancel the previous one. The Policyholder or Insured must return the card corresponding to the insured to ASISA when the contract is terminated.

EIGHTH: POWERS OF THE POLICYHOLDER AND/OR INSURED

a) The Policyholder may request the Insurer to rectify any discrepancies between the contract and the proposed insurance or the agreed clauses within one month of

delivery of the contract, as provided in article 8 of the Insurance Contract Law. After this period has elapsed without any request being made, the provisions of the contract will apply.

b) Registration of the newborn as an ASISA insured party may be requested, with no waiting periods applicable in each case and without assessment of the Health Questionnaire, provided the delivery or caesarean section was covered by ASISA and the request is made within the 30 days of the birth date. For registrations requested outside the aforementioned period, as well as for those born in deliveries or caesarean sections not covered by the Company, a Health Questionnaire will be required, with an assessment of the risk and the possibility of not accepting the contract, and application of the established waiting periods in the General Conditions applicable for each insurance.

c) If the Policyholder inaccurately declared the date of birth of the insured when requesting the Insurance, the Company may terminate the contract only if the true age exceeds the established admission limits of the Insurer on the date the contract starts. If it does not exceed the aforementioned limits, the Company is empowered to regularise the difference between the amount actually paid by the Policyholder and the amount it should have paid if it had declared the correct age of the insured at the time of contracting.

d) When the insurance contract is entered into using a distance contracting technique, the Policyholder may terminate it unilaterally by means of a written communication to the Company, without indicating the reasons and without penalty, if the claim covered has not occurred within 14 days of signing the contract, or the Policyholder has not received the contractual conditions and mandatory prior information before the signing of the contract.

NINTH: POWERS OF THE INSURER

a) When ASISA becomes aware of incomplete or inaccurate information provided by the Policyholder/Insured in the Health Questionnaire, it may terminate the contract by writing to the Policyholder within a month of when this becomes known.

b) If a claim occurs before the Insurer can send the communication referred to in the previous paragraph, its benefit will be reduced proportionally by the difference between the agreed Premium and the one that would have applied if the true risk had been known by the Company. If the Insured was grossly negligent or committed fraud, the Insurer will be released from having to pay the benefit.

TENTH: LOSS OF RIGHTS, INDISPUTABILITY AND NULLITY OF THE CONTRACT

1. The Insured will lose the right to the guaranteed benefit if the following occurs:

   a) Incomplete or inaccurate information is provided by the Policyholder or, where appropriate, the Insured, when declaring the risk by completing the health questionnaire before signing the contract, and gross negligence or fraud was involved (Article 10 of the Insurance Contract Law).

   b) The guaranteed event occurs before the first Premium payment has been made, unless otherwise agreed (article 15 of the Insurance Contract Law).

c) The claim was caused by bad faith of the Insured (article 19 of the Insurance Contract Law).

2. If prior recognition has been practised or full rights recognised, the contract will be indisputable as regards the state of health of the Insured, and the Insurance Company cannot deny any benefits alleging the existence of previous illnesses, unless any express exception is made in the Policy particular conditions as a consequence of this recognition; or the Insured completed the health questionnaire with incomplete or inaccurate information acting fraudulently or with gross negligence.

   If no medical examination was made or full rights have been recognised, the contract will be indisputable after one year from the conclusion of the contract, unless the Policyholder or the Insured acted fraudulently when completing the health questionnaire.

3. The insurance contract will be void if the Claim had already occurred at the time of its conclusion, except in the cases provided by the Insurance Contract Law.

ELEVENTH: COMMUNICATIONS

Communications to the Insurance Company by the Policyholder or Insured will be made at the registered office of the company indicated in the contract. Communications made by an insurance broker to the insurer on behalf of the policyholder will have the same effect as if made by the policyholder himself, unless otherwise indicated by the latter.

Communications from the Insurance Company to the Policyholder or the Insured may be made by post, email or any other means of instant messaging provided by the policyholder at the time of making the insurance request, providing no change to this is made. The Policyholder may object to sending emails to the following addresses: DPO@grupoasisa.com

For the purposes of this insurance, a claim is understood to be made when the Insured requests the provision of the service.

TWELFTH: CLAIMS AND EXPIRY

Policyholders, Insured parties, beneficiaries, injured third parties or their beneficiaries may file claims internally at the Asisa Provincial Office, using a claim form made available to them at the Insurance Company offices.

Without prejudice to any other channel that may be competent, the persons indicated in the preceding paragraph may file a claim with the ASISA GROUP CUSTOMER SERVICE, Calle Juan Ignacio Luca de Tena 12, 28027 MADRID, sac@asisa.es, in accordance with the provisions of the applicable regulations, Order ECO/734/2004, March 11, for which a claim form is available at the Insurance Company offices or the Company's website (www.asisa.es). The foregoing is a prerequisite for the formulation of any complaint or claim made to the Claims Service/General Directorate of Insurance and Pension Funds (Article 97, Law on the Regulation, Supervision and Solvency of Insurance and Reinsurance Entities).

ASISA is not a member of any Consumer Arbitration Board. Any conflicts that may arise between the Insurance Company and Policyholders, Insured parties, beneficiar-

ies, injured third parties or right holders of any of these will be resolved by the competent judges and courts. (Article 97 of the Law on the Regulation, Supervision and Solvency of Insurance and Reinsurance Entities).

For the purposes of this insurance contract, regardless of previous legal recourse, the competent court for hearing the actions derived from it will be that applicable at the Insured's address; however, if this is abroad, he will have to designate an address in Spain for such purposes.

The actions derived from this insurance contract will expire after five years (Article 23, Insurance Contract Law).

THIRTEENTH: SCOPE OF INSURANCE

The guarantees of this insurance extend to the entire national territory, except as established for Travel Assistance coverage (Annex IV).

FOURTEENTH: PERSONAL DATA PROTECTION

1. Personal data controller and processor

The data controller is ASISA ASISTENCIA SANITARIA INTERPROVINCIAL DE SEGUROS, S.A.U. (hereinafter, ASISA), with tax number (C.I.F.) A08169294 and registered office at Calle Juan Ignacio Luca de Tena, 12, 28027, Madrid.

ASISA has formally appointed a Data Protection Officer as data processor, with the following email address: DPO@grupoasisa.com

2. Personal data processing.

The data processed are personal identification data, employment data, personal features, social circumstances, socioeconomic data and health data provided at the insurance application, and during the term of the contract, as well as data found from accessing existing files from public or private sources whenever there is a legitimate interest and/or a need to comply with a legal obligation.

The Policyholder guarantee that all the information provided, including that relating to the insured, is true, with no information about the health status of any of the Insured parties being omitted. When providing data related to other natural persons, they must first be informed of the reason for providing their data contained in this clause and consent to their inclusion.

3. Personal data processing purpose

The data are processed to attend to, manage and execute the insurance contract, and to provide the services directly or indirectly related to its maintenance.

Additionally, ASISA is protected by its legitimate interest to:

- Assess, select and price the risks associated with the insurance requested; for example, by evaluating financial solvency, carrying out statistical, quality or technical analysis studies, as well as preventing fraud in contracting the insurance.
- Send commercial information adapted to the interests of the insured, including electronically, as well as conducting opinion surveys. In this case, the only information sent will be that related to the Company's own products and/or services similar

to those the insured has contracted to improve the degree of customer satisfaction. If the insured does not wish to receive advertising by electronic means, he may contact the address DPO@grupoasisa.com.

- Transfer the insured's personal data within the business group for internal administrative purposes.
- Keep the insured's personal data once the insurance contract has been terminated as a result of the reservation or inaccuracy of the information provided or due to non-payment of premiums to detect, prevent, remedy and impede fraudulent conduct or conduct that poses a risk to ASISA.
- If payment is not made within the term provided for and the requirements established in the current regulations are met, communicate the data relating to non-payment to credit information systems relating to non-compliance with monetary, financial or credit obligations.

Other purposes of the data processing are related to compliance with legal obligations, as follows:

- Conduct the statistical-actuarial analysis to determine the associated risk and to price the policies of customers and potential customers either in the insurance application process or during the term of the contract to respond to any new circumstances of the Insured or to change the actuarial base.
- Comply with the obligations established in the current regulations relating to insurance, tax laws and the protection of personal data.

In addition, the consent of the insured person will allow ASISA to process their data in order to:

- Send personalised offers of products and services from the companies in the ASISA Group and its Collaborators. The identity of these companies can be checked on the website https://www.grupoasisa.com/.
- Share personal data with the ASISA Group companies and collaborating entities so that they can offer commercial information regarding their own products and services. The identity of these companies can be checked on the website https://www.grupoasisa.com/.

The lack of authorisation of data processing for the above purposes will not affect the maintenance or fulfilment of the contractual relationship.

4. Personal data processing legitimacy.

The basis for processing the insured's personal data is:

- Execution of the contract for the provision of healthcare to the insured by ASISA, based on the provisions of the insurance contract binding it to the insured.
- Compliance with the legal obligations established in the current regulations relating to insurance, tax laws and the protection of personal data.
- Sending personalised offers and promotions, to prevent fraudulent conduct and that of risk for ASISA with respect to customers and former customers, as well as for internal administrative purposes.
- In your consent to communicate data to other companies from which you will receive personalised offers and promotions advertising products and services from third-party companies.

5. Personal data processing recipients

The personal data processed by ASISA for the purposes detailed above may be communicated to the following recipients, depending on the legitimising basis of the communication.

- General Directorate of Insurance, Organisations and Public Administrations.
- Reinsurance or Coinsurance Companies to hold, process or manage the benefits contained in this Policy, where appropriate.
- Doctors, medical centres, hospitals and other institutions or persons identified as health service providers in the Authorised List of Doctors prepared by ASISA which can be consulted on its website www.asisa.es.
- Financial entities for the management of collections and payments.
- Spanish Union of Insurance and Reinsurance Entities (UNESPA) for the inclusion of your personal data, if deemed necessary, in its common fraud prevention file.
- Entities that own information services files on financial solvency and credit, both for consultation in the legally established cases and after non-compliance with monetary obligations.
- In those cases in which the insured person has given his consent in accordance with the purposes indicated, ASISA will share his information with the Group companies and collaborating entities so they can offer him commercial information in relation to their own products and services. The identity of these companies can be checked on the website https://www.grupoasisa.com/.

6. Personal data retention period

Personal data will be kept during the term of the contract and, subsequently, according to the applicable legal periods for each specific case, depending on the type of data and purpose of the processing, unless the insured exercises his right of deletion.

Once the aforementioned period has expired, ASISA undertakes to cease processing all personal data and freeze them properly. However, personal data may be kept for longer periods when necessary, provided they are processed exclusively for the purpose of preventing, remedying or impeding fraudulent behaviour or risk for ASISA.

These periods are specified in the ASISA Data Conservation Policy on the website www.asisa.es, as well as in other locations visible to the data owner.

7. Personal data processing rights.

The insured has the right to access his personal data and obtain information on they are being processed. They also have the right to request the rectification of incorrect or inaccurate data and, where appropriate, request their deletion when the data are no longer necessary for the purposes they were collected for by ASISA, among other reasons.

In certain circumstances, the insured may request the limitation of their data processing, in which case ASISA will keep them only for the exercise of or defence against possible claims.

The insured may also object to the processing of their personal data in certain circumstances for the purpose reported by ASISA. In this case, ASISA will cease processing personal data, unless there are legitimate reasons to do so or to guarantee the exercise of or defence against possible claims.

Finally, the insured may request the right to portability and obtain certain information derived from the contractual relationship entered into with ASISA for himself or for another service provider.

These rights may be exercised by:

- Letter addressed to ASISA, ASISTENCIA SANITARIA INTERPROVINCIAL DE SEGUROS, S.A.U., Calle Juan Ignacio Luca de Tena Nº 12, 28027, Madrid.
- Via communication addressed to the email address DPO@grupoasisa.com

In both cases, the person exercising these rights will be required to prove his identity by sending a copy of both sides of his ID no (DNI), tax no (NIE), Passport or equivalent document.

ASISA will provide the requested information within one month of receipt of the request. This period may be extended for another two months if necessary, depending on the complexity and number of requests.

The insured may withdraw consent at any time, if it has been granted for a specific purpose, without affecting the legality of the processing based on the consent before this withdrawal.

The insured may file a claim with the competent Control Authority in matters of data protection. However, in the first instance, he should file a claim with the Data Protection Officer, who will review it within two months.

FIFTEENTH: DISCLAIMER OF LIABILITY

The Company makes available professionals, centres and health services, duly authorised in accordance with current regulations, to the insured who has the right of freedom of choice of doctor and centre. These professionals, centres and health services enjoy full autonomy, independence and responsibility in the provision of health care. Therefore, **the Company will not respond in any case directly, jointly or alternatively, in relation to any acts and/or omissions of the aforementioned professionals and centres in the exercise of their professional business, over which it exercises no control; as they are subject to professional secrecy due to the confidentiality of their health information.**

ANNEX I

COVERAGE FOR PET/PET-CT: FLUDESOXYGLUCOSE (FDG) INDICATIONS

a) ONCOLOGICAL Diagnosis:

Characterisation of solitary pulmonary nodule.

Detection of tumour of unknown origin evidenced, for example, by cervical adenopathy, liver or bone metastases.

Characterisation of pancreatic mass.

Staging:

Head and neck tumours, including assisted guided biopsy.

Primary lung cancer.

Locally advanced breast cancer.

Oesophagus cancer.

Pancreatic carcinoma.

Colorectal cancer, especially recurrent.

Malignant lymphoma

Malignant melanoma, with Breslow > 1.5 mm or lymph node metastases at initial diagnosis.

Monitoring of treatment response:

Malignant lymphoma

Head and neck tumours.

Detection if there is reasonable suspicion of recurrence:

Gliomas with a high degree of malignancy (grades III or IV).

Head and neck tumours.

Thyroid cancer (non-medullary): patients with increased serum thyroglobulin levels and negative radioactive iodine body scan.

Primary lung cancer.

Breast cancer.

Pancreatic carcinoma.

Colorectal cancer.

Ovarian cancer.

Malignant lymphoma.

Malignant melanoma.

b) CARDIAC

Evaluation of myocardial viability in patients with severe left ventricular failure who are candidates for revascularisation, only when conventional imaging techniques are inconclusive.

c) NEUROLOGICAL

Location of epileptogenic foci in the pre-surgical evaluation of temporal partial epilepsy.

ANNEX II

SECOND MEDICAL OPINION AND CONSULTATION WITH INTERNATIONAL EXPERTS

The insured or the Company specialist attending him may request a SECOND medical OPINION regarding both the diagnosis and the treatment of any of the processes or serious diseases listed below:

1. Oncology.
2. Heart disease, including heart surgery and angioplasty.
3. Organ transplants.
4. Neurological and neurosurgical diseases, including strokes.
5. Complex orthopaedic surgery.
6. Syndromes and congenital malformations.
7. Degenerative and demyelinating diseases of the nervous system.
8. Diseases and problems due to kidney failure.

The service may also be requested for diseases other than those listed, including diseases considered rare or complex pathologies, **provided that the applicant provides sufficient medical information (diagnosis and treatment) to be able to submit to renowned experts.**

To use the Second Opinion service, the insured must call 91 075 71 95, where they will indicate the documentation (medical tests and reports) related to the first established diagnosis to be sent to the address provided, along with the questionnaire to be completed for this purpose.

Experts of recognised international prestige in the disease in question will assess the established diagnosis and treatment and issue the appropriate report within five working days of receipt of all the necessary documentation.

This report will be based at all times on the patient's medical history and the corresponding first diagnosis made by the doctors who attended him.

Consultations, tests and/or treatments not carried out in accordance with healthcare insurance rules and coverage are not covered by the Company.

The insured who meets the above criteria will also have the following services available by calling the aforementioned telephone number:

a) MEDICAL GUIDANCE

The insured can use this service 24 hours a day to ask medical questions by consultation with doctors. If the insured has managed a Second Medical Opinion, he will have an assigned doctor at his disposal to comment on the evolution of his case by telephone and resolve any doubts that may arise.

The objective of this service is to provide additional medical care and resolve doubts, and will never replace the normal doctor.

b) PSYCHOLOGICAL AND EMOTIONAL HELP FOR PATIENTS WITH SERIOUS ILLNESS

In relation to the serious illnesses listed in the previous section, the insured will have the possibility of requesting psychological telephone support related to his illness or state of health. This service will consist of arranging a conference with a psychologist, who will advise, guide and provide emotional support to overcome adversity.

The service will consist of a maximum of 5 telephone sessions.

ANNEX III

PREVENTIVE MEDICINE

Programmes are incorporated in the specialities listed below that include consultation with a specialist doctor as well as the necessary diagnostic tests, for example, whenever deemed necessary by the doctor (**in any case, both the consultations and the tests for the corresponding diagnoses according to the different programmes will be carried out by Company Medical Panel doctors and centres**).

Paediatrics: This covers newborn health examinations (including detection of metabolic diseases as well as early detection of hearing loss by means of otoacoustic emissions or auditory evoked potentials, if necessary) and periodic health examinations to monitor child development (from birth to 11 years of age).

Gynaecology: Annual gynaecological examination for the prevention of cervical, endometrial and breast cancer. It includes consultation, examination and diagnostic tests (e.g., mammography, cytology or gynaecological ultrasound) the ASISA Medical Panel gynaecologist indicates for the patient.

- A mammogram is recommended every 2 years in women over 50 years of age for the prevention of breast cancer (the Gynaecologist, however, will indicate to the insured how often this examination should be performed in a particular case).
- A cervical screening or pap smear test is recommended in women from 25 to 65 years of age for the prevention of cervical cancer. At first, annually, then every 3-5 years, according to the guidelines recommended by Scientific Societies. Depending on the particular features, the gynaecologist from the ASISA Medical Panel may indicate a different frequency for the examination. These recommendations do not apply to women who have not had sexual intercourse or who have undergone a total hysterectomy.

Cardiology: Prevention of coronary risk in people over 45 years of age or patients with cardiovascular risk factors (e.g. hypertension or dyslipidaemia). It includes consultation and examination by specialist doctors, as well as the necessary examinations (e.g. ECG, basic blood and urine analysis, stress test), according to the ASISA Medical Panel cardiology specialist recommendations.

The recommended frequency for these examinations varies with age and whether or not there are coronary risk factors, so the ASISA Medical Panel Cardiology specialist will determine the appropriate frequency for a particular case.

Urology: Early diagnosis of prostate cancer in men aged 50 years and older (or earlier if there are known risk factors).

This includes a medical consultation and blood tests (including determination of Prostate Specific Antigen, PSA), urine and other tests the specialist deems appropriate (e.g. ultrasound and/or prostate biopsy). In general, an annual exam is recommended starting at age 50; however, the urology specialist from the ASISA Medical Panel will indicate the frequency and precise examinations in a particular case.

Digestive system: Prevention of colorectal cancer in people at risk (family or personal history). This includes a consultation and physical examination, as well as diagnostic tests (e.g. faecal occult blood test or colonoscopy) that the specialist deems necessary in a particular case.

ANNEX IV

TRAVEL ASSISTANCE

The insured, with residence in Spain, will have the right to this coverage with the following conditions and limits:

INSURED

The natural person residing in Spain with Asisa health care insurance.

FAMILY

Spouse or common-law partner duly registered in the corresponding Official Registry, parents, mother-in-law, father-in-law, children, grandparents, brothers, grandchildren, sons-in-law, daughters-in-law and brothers-in-law of the Insured.

ACCIDENT

A bodily injury or material damage suffered during the term of the contract, due to a violent, sudden, external cause beyond the intention of the Insured.

Regarding vehicles, an accident will be considered a violent, sudden, external and involuntary event that causes damage to the vehicle included in the coverage.

UNEXPECTED ILLNESS

Any alteration in the health status of an individual that occurs during the course of a trip covered by the insurance contract, whose diagnosis and confirmation is made by a legally recognised doctor or dentist, and which requires medical assistance. **Unless expressly agreed otherwise, only care derived from an unexpected illness is covered by this contract.**

SERIOUS ILLNESS

Any unexpected alteration in the health status of an individual involving hospitalisation which makes it impossible for the Insured to start the trip, prevents its continuation on the scheduled date or entails the risk of death.

TERRITORIAL SCOPE

Assistance will be valid worldwide, **except for Iran, North Korea, Syria, Crimea and Venezuela.**

In addition, all countries in a state of war, rebellion or with violent conflicts of any kind or nature, even when not officially declared, are excluded.

Assistance will be valid from 35 km from the insured's habitual residence, except for the Balearic Islands, Canary Islands, Ceuta and Melilla, where it is 15 km.

TEMPORARY SCOPE

The defined benefits will be valid **as long as the insured is on a trip or journey away from his habitual residence for no more than 90 consecutive days.** The limitation on the duration of the journey will not apply when it is inside Spanish territory.

COVERED BENEFITS

1. Medical expenses abroad

If the Insured suffers an illness or accident during the course of a trip abroad, the insurer guarantees **a maximum of €14,000 per insured person and journey** during the term of the Contract for the following expenses:

- Designated medical fees as chosen by the insured.
- Medicines prescribed by a doctor or surgeon.
- Hospital expenses.
- Ambulance expenses ordered by a doctor for a local journey.

For such expenses to be liable for reimbursement, the corresponding original invoice must be submitted, which must be accompanied by the complete medical report, history, diagnosis and treatment to establish the nature of the disease.

All dental expenses are limited to €120 per person per trip.

2. Extension of hotel stay due to illness or an accident

When the nature of the illness or accident does not require admission to a clinic or hospital centre, the insurer will pay the expenses incurred by extending a stay in a hotel, as prescribed by a doctor, **up to €60 per day per sick or injured person**.

3. Medical transfer of the sick and injured

If the Insured suffers an illness or accident during the term of the Contract as a consequence of travelling from his habitual residence, the insurer will organise the necessary contacts between its medical service and the doctors attending to **the Insured as soon as it is notified**.

When the insurer's medical service orders the transfer of the Beneficiary to a better equipped or specialised hospital centre near his habitual residence in Spain, it will take responsibility for this transfer under medical observation and carry it out as follows according to its severity:

- Special medical plane
- Medical helicopter
- Scheduled flight
- First class sleeper
- Ambulance.

When the insured who is transferred or repatriated due to illness or accident is under 18 years of age, another person will accompany him at the expense of the insurer.

If the insured wishes to continue his journey after his recovery, and his state of health allows, the insurer will take responsibility for organising the transfer to his destination, **provided the cost of this journey is no higher than the return to his usual address. However, the expenses derived from the pathology suffered by the beneficiary will not be covered if he makes the decision to continue to his destination.**

4. Return of the insured following the death of a family member

If the spouse, common-law partner, parent, mother-in-law, father-in-law, child, grandparent, brother, grandchild, son-in-law, daughter-in-law, brother-in-law or sibling of the Insured dies in Spain while the Insured is on a journey covered by this contract, the insurer, after being notified of the event, will organise his return to attend the funeral and burial place in Spain via a return ticket by scheduled flight, economy class; by train, first class; or with two return tickets when returning with a companion registered in the particular conditions.

5. Transport of mortal remains

If the Insured dies during a trip covered by this contract, the insurer will organise and take responsibility for organising the transportation of the mortal remains to the place of burial in Spain in the municipal area of his habitual residence, as well as pay for the costs of embalming, a mandatory minimum casket and administrative formalities. **In no case will this coverage extend to funeral and burial expenses.**

If the deceased was accompanied by a person (or persons) who is a minor or disabled, the insurer will pay the transportation costs for a relative to travel to meet this person and accompany him on his return.

6. Accompaniment of mortal remains.

If there is no one to accompany the mortal remains of the deceased Insured during his transfer, the insurer will provide a return train ticket (first class) or plane ticket (economy class) from Spain for the person designated by his heirs, to accompany the body to the burial site.

After submission of the corresponding invoices, the insurer will pay the costs of the companion's hotel accommodation **up to €90 per day for a maximum of 3 days**.

7. Travel assistance for a relative

If the insured has to be hospitalised for more than 5 days during a trip, or 3 days in the case of minors or the disabled, **and he is not accompanied by any direct family member**, the insurer will provide a return ticket for a scheduled flight (economy class) or train (first class) for a member of the family or a person designated by it, with habitual residence in Spain, to accompany the Insured.

If the Insured's hospitalisation occurs during a trip away from his habitual residence, the insurer will pay for the cost of the hotel accommodation, **upon submission of the corresponding invoices, for up to €60 per day for a maximum of 10 days.**

8. Early return of a companion following the death or medical transfer of the sick or injured person.

When the Insured has been transferred due to an Unexpected Illness or Accident in application of the "Medical transfer of sick and injured" benefit, or due to death, and this circumstance prevents the Insured's companion from returning to his home by the means initially planned, the insurer will take responsibility for the expenses corresponding to the transport of the companion to his Habitual Residence or to the place where the transferred Insured is hospitalised, by means of a ticket for a scheduled flight (economy class) or train (first class).

9. Accompaniment of minors and the disabled

If the insured is travelling with minors or disabled people and is unable to take care of them due to an illness or accident covered by the insurance contract, or they are repatriated by the insurer, the latter will organise and take responsibility for providing return travel arrangements for a person residing in Spain, designated by the insured or their family, or a hostess of the insurance company, to accompany the minors or disabled people on their return to their habitual residence in Spain in the shortest possible time.

10. Medication delivery

If the Insured needs medication that cannot be acquired in the place where he is, the

insurer will obtain this and send it to him by the fastest means possible, subject to local legislation.

This will not apply if the drug is no longer manufactured or is unavailable in distribution channels in Spain.

The Insured will have to reimburse the insurer for the cost of the medicine, upon submission of the invoice.

11. Searching and finding luggage

If the insured's luggage is delayed or lost, the insurer will assist him in his search and advise him on how to file any corresponding complaint. If the luggage is found, the insurer will send it to the insured's habitual residence in Spain or his accommodation during the trip, if this can be accessed, when the presence of the owner is not necessary for its recovery, in which case the necessary assistance and collaboration will be given.

12. Sending urgent messages

The insurer will receive and send urgent messages from and to the Insured via a 24-hour service, **provided there is no other method for him to reach his destination.**

13. Civil liability

The insurance guarantees a first loss compensation of **up to €4,000** for personal and material damages and/or their consequential damages caused by the Insured to a third party which may be required for liability of a non-contractual nature, depending on the legislation in force in the corresponding country.

Professional civil liability derived from the use, operation and movement of vehicles; that derived from the use or ownership of explosives or weapons of any type or nature; and compensation as a result of financial damages not derived from prior personal or material damage is expressly excluded.

14. Information service

The insurer will provide its insured with a free, uninterrupted 24-hour service every day of the year for all kinds of tourist information, administrative formalities, medical precautions, travel conditions and local amenities, means of transport, accommodation and restaurants; and information related to a vehicle, such as garages, petrol stations and insurance companies, for example.

15. Advance funds

The insurer will advance funds to the Insured, if necessary, **up to the limit of €9,000. The insurer will request some type of endorsement or guarantee to ensure later collection of the advance from the Insured. All amounts advanced must be returned to the insurer within 30 days.**

16. Interpreter service

The Insurer will provide the insured with a telephone translation service for major languages (English, French and German) and will facilitate contact with interpreters in the country in which they are located.

17. Telephone medical guidance

This service is to resolve doubts of a medical nature that the Insured may have about the interpretation of clinical tests and medication, for example. The insurer medical

service will advise whatever it deems appropriate, in view of the service request information, and will guide the Insured towards the healthcare environment it considers best, where necessary. **In no case will the medical guidance service diagnose or prescribe any treatment.**

For the most serious and urgent cases, the insurer may initiate the necessary health care services, prioritising emergency public services, with the expenses incurred as a result of this service being the responsibility of the Beneficiary.

This service will be provided at the request of the Insured from 9.00 am to 9.00 pm every day.

18. Probate advice.

The insurer will provide integrated management of the extrajudicial testamentary process as well as initial advice for the Insured. This includes the following services:

a. Legal advice to the insured on the granting of a will.

b. Design, drafting, preparing and, where appropriate, intervention in the act of the notarial signature.

c. Personalised attention to beneficiaries.

d. Permanent telephone legal assistance service for inheritance matters.

e. Collection of all the necessary certificates:
   - Death.
   - Birth.
   - Marriage or coexistence.
   - Civil status.
   - Last will and testament register.

f. National Social Security procedures:
   - Withdrawal
   - Death aid.
   - Spouse registration.
   - Registration of other beneficiaries.

g. Annotation of death in the Family Book.

h. Processing of widowhood and orphan pensions.

i. Advice on non-litigious inheritance processing:
   - Copy of the last will.
   - Declaration of intestate heirs.
   - Opening of the will.
   - Determination of hereditary wealth.
   - Adjudication and partition of the inheritance.

j. Processing of the payment letter.

k. Payment of inheritance tax and other tax obligations.

l. Management of the necessary registry entries.

All the above services, with the exception of those indicated in letters

(a) and (b) above, will also be provided to the Beneficiaries of the insured.

If there is a conflict of interest between the Insured parties, **the insurer will limit its services to general telephone advice to all Insured parties.**

19. Administrative procedures to obtain visas

At the request of the Insured, the Insurer will take responsibility for managing the necessary documentation to request the corresponding visa. **Consular, intermediary (if necessary) and courier fees will be the responsibility of the Insured.**

Both the documentation and the fees required vary according to the visa requested. The visa duration also varies with the country. In all cases, an application form must be filled in and the documentation submitted.

Types of visas in different countries:

- Tourism
- Business
- Studies
- Work
- Temporary journalist
- Groups
- Private trips
- Temporary residence
- Special (for exceptional reasons)
- Courtesy
- Residence
- Work and residence
- Simple: allowing only one entry
- Multiple: allowing multiple entries for 6 months. (Hashemite Kingdom, Jordan)

20. Card cancellation

The Insurer will perform the necessary procedures in the shortest possible time for the cancellation of bank and non-bank cards, issued by third parties in Spain, following theft, robbery or loss.

The Insured must personally provide the following information: ID card (DNI), card type and issuing company.

The corresponding claim must be submitted to the competent authorities in all cases.

21. Mobile phone blocking

If the Insured reports the theft or loss of his mobile phone, the Insurer will inform the corresponding operator of this and request the line is blocked.

In no case will the Insurer **be responsible for any improper use.**

22. Communication expenses

Reimbursement of expenses, **up to a limit of €100,** for telephone calls, faxes or similar procedures to communicate and process claims. **To make this reimbursement effective, the insured must send the original invoices or copies of them, proof of payment with the details of the expenses included in these documents.**

EXCLUSIONS

Generally, those benefits that have not been communicated to the insurer beforehand and those for which the corresponding authorisation has not been obtained are excluded, except in cases of duly accredited material impossibility; they are, however, subject to the exclusions listed below:

1. Previous or chronic illnesses, injuries or ailments suffered by the insured before signing the Healthcare Insurance Contract, or its renewal or extension, as well as those that appear during its term and before the start of a trip, except for the first emergency assistance or until the adjustment of the insured.

2. Mental illness.

3. Medical check-ups of a preventive nature (check-ups, thermal cures and cosmetic surgery).

4. Cases in which the purpose of the trip is to receive medical treatment or surgery abroad.

5. Diagnosis, monitoring and treatment of pregnancy, voluntary termination and deliveries, except in the case of urgent care, and that occurring during the first 150 days of gestation.

6. The insured's participation in bets, challenges or fights.

7. Practising sports in competitions or motorised competitions (races or rallies), as well as the practice of dangerous or risky activities such as:

- **Boxing, weightlifting, wrestling (in its different classes), martial arts, mountaineering with access to glaciers, sledding, diving with breathing apparatus, caving and skiing with trampoline jumps.**
- **Air sports in general.**
- **Adventure sports, such as rafting, bungee jumping, hydrospeed and canyoning.**

8. Suicide, attempted suicide or self-harm of the insured. 9. Rescue of people in mountains, chasms, at sea or in the desert.

10. Illnesses or accidents following the consumption of alcoholic beverages, narcotics, drugs or medicines, unless the latter have been prescribed by a doctor.

11. Fraudulent acts by the Policyholder, insured or their heirs.

12. Epidemics and/or infectious diseases of sudden appearance and rapid spread in the population, as well as those caused by pollution and/or atmospheric contamination.

13. Wars, demonstrations, rebellions, tumultuous popular movements, acts of terrorism, sabotage and strikes, whether or not they are officially declared. The transmutation of the nucleus of the atom, as well as the radiation caused by the artificial acceleration of atomic particles. Earthquakes, floods, volcanic eruptions and, in general, those that come from the unleashing of the forces of nature. Any other extraordinary catastrophic phenomenon or event classified as a catastrophe or calamity, due to its magnitude or severity.

Regardless of the foregoing, the following situations are particularly excluded:

1. The medical transfer of the sick or injured caused by conditions or injuries that can be treated "in situ".

2. Expenses for glasses, contact lenses and crutches, as well as the acquisition, implantation, replacement, extraction and/or repair of prostheses and anatomical and orthopaedic parts of any kind.

3. Medical, surgical and pharmaceutical expenses prescribed in Spain even if they are the result of unexpected illnesses or accidents occurring abroad and those of less than €6.

CLAIM PROCEDURE

The benefits established above will be provided at the express request of the insured by phoning 34 915 143 611 or by fax on 34 915 149 950.

The Insured will call the above number, give his full: name, Asisa health care insurance contract number, location, address, telephone number and the nature of the assistance required or problem to ensure the provision of services with the greatest diligence, 24 hours a day, including Sundays and holidays.

In case of force majeure preventing this notification, **it must be reported as soon as the cause preventing it ceases.**

To reimburse any expense, go to https://asisa.eclaims.europassistance.com, to access "Online Procedures", initiate your own reimbursement request and monitor the process, or go to Post Office Box 36316 (28020 Madrid). **The submission of original invoices and supporting documents is essential in all cases.**

DEBT RECOGNITION

All amounts paid by the insurer, or the cost of the services provided, at the request of the insured and that, by virtue of this contract, are not paid by the insurer, constitute advances accepted by the insured, **who is obliged to reimburse them to the insurer within 30 days of the insurer requesting this.**

In these cases and for all other benefits in which the insurer advances a payment to the insured, **it reserves the right to request sufficient guarantee or surety from the insured before starting the provision of the service.**

SUBROGATION

The insurer is subrogated up to the total cost of the services provided by it for the rights and actions that motivated its intervention. When the benefits carried out in

execution of this contract are covered in whole or in part by an insurance company, by the Social Security or by any other institution or person, the insurer will be subrogated in the rights and actions of the insured against the aforementioned company or institution. For these purposes, the insured undertakes to actively collaborate with the insurer by providing any help or granting any document that may be considered necessary, at no expense to the insured.

The insurer will have the right to request proof of transport from the insured (e.g. train or plane ticket) held by the insurer, when the return expenses have been borne by the insurer.

ASISA SALUD INSURANCE CONTRACT

ADDITIONAL TERM: Acceptance of limiting clauses

The Policyholder declares he has received a copy of these General Contract Conditions and specifically accepts the clauses appearing in it that limit rights, highlighted **in bold typeface**. Below is a written record of this acceptance.

....., from.....from .....

Signed: ..... Policy number:.....

ASISA SALUD INSURANCE CONTRACT

ADDITIONAL TERM: Acceptance of limiting clauses

The Policyholder declares he has received a copy of these General Contract Conditions and specifically accepts the clauses appearing in it that limit rights, highlighted **in bold typeface**. Below is a written record of this acceptance.

....., from.....from .....

Signed: ..... Policy number:.....

PLEASE CUT ALONG THE DOTTED LINE AND
RETURN SIGNED

AIG3970I M-03-22

asisa

Asisa **Contrata**
900 10 10 21

asisa.es